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INSANITY, INTIMACY, AND INSTITUTION: GOVERNANCE AND CARE UNDER THE MENTAL HEALTH LEGAL REFORM IN CONTEMPORARY CHINA

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Eight years ago, I arrived at Hyde Park, not having a clue about anthropology, graduate studies, or the United States. Eight years later, as these words appear on the computer screen, I am setting off for another destination. Although I am again not quite sure what lies ahead, at least this time I have a dissertation in hand, reminding me of what I might achieve with all the guidance, friendship, and love from others.

Foremost I wish to express my appreciation to the members of my dissertation committee. Soon after I decided to come to the University of Chicago, Judith Farquhar got in touch with me and gave me a precious opportunity to work on—or rather, learn from—her research. Since then, she has been tirelessly showing me the beauty of anthropology. She allowed me the freedom to do whatever I want, while always nudging me to go a bit further and be a bit more creative. She is a rigorous thinker, but she always engages with students' works and words in a generous spirit. This gave me warmth and confidence that I, as an international student, desperately needed. Whether in Chicago, Chapel Hill, or Beijing, whether in person, by phone, or via email, she always made herself available for graduate student consultation. Judy has been, and will continue to be, my lighthouse in academia and in life.

Even before he formally assumed the faculty position at Chicago, Eugene Raikhel had been advising me on my Trial Research thesis. From then on, he has read and commented on countless drafts of my thesis, grant proposals, and journal article submissions. Eugene was mindful of my professional development. He took me to lectures out of town, introduced me to scholars who might be interested in my work, and invited me to be a teaching assistant and then a guest speaker at his popular course *Culture, Mental Health, and Psychiatry*, a course highly relevant to my research. In the 2015 Society for Psychological Anthropology Biennial Meeting, Eugene offered to organize a panel with me on the specter of institutionalization in psychiatric reforms around the world. That panel helped me think through many issues in my dissertation. I am also grateful for his advice, when I was most uncertain about continuing with graduate studies, that one should persevere and not think about Plan B when striving for intellectual achievements.

While I appreciate other teachers' generosity to my work, I am also indebted to Don Kulick's strictness. In his weekly "lab" with students, he challenged us to write in a clear, succinct, and jargon-free way, questioned our research with "so what," and asked us to show our work ethics by sticking to deadlines, time limits, and so on. The training might be painful, but it showed me a path out of the disorienting experience of dissertation writing. My research also benefited from Don's idea of vulnerability as a starting point of ethics.

The *Narrative* seminar that Susan Gal offered in my first year opened a new world called semiotic analysis for me. In our conversations, she urged me to pay attention to discursive constructions of the public/private divide, to routes of translation, and to entanglements of discourse and institution. With her work in Eastern Europe, Sue was always able to give me comparative insights on post-socialist experiences.

Teachers outside of my committee, or even outside of the University of Chicago, have helped me in various ways. Richard Taub's urban ethnography course sharpened my perspective as a fieldworker. Although he was only my first-year advisor, he continued to give me emotional support and practical advice through laid-back conversations. As the outside reader of my dissertation proposal, Kaushik Sunder Rajan asked me incisive questions, warning me against applying Foucault's historical narratives directly onto China. His course *Health, Value, and*

Politics pushed me to think more deeply about political economy. Summerson Carr reminded me to put Chinese mental health in the context of global circulations. I also appreciate her difficult yet important questions for my work, such as institutional processes of community mental health, my own attitude toward drugs, and my definition of paternalism. Angela Zito at New York University pointed out the pivotal role of filiality in imperial Chinese kinship and kingship. She also suggested that I organize an AAA panel on contemporary Chinese families, which turned out to be an inspiring conversation. Hsuan-Ying Huang, now at Chinese University of Hong Kong, impressed me with his encyclopedic knowledge on Chinese psychotherapy and psychiatry. He was munificent in sharing his knowledge and connections.

At the University of Chicago, support from department administrators might at times be invisible, but it is always indispensible. Whenever I was faced with bureaucratic troubles, Anne Ch'ien (Anthropology), Janie Lardner (Comparative Human Development), and Spencer Bonadeo (Comparative Human Development) quickly brought me peace of mind by patiently explaining to me the institutional procedures, sharing their experiences, and connecting me to relevant resources. As I juggled between two programs, they often went out of their way to explore the requirements I should meet, to communicate with faculty and staff at their own and/or the other departments about my needs, and to negotiate between different or even contradicting demands on my behalf.

In the difficult journey of graduate studies, fellow students at or beyond the University of Chicago have provided invaluable comradeship. As my first friend in the United States, Amir Hampel was always there to help when I needed suggestions on a paper or a presentation. Conversations with him never failed to inspire, be they on Nietzsche, on mental health, or on political culture in China. Michael Chladek is one of the most magnanimous persons I know.

During my distress, his words could always calm me down. I was fortunate to have both Jenny Miao Hua and Hiroko Kumaki as my interlocutors on East Asian medicines. Jenny read and commented on some of my chapter drafts, and Hiroko kindly shared many relevant course materials with me. I also benefited from the help of more advanced graduate students (or 学长 /*xuezhang* in Chinese). Jason Ingersoll's work set a great example of anthropological studies on mental health in China. Conversations with him were critical in the early formulation of this project. As my graduate student mentor, Aaron Seaman frequently checked in with me on my academic and personal life. He sent me news or journal articles relevant to my research, and we often compared notes on family and care in China and in the United States. Julia Kowalski helped me revise one of my earlier publications. In Spring 2014, Julia and I organized a panel on rethinking care as labor at the Society for Cultural Anthropology Conference. It was on that panel that I first compared *guan* with care, and came to see *guan* as a central notion in my dissertation.

Comradeship can also come in groups. Hayden Cantor, Ender Ricart, and Tal Liron demonstrated tremendous patience, commitment, and critical sensibility in reviewing many of my dissertation chapter drafts over the course of our writing group meetings. Without their insightful and candid comments, I certainly would have been much the worse in composing initial chapter drafts and submitting them to my committee. My feminist reading group with Mengqi Wang, Yige Dong, and Yang Zhan became a safe space for all of us, where we valued careful engagement with texts and with each others' thoughts, where we could expose our vulnerability without feeling judged, where we dared to connect everything personal to the political and the academic. As a former student coordinator and then a frequent participant, the *Medicine, Body, and Practice Workshop* (lately renamed as *Medicine and Its Objects Workshop*) provided an intellectual home for me. Not only did I present my work and receive useful feedbacks, but I also basked in the truly interdisciplinary dialogues there.

This project, or my graduate studies as a whole, would never have been possible without the generous financial support I received from a number of organizations. Besides my five-year graduate studies fellowship, I was also fortunate to receive a number of ad hoc grants from the University of Chicago, including research funds from the Human Rights Program (2012), a summer research grant from the Beijing Center (2012), an overseas research travel grant from the Division of Social Sciences (2012), a Rynerson Fellowship from the Department of Comparative Human Development (2012), a summer grant from the Division (2014), and a William Rainey Harper Fellowship (2015-2016). The Lemelson/Society for Psychological Anthropology Pre-dissertation Fund (2010) helped turn my small Masters research into a more ambitious dissertation project. Thanks to an Andrew W. Mellon Foundation Research Fellowship, I visited Needham Research Institute, Cambridge, U.K. for three months in 2011, where I conducted archival research on madness in China and conversed with great scholars on Asian medicines. My dissertation fieldwork was also supported by a small grant for research travel from the China and Inner Asia Council of the Association for Asian Studies (2012), as well as a Henry Luce Foundation/ACLS Pre-dissertation Grant for China Studies (2013). The New Generation China Scholar Fellowship (2013), co-sponsored by Ford Foundation and the University of Chicago Beijing Center, allowed me to share my research with, and learn from, junior scholars from China and the United States. Finally, a doctoral fellowship from Chiang Ching-kuo Foundation gave me financial security to perform the dual tasks of dissertation writing and job search in 2015-2016.

The eight years of my graduate studies have also been eight years of radical changes in my parents' life. I often feel sorry for not being able to be at their side. But they have always shown unlimited understanding of and unwavering support for my intellectual pursuit. My fieldwork in Guangzhou would not have been so successful without their instrumental help. More importantly, my parents' experiences with and perspectives on social transformation are the first personal histories of China that I have ever learned, which fueled my interests in China Studies. Their devotion to work and insistence on social justice have helped set the moral compass of my personal and academic life.

I dedicate this dissertation to my husband Dongzhou Zhang. Because of love, he gave up his comfortable life at Pasadena and followed me to Chicago, only to find me having to leave for fieldwork for a year and a half. When I came back, I was always tied to the desk. He never frowned, but simply shouldered the lion's share of housework. Many evenings, when he drove me back from Hyde Park to our home at Westmont, I talked on and on about my research or other stray observations on sociocultural issues. He always listened attentively, asked me stimulating questions, and pushed me to think in a more logical way. All theory is gray, but the golden tree of love springs ever green.

In the very end, despite all said above, this dissertation is owed to all the participants who agreed to share with me their experiences with mental illness, family relations, and/or psychiatric institutions. I kept returning to this topic and to the field sites, all because of my participants' trust in and expectations for me, their suffering, frustrations, and aspirations, as well as our friendship that accrued over the years. Because of privacy concerns, I can only use pseudonyms for anyone who is not a widely acknowledged public figure, but all participants live vividly on my mind. If my brief companionship made them feel slightly better, if my publications will make small but positive changes in their lives, then my past eight years of struggle were totally worth it, and so will be my future academic life.

ABSTRACT

Over the last three decades, most psychiatric inpatients in China have been hospitalized against their will, by their families. Despite intense public discussion on patient rights over the last ten years, the first national Mental Health Law, effective since 2013, has reinforced the family's rights and responsibilities in psychiatric care. The family's involvement is inscribed in a technico-administrative discourse of risk management. It is also inscribed in the law's central motif of 管/*guan*, a polysemous word that can refer to concerning oneself with and being responsible for another individual, and/or to managing, governing and control. The family, as it is conceived in the Mental Health Law, thus becomes a primary unit to mediate individual liberty, wellbeing, and population security in post-socialist China.

Why does the family continue to occupy such a critical role in Chinese psychiatry? Although Confucian family ethics certainly have an enduring legacy, my research examines the family's involvement in psychiatry as technological, institutional, and ideological configurations. It explores their implications for the ethics, affects, and political economy of care and population governance in post-socialist China. To those ends, I conducted 32 months of fieldwork in psychiatric hospitals, community mental health teams, social work centers, family support groups, and human rights agencies, mostly in Guangdong. I also interviewed lawmakers, attended national conferences, and conducted archival and media analysis to understand historical developments and contemporary debates of Chinese psychiatry.

In China's mental health legislation reform, the notion of paternalism was used to justify involuntary commitment and surveillance by families. My research shows that this notion of paternalism allows the post-socialist state to fashion itself as humanitarian, while relegating to the families responsibilities to care for vulnerable patients and to prevent potential violence.

With its critique aimed only at the state and its inability to conceive of intimate politics, the human rights campaign has inadvertently reinforced this family-mediated, biopolitical paternalism. I argue that this biopolitical paternalism bespeaks the general tenor of post-socialist governance, which is shaped by conditions such as the retreat and uneven resurrection of the welfare state, and the rise of security apparatus.

My research also reveals that this paternalistic governance requires and transforms the family ethics of care. Existing literature on biopower attends to how biomedical knowledge shapes bodily discipline and population governance. Yet it often ignores how biopower is mediated by modalities of intimate practices, by people's desire and responsibility to care for the vulnerable other. In Chinese psychiatry, governance and care are entangled in *guan*, the central mandate of the Mental Health Law. Tracing how *guan* is invoked, defined, and enacted in everyday practices and medico-legal discourses, I show that mental illness is inscribed in a chronic trajectory of risks, requiring management in the form of medication and institutionalization. Families that *guan* thus come to shoulder responsibilities of financial provision, tasks of medical surveillance, and affects of ambivalence. Meanwhile patients long for the emotional ties but fear the intimate domination in practices of *guan*. However, family members may also flip the demand of *guan* back onto the state, asking the state to become a proper parent. My analysis of *guan* contributes to the anthropological and philosophical literature on care by revealing the intimate politics, ethical contestations, and political potentials in care.

Because biomedicine is redefining individual wellbeing and population security, and because neoliberal policies throughout the world tend to generate moralized discourses of private care to evade public responsibilities, this research provides a lived critique of biopolitical paternalism in and beyond China.

INTRODUCTION

On May 1, 2013, the first national mental health law in China came into effect. It was the first law to proclaim that patients with mental illness are sovereign individuals, with rights to autonomy in hospitalization and discharge. Cutting across this idea of autonomy, however, is the mandated subjection of the patient to his family's guardianship. The law grants family members the rights to consent to patients' treatment and to decide upon involuntary commitment for those who pose an actual or potential danger to themselves. It also stipulates that families have the responsibility to provide for, look after, and monitor the patients. The law thus makes the family the pivot of a network of medical and administrative agents. In this network, the family not only directs the flow of patients in and out of the psychiatric hospital, but also constantly reports the patient's symptoms, risks of violence, and pharmaceutical compliance to community mental health workers. The family, as it is conceived in the Mental Health Law, thus becomes a primary unit to mediate individual liberty, well-being, and population security in post-socialist China.

Drafted by prominent psychiatrists, the mental health law's stipulation on family rights and responsibilities largely continues and legitimizes the de facto psychiatric practices which have arisen along with the development of biomedicine and the market economy in the 1980s. During this period, families were not only the main payer for expensive psychiatric treatment; they also decided upon most inpatients' hospitalization and discharge. According to a conservative estimate, in the early 2000s, involuntary admission by families accounted for 60% of all psychiatric inpatients, and involuntary admission by police or other public sector agents accounted for another 20% (Pan, Xie, & Zheng, 2003).

One might attribute the family's central role in psychiatric care to an unchanged culture of Confucian familism (Lin & Lin, 1981). Yet, if we take a historical overview, we find that the family's role in Chinese psychiatry has not always been central or uncritically accepted. For example, in the Maoist era, although mental health care in China was less professionalized and received less government and public attention, more agents were involved in the care of mentally ill patients. Those agents included not just families, but also work units, neighborhood committees, the police, local governments, and so on. Furthermore, the service that was provided was more diverse, eclectic, and community-based. It has only been since the market reforms in the 1980s that families have gradually come to be the key agents in securing biomedical and institutional treatment for patients. Moreover, in the past decade, human rights activists in China have launched a vehement attack on the prevalence of involuntary hospitalization and on families' involvement in it. It was thanks to the pressure exerted by these human rights activists that the drafting of the Mental Health Law, which began in 1985, finally gathered speed and was passed by the National People's Congress in October 2012.

This book thus examines why, despite these historical contingencies and contemporary challenges, the family occupies such a critical role in psychiatric care in China, especially today. I examine the family's involvement in medicine as technological, institutional, and ideological configurations, and explore their implications for the ethics, affects, and political economy of care and population governance in post-socialist China. Data is drawn from my 32 months of fieldwork (2008-2014) in a variety of settings engaged in serving, monitoring, and challenging the family in psychiatric care. They include psychiatric hospitals, social work centers, family support groups, and human rights agencies, mostly in Guangdong. I also interviewed lawmakers, attended national conferences, and conducted archival and media analysis in order to understand historical developments and contemporary debates within Chinese psychiatry. Through exploring the family's role in psychiatry, we will arrive at a conjunctural terrain on which more sweeping trends of subject formation, intimate association, expert practice, and population management in post-socialist China can be revealed.

Theoretical/Historical Currents

The Family in Modern Chinese History

An examination of the family's role in times of mental illness draws on, and also contributes to, the broader history of the family in modern China. Particularly pertinent to this study is the history of how the Chinese family has been reconfigured as both an ideological and an institutional construct, and how such constructions have shaped the practices, ethics, and affects of family life.

As a state-sponsored ideology throughout most of the Imperial China, Confucian thoughts generally ran on "family-state isomorphism" (家国同构/*jiaguo tonggou*); that is, the assumption that the family and the state are constructed on the same ethico-ontological principles (Shu, 2003). Since the late 19th century, the family has been a focal point of the struggles between competing cultural imaginaries of personhood, of state-society relations, and of the relationship between tradition and modernity in China (Barlow, 1993). As a hallmark of liberalism in modern China, the "New Culture Movement" of the 1910s traced many evils of traditional Chinese society to a patriarchal Confucianism, which had presumably subjected individuals to inhumane moral codes, heavy kinship responsibilities, and distortions of personality. Literary and social discourse from that time on were suffused with the metaphor of breaking the "iron cage of the feudal family" in the service of individual freedom, romantic love and national citizenship (Glosser, 2003; H. Lee, 2007). The Nationalist (1912-1949) and Maoist (1949-late 1970s) governments both launched social campaigns and policy reforms along these lines. For examine, the 1950 Marriage Law not only abolished polygamy and arranged marriages, but also established women's right to divorce. It thus congratulated itself for "upending patriarchal domination and protecting the proper interests of women and children" (Glosser, 2003, p. 170). As such, the "patriarchal" Chinese family has become a cultural indicator of backward tradition, the antithesis of diverse modernizing projects that seek to establish the rights-bearing individual or the revolutionary citizen.

In most sociopolitical discourses, the emphasis on the rights-bearing individual in diverse social projects is ultimately tied to strengthening and modernizing the nation-state. To aid this latter aim, the family—this time imagined as a heterosexual marriage and a nuclear family—often returns in different ideologies as a telos for individual development, as a safe haven from political chaos, or as a source of moral value for social stability (Stacey, 1983). In its 1930's New Life Movement, the Nationalist government reclaimed ritual propriety and filial piety as virtues that had informed ancient Chinese civilization, and that would be conducive to social stability and state-building (Dirlik, 1975). The Socialist government when it gained ascendancy in 1949 did not reclaim the Confucian tradition, but it did seek to mitigate its revolutionary promise of gender equality by supporting peasants' demand for intact, well-functioning families. Therefore, in the 1953 and 1980 versions of the Marriage Law, the goal of marriage and family life was set: the standard family would maintain domestic emotional relationships (*ganqing*) (P. C. C. Huang, 2005), which in turn would serve the production and reproduction needs of the modern state (D. Davis & Harrell, 1993). Of course, the state itself, by organizing citizens' lives through its communes and work units, served as an overarching "parent state" that overshadowed individual households in many regards (Walder, 1988).

The post-socialist era (late 1970s to present) has seen the renunciation of many socialist values. For example, collectivization is now seen as having destroyed Confucian virtues, eliminated private life, and produced general economic apathy. In reaction, policy and popular discourse in the new era have enshrined the family as a biologically, culturally, and economically essential unit of social life. For example, the year 1982 saw the establishment of the household contract responsibility system, which sought to return the agency of economic production not to the individual or to the firm, but to the family. This enshrinement of the family is intertwined with the devolution of welfare systems. In 1996, for example, the Law on Protection of the Rights and Interests of the Elderly was passed. The law claimed to "promote the Chinese people's virtues of respecting and providing for the elderly," but the familial provision and care that it requires is financial as well as emotional and physical (NPC, 1996). The family is not just the site from which the state retreats. Especially in the post-socialist era, the state's institutional powers have increasingly intervened into family life to produce a newly imagined normality. In 1982, family planning (计划生育/*jihua shengyu*)—or what English speakers usually call the "One-Child Policy"[1]—became one of the post-socialist regime's basic national policies. It has made the married couple into the unit and agent of population control, and has allowed the state to directly reach women's bodies (Greenhalgh, 2008).

Different ideological imaginaries of the Chinese family have been drawn upon in both everyday practices with mentally ill patients and national debates regarding mental health legislation reform. They allow people to articulate their normative views of rights and

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[1] The policy's target was always more complicated than "just one child." As of Oct. 2015, even the more stringent requirement of "just one child" was relaxed, becoming a "two-children policy" (Jiang & Cullinane, 2015).

responsibilities, of freedom and constraint, of professional expertise and intimate care, and of what constitutes legal reform and historical progress. For example, while human rights activists have invoked the trope of the oppressive patriarchy in order to promote patients' right to autonomy and the rule of law, the idea of the caring family as China's cultural backbone has at the same time allowed policymakers to legitimize the rollback of the welfare state. Because of people's familiarity with and historical attachments to them, these imaginaries have been particularly potent in mobilizing (or forestalling) policy change. The policies that are built on these imaginaries have in turn allowed institutional powers to intervene into everyday family practices with mentally ill patients. By examining the ideological imaginations of and institutional interventions into the family in times of mental illness, this book will thus chart the making of the ethical and political landscape within which the Chinese state and its citizenry relate to its vulnerable populations.

While imagery of the family has helped to articulate the sociopolitical conditions of modern China, the latter in turn have also shaped families' socio-economic strategies, power relations, ethical practices, and emotional dynamics. Anthropologist Yunxiang Yan has argued that in the post-socialist era, many people choose to only live with their nuclear families because of a relatively novel ideological predominance of conjugality and privacy, large-scale internal labor migration, and the rise of the private real estate market (Yan, 1997). However, other scholars contend that especially in trying times such as those of sickness and elderly care, more flexible patterns of living, mutual assistance, and family membership are often arranged among a wide network of kin relations (Phillips, 1993; Whyte, 2005). Taking a cue from this observation, this study does not assume residence, conjugality, or blood relations as the only definition of family. Instead, I examine how people in practice invoke the term “family,” designate its membership, draw its boundaries, and determine its powers in different circumstances.

Recent studies of Chinese families have moved away from depicting formal kinship organizations and roles to studying material, emotional and ethical practices of making relatedness, such as practices of 养/*yang*—raising and caring for—that often constitute the parent-child relationship (Stafford, 2000). Scholars have noted that these relational practices are often charged with inequality and ambivalence. Take for example the character 孝/*xiao* (filial piety), which is constructed of an elder (老) positioned above a son (子). According to Charlotte Ikels, the preferred reading of this character in Confucianism is that the young support and respect the old. But it can also be read as the young being burdened, or even oppressed, by the old. Or, if we consider the temporality of character writing (from top to bottom), it can also mean the son continuing the father’s family line. Corresponding to this ideographic multiplicity, “in the classics and in popular thought, support, subordination…and continuing the family line have all been touted as the essence of filial piety” (Ikels, 2004, p. 3). While this ambiguity is always present in the notion of filial piety, it has been transformed by conditions of the market economy. Ikels has found that nowadays, after they invest heavily in children’s education and marriage arrangements, elders have to worry about whether they can depend on their children’s recognition and care. The sacredness of parenthood and of unconditional filial piety have been demystified and transformed into a contractual relationship of material reciprocity. Nevertheless, other scholars have shown that liberalism’s emphasis on private affects has reworked the emphasis in filial piety from ritual propriety to emotional responsiveness in intergenerational relationships (Evans, 2010).

Drawing from these insights, this study examines how people navigate socio-economic conditions and welfare resources to look after their family members with mental illnesses, in particular the material strategies, household arrangements, and emotional exchanges involved in such practices. I pay specific attention to native notions of relational practices, such as the character 管/*guan* that encompasses care, control, and management in hierarchical relations. Like the literature on *xiao* (filial piety), I am interested in how ideological, institutional, and socio-economic conditions transform how people conceptualize, practice, and experience these culturally ingrained notions of social relations in times of mental illness. Similar to the way in which the ideographic multiplicity of *xiao* generates practical ambiguities, I examine how the multiple meanings of *guan* and their historical transformations generate ambivalence and contestation in familial practices. Such ambivalence is analytically productive, because it reveals how people grapple with different—and at times conflicting—visions of family life and power relations, as well as "the potentially jarring and traumatic disjunction between heavily idealized expectations and oftentimes painful experience'' in kinship (Peletz, 2001).

Between Biopower and Care

Besides revealing the ideological imagery about, institutional interventions into, and everyday practice of the family in contemporary China, a study of the family's involvement in psychiatric care can also further our theorization of the relationship between care and biopower in general. As Michel Foucault has famously argued, modern nation states have developed in tandem with the rise of biopower, that is, the set of knowledges, experts, and institutions "through which the basic biological features of the human species became the object of a political strategy, of a general strategy of power" (Foucault, 2009, p. 1). This biopower is not a substance oppressing the subject from the top; rather, it is dispersed into the "microphysics" of actions and relations. Correspondingly, Foucault turns our attention from the government of the central state to what he calls governmentality, that is, a "plurality of governing bodies and the practices, techniques and rationalities through which governing is accomplished and authority exercised" (Dean, 1998, p. 133). Governmentality shapes how people conduct the conduct of themselves and others. It constitutes subjects that are either subjugated to "someone else by control and dependence," or tied to their own identities "by a conscience or self-knowledge" (Foucault, 1982, p. 781).

Chinese psychiatry is a mechanism of power, more specifically biopower, for it relies on biomedical, legal, and other allied knowledges to define who mentally ill patients are, in order to subject them to discipline and management. Taking cues from this Foucaultian literature, this study focuses not on a specific institution, but on a variety of institutions and actors that interact with patients and their families. I pay attention to how these diverse techniques and rationalities may or may not converge to form dominant forms of governmentality. However, I do have a qualm about reading psychiatry purely through the lens of biopower. Following Foucault, existing literature on biopower has emphasized how formal institutions and professional experts—or the knowledge they instill—serve to discipline the individual body[2] or regulate the population (the latter function also called biopolitics).[3] But in everyday life, those who are deemed pathological also closely interact with their family members and other caregivers in intimate settings, as well as in institutional or public non-institutional environments. Power strategies in these interactions cannot be separated from people's ethical visions and emotional experience with one another. How, then, does institutional discipline and regulation necessitate,

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[2] In the Chinese context, e.g. (Chiang, 2010).

[3] For the definition of biopolitics, see (Foucault, 1978, p. 140). For an example of biopolitics in China, see (Rogaski, 2004).

transform, and even become destabilized by modalities of intimate practice? How does biopower constitute not only subjects to be disciplined and regulated, but also subjects that care and the entity called "the family"? These are questions that have largely been ignored in the literature on biopower.[4]

For discussions on intimate engagement with the sick and other vulnerable people, scholars have lately turned to the concept of care. In her 1995 book *Maternal Thinking*, Sara Ruddick argued that maternal practice is characterized by the demands of preservation, growth, and social acceptance; that these demands are met by works of preservative love, nurturance, and training; and that such work is done through activities such as scrutinizing, holding, and concrete thinking (Ruddick, 1995). Since Ruddick, a feminist ethics of care has emerged to analyze and promote such maternal practices, seeking to counter a masculine ethics that appears to be based on the social contract between self-interested individuals (Kittay, 1999). Some of this literature has also been inspired by Emmanuel Levinas's argument that human beings are primarily constituted by our ethical responsibility to suffer for the suffering of others (Levinas, 1988). More recently, Arthur Kleinman has pointed us to an art of caregiving that acknowledges and affirms the suffering subject, and that values everyday, lived moral experience. An attention to care, he argues, should help us transcend a purely scientific and technical notion of medicine (Kleinman, 2009a). Following these scholarly traditions, we can read the workings of

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[4] Foucault himself analyzed how the family functioned as a node of biopower in Europe in the 18th and 19th centuries. In his study on the rise of sexuality, certain disciplinary subjects emerged from medicine and psychiatry and became the privileged objects of knowledge, including "the hysterical woman, the masturbating child, the Malthusian couple, and the perverse adult" (Foucault, 1978, p. 105). Correspondingly, family members (esp. parents) became doctor-figures, closely monitored and corrected each other's behavior and psychological status, and built alliances with the experts by offering to the latter the private truth of the individual (Foucault, 2006). In such processes, the family became a site where sexual desires were incited through prohibition, both circulated and regulated. Following Foucault, Jacques Donzelot has analyzed how, in France since the 18th century, there has been a transition from "a government of families to a government through the family" (Donzelot, 1979). While these historical analyses have given us inspiration, few studies have followed in their footsteps. Their findings are also not directly applicable to situations in post-socialist China.

contemporary psychiatry as hinged upon an ethics of care, because in seeking treatment for the mentally ill patient, family members assume responsibility for those vulnerable others and in some sense explore visions of the good life (Mol, Moser, & Pols, 2010). This study will pay attention to the moral visions and affective exchanges in family members' engagement with mentally ill patients.

However, as Tom Shakespeare has argued, the literature on care sometimes tends to idealize care, treating it as spontaneously springing from loving family feelings (Shakespeare, 2006). Anthropologists might protest Shakespeare's criticism by saying that they have studied the institutional arrangements of care, especially those that condition paid or unpaid care (Buch, 2013), and that lead to a lack of care, such as confinement, neglect (Scheper-Hughes, 1993), or abandonment (Biehl, 2005). Yet in making an analytical presupposition of what is care and what is not, instead of listening to how actors themselves make (or do not make) the distinction, some of these studies turn care from a category for empirical investigation into a normative assumption. They thus risk treating practices of care as impervious to ethical ambivalence and microphysical power dynamics. In our case, when family members commit patients to the hospital, the former may claim that their actions are care, and they may indeed have the best intentions for the patients. However, the patients often refuse to recognize such caring intentions, treating the involuntary commitment as ill-willed confinement or abandonment. We need to know what makes people see these practices in different or even opposing ways, as well as the consequence of this divergence.

On the other hand, some philosophers do want to promote care as a pre-defined normative category that can provide an ethical foundation to politics.[5] This proposal deserves much respect, but we need to know how it might work empirically, in concrete sociopolitical conditions. For example, can the way in which people define and enact care in everyday life shape how welfare is distributed, how law is made and implemented, and so on?

By examining families' interactions with medical and legal institutions in times of mental illness, this study can bridge the literatures on biopower and care. Specifically, this book will address how biopower requires and transforms care, as well as the ethical ambivalence, power relations, and political potentials in the provision of care (or whatever people come to call their intimate practices with those who they deem as vulnerable) in all its practical heterogeneity.

One way to look at the relationship between biopower and care is through examining the relationship between risk and vulnerability. In Chinese psychiatry, the management of "risk" is an important aspect of biopolitical governmentality. For example, in the new Mental Health Law, the only patients who can be involuntarily hospitalized are those who pose risks to (or in the law's language, "have the danger to endanger") ((NPC, 2012c), Art. 30.) themselves or others. Foucaultian scholars have pointed out that risk is a mechanism by which the future is brought into present calculations, and through which the population is monitored and managed. While it asks everyone to be a prudent manager of one's own risks, this mechanism highlights specific risk groups, such as people diagnosed with severe mental illnesses in our case, that need to be disciplined by others (Lupton, 2013). Following the Foucaultian tradition, this study defines risk as an ideological and institutional construct, and examines how patients are constituted in risk management.

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[5] Examples include Levinas's claim that "it is ethics which is the foundation of justice" (Levinas, Wright, Hughes, & Ainley, 1988, p. 175), Eva Kittay's notion of "connection-based equality" (Kittay, 1999, p. 28), and Martha Nussbaum's (2006) capabilities approach.

However, the danger, suffering, uncertainty, and inability that people—including but not limited to patients—experience in everyday life may or may not be encompassed by the category of risk. Scholars concerned with ethics, including the ethics of care, call this lived experience vulnerability. They argue that human beings are all vulnerable, but that the extent and specific experience of vulnerability varies through time and between persons. Attention to vulnerability reveals our fundamental dependency on each other. Vulnerability may allow us to engage with and take responsibility for each other, and to redistribute resources in a more just way (Derrida, 2002; Kulick & Rydstrom, 2015; Nussbaum, 2006). However, as Nancy Fraser and Linda Gordon have pointed out, in neoliberal societies where the self-interested and productive individual is enshrined as central, public policies' denigration of dependency and vulnerability may add vulnerabilities to not just the care receiver, but also the caregiver. It generates a "secondary dependency" for caregivers on subsistence providers (the household head, other institutions, and the state) (Fraser & Gordon, 1994, p. 527).

Risk management in Chinese psychiatry also follows a neoliberal logic, in that the family as a private agent is tasked with monitoring the risk posed by the patients, in order to protect public order. Thus, this study examines how a risk management discourse shapes family caregivers' interactions with patients. Specific attention will be paid to whether the medico-legal emphasis on risk allows vulnerability to be addressed, or whether it elides, reshapes, or even increases people's vulnerabilities. Meanwhile, I will consider whether the ways in which people engage with each other's vulnerabilities in daily life may exceed or disrupt the logic of risk management.

Paternalism as a Medical Ethic and a Political Ideology

Both the de facto psychiatric practice in the Reform Era and the new Mental Health Law grant family members the right and authority to make medical decisions for the patient, because presumably "mother/family member knows best." Therefore, by looking at how medical and legal institutions configure the role of the family in psychiatric care, we can gain insight into the ethics and politics of paternalism.

Discussions of paternalism are often found in the literature on medical ethics. This literature often quotes philosopher Gerald Dworkin's definition of paternalism, that is, "the interference with a person's liberty of action justified by reasons referring exclusively to the welfare…of the person being coerced" (Dworkin, 1972). Other scholars have made revisions to this definition. For example, Simon Clarke argues that paternalism need not be coercive, interfere with liberty of action, or be against one's will; the only requirement is that an option is foreclosed or a choice is made for a person in order to promote his welfare (S. Clarke, 2002). In any case, grounded in liberal individualism, this literature is concerned with whether paternalism really helps realize the individual's best interests, and whether it is justified to claim a person as incapable of self-determination (Buchanan, 1978; Bullock, 2012). However, it ignores how the very definition of the individual subject is shaped by different scientific discourses and sociopolitical conditions, in relation to different imaginations of the social order. In the recent mental health legislation debate in China for example, psychiatrists who drafted the law did invoke the medical ethics notion of paternalism to justify involuntary hospitalization. However, the way in which the target of paternalistic intervention was imagined was tied to the psychiatric vision of ab/normality. Moreover, this paternalism was aimed at not just protecting the vulnerable patients, but also protecting society from their potential violence.

Pertinent to our discussion here on the sociopolitical conditions of paternalism, social scientists have pointed out that socialism—both the Eastern European and the Chinese versions—often ran on a model of state paternalism. It asked citizens to identify themselves as workers, cultivating their political, socioeconomic, and personal dependence on the revolutionary state and its institutions, while the state in turn promised fair and equal distribution of resources (Verdery, 1996; Walder, 1988). Currently, we are already in an era of post-socialism, when forces of marketization, privatization, and global capital entangle with "the lingering effects of socialist institutions and practices" (Li Zhang, 2001, p. 179).[6] We have to ask to what extent the promises of state paternalism are still upheld, and who actually assumes the authority and responsibility of being paternal. Also, now that many socialist values have been destabilized, one also wonders what political and scientific discourses come to constitute the target and the agent of paternalistic practices. Moreover, the notion of paternalism, whether as a medical ethic or as a political ideology, implies its agent to be omniscient (always knowing what's best for the target), omnipotent (always interfering successfully), and thus ultimately masculine. However, in everyday life, paternalistic interventions are often carried out by vulnerable, rather than powerful, agents. For example, family members who paternalistically manage mentally ill patients in China are often women and the elderly. The gendered implications of paternalistic practices are thus worthy of examination.

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[6] In this article, Li Zhang uses the term "late socialism" instead of "post-socialism," in order to "avoid implying that current social transformations in China will necessarily lead to the demise of the socialist regime (pp. 196). However, most of the scholars who I have seen invoke the concept "post-socialism" do not imply this capitalist teleology (e.g. (Farquhar, 2002; Rofel, 1999)). In fact, just like the term "postmodernity," the "post-" in "post-socialism" conveys the reflexive stance people take toward past formations of socialism. This point will be clear in Chapter 2. Therefore, in this book I choose to use the term "post-socialism." In a later publication, Aihwa Ong and Li Zhang also go back to the concept "post-socialism." (Ong & Zhang, 2008)

By looking at how families intervene into patients' lives through psychiatric and other means, including the socioeconomic conditions, discursive legitimation, and practical consequences of such interventions, this study can address the questions above. It will thus illustrate how paternalism is enacted both as a medical ethic and a political ideology in post-socialist China.

Guan and the Rise of Biopolitical Paternalism in Post-Socialist China

This book examines the family's involvement in medicine as technological, institutional, and ideological configurations. My fieldwork, which I will detail soon, shows that a prominent way in which the role of the family is configured in relation to the severely mentally ill patient is one of *guan*. *Guan* is a Chinese word and Chinese character. It is technological, institutional, and ideological. In classical Chinese, and often still in contemporary colloquial parlance, a character often constitutes a word in and of itself. Such single-character words are usually polysemic; that is, they have two or more somewhat related meanings, and the context in which such a polysemic monosyllable is uttered often—but not always—helps to specify its meaning.[7] In modern Chinese, especially in written language, these same characters often become monosyllabic morphemes. Two or more characters can combine to make a single word, whose meaning is often more specific. So depending on the context and the word combination, *guan* can refer to concerning oneself with and being responsible for another individual, and/or to managing, governing, intervening, and control.

Here is an example that illustrates the everyday practice of guan and its intricacies: One day in fall 2013, I accompanied Mrs. Yuan, a woman in her late fifties, to visit her daughter Tingting in a locked psychiatric ward in Guangzhou. Two months before, when Tingting had

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[7] See Chapter 6 of (Cruse, 2004).

been disturbed and rendered sleepless by her chaotic experience both at work and in her love life, Mrs. Yuan had taken her to the hospital, telling her that it would just be for a brief check-up. However, Tingting had been kept on the ward ever since. Now that Tingting's condition had been stabilized by medication, Mrs. Yuan felt the need to plan for Tingting's life after discharge. As Mrs. Yuan saw it, Tingting's workplace had proven to be too stressful an environment. In fact, any job that required Tingting to work "outside" on her own would probably expose her to undue stress or unhealthy romantic relationships. It would also make it impossible for Mrs. Yuan to monitor her daughter's medications. So without Tingting's knowledge, Mrs. Yuan had sent a resignation letter to Tingting's company, and had bought a small storefront near her home, in the hope that she and her daughter could run an herbal tea stall together. On the ward, Mrs. Yuan presented her plan to Tingting with a big smile on her face, saying, "From now on life will be more relaxing for you." "NO!" Tingting screams, "I'm 30 years old. I'm not a kid anymore. Why do you still want to control (*guan*) me?" "You're sick, Tingting," sighed Mrs. Yuan, "how can I not look after (*guan*) you?"

Here, the same action—the mother hospitalizing the daughter against her will, planning her future, protecting her from potential harm, and ensuring her medical compliance—was seen by the daughter as control, and by the mother as care. But their different ethical evaluations were contained within the same Chinese character, *guan,* as they supplied different contexts in which to understand the character (i.e. the daughter as an independent adult or as a vulnerable patient). The polysemy of *guan* thus allows an utterance of *guan* to be understood in ways not entirely predicted by the speaker. People constantly struggle over the practical contents, ethical evaluations, and relational implications of the term.

Guan is not invoked only in everyday family strife. Psychiatrists also use the language of *guan* as they teach family members to monitor patients' symptoms and pharmaceutical compliance. And they often use the different meanings and ethical evaluations of *guan* to admonish family caregivers when to intervene and when not. Moreover, a language of *guan* has also dominated the legal/policy texts produced and actively promoted by the central government. The new Mental Health Law highlights *guan* as a principle of mental health work. Article 6 stipulates "Mental health work operates on a comprehensive management (管理/*guanli*) mechanism, involving the collective participation of all facets of society…" ((NPC, 2012c), Article 6). Note that here, as in many other places of the law, *guan* appears in this "management/*guanli*" compound. (The other morpheme *li* could mean treating, handling, paying attention to, or bringing something to order.)[8] When a word combines two morphemes to make a more specified meaning, the morphemes themselves may also undergo a transformation in meaning.[9] For instance, when people now use the single character *guan* in their everyday interactions with mentally ill patients, the meaning that they invoke or that is taken up by the listeners might become tainted by the legal-administrative concept of management. In any case, while the law opens by requiring "all facets of society" to participate in *guan*, it quickly relegates this responsibility to the patients' families. Article 21 of the law stipulates: "If it appears that a family member may have a mental disorder, other family members shall help them obtain prompt medical care, provide for their daily needs, and assume responsibility for their supervision and management (*guanli*)."

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[8] Many of my informants were Cantonese. Besides/instead of using *guan*, they often used 理/*li* as a monosyllabic word when describing relationships with mentally ill patients. Yet the semiotic dynamics of *li* was similar to that of *guan*. And in slightly formal parlance, they often turned to *guan*. Therefore, in order to streamline the analysis, I will only pay attention to *guan* in this book.

[9] Here I differ from linguist Jerome Packard, who argues that for established words in Mandarin Chinese, "pragmatic modulation of lexical meaning occurs at the word rather than the morpheme level" (Packard, 2003, p. 394).

As a medico-legal mandate and a relational ethic, *guan* circulates between and ties together the state, medical and administrative agents, and families. Tracing how *guan* is invoked, enacted, contested, and transformed in its circulation provides a perfect entry point to studying the relationship between care and biopolitical governance. Moreover, as we saw in Tingting's case, *guan*, at least for the family member who performs it, means caring for the vulnerable by means other than intervening in her life and making decisions on her behalf. In the mental health legislation debates, lawmakers also invoked the family's authority, knowledge, and commitment in/to *guan* to legitimize involuntary hospitalization of patients. Therefore, examining the idealization and enactment of *guan* can provide insight into the ethics and politics of paternalism.

By examining *guan* and other medico-legal configurations of the family, this book will argue that a biopolitical paternalism has emerged in post-Socialist China. It constitutes mentally ill patients as subjects of perpetual risk management. The cultural ethics of paternalism lend ideological legitimacy to the post-socialist state's control over the population. Meanwhile, through the circulation of paternalistic values from the state to the medical professional and then to the family, the actual responsibilities of care and control end up falling on families, particularly female caregivers. This biopolitical paternalism thus produces desires, vulnerabilities, and even forms of violence within families.

Methodological Journey

Growing up in a rapidly transforming China, I was wary of any ahistorical argument that might portray Chinese culture as always, unproblematically family-centered. So although I had long been interested in psychiatry and mental illness, it took me a while to figure out that the role of the family was worthy of—or rather, desperately in need of—study. As a senior anthropologist[10] once told me, how we encounter and “figure out” what we want to study constitutes part of the empirical that we should account for. Or following Donna Haraway’s thesis on “situated knowledges,” researchers should be reflexive about how our embodied and locatable visions allow us access to the particular worlds we see, and also about our responsibilities to build better worlds with our interlocutors (Haraway, 1988). Therefore, in lieu of a standard methods section, let me recount the journey of encounters that has led me to the intersection of mental illness, families, and institutions in China.

Encountering Psychiatry, and the Family

My first encounter with psychiatry and mental illness took place during my college years in Beijing as a psychology major. In a psychopathology class, students went to a major psychiatric hospital to interview inpatients in order to assess their symptomatic manifestations. The patient whom I interviewed was a woman who had been hospitalized by her family members for schizophrenia for 11 years. I could easily follow the teacher’s instructions and fit the patient’s words into the authoritative disease categorization of the DSM-IV. Yet I was struck by the fact that the patient’s illness experience was entangled with her troubled family life, such as her stigmatizing childhood experience living with a schizophrenic father, and the indefinite separation from her family and the outside world that she was now experiencing. Ever since that encounter, I have been intrigued by the psychiatric hospital, and fascinated by how people’s experience with mental illness is shaped by, and reveals, sociocultural conditions of our times. Before long, this fascination led me to travel halfway around the world, to study cultural and medical anthropology in the United States.

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[10] I thank Angela Zito for her inspiring comments and dinner treat on the Lunar New Year’s Eve of 2015.

In the summers of 2008 and 2009, I began conducting fieldwork in Guangzhou Brain Hospital (GBH).[11] It was—and still is—a flagship psychiatric hospital in South China, housing 19 wards and nearly 2,000 beds in total. I chose it as a major field site, to which I would regularly return, because it allowed me to observe and analyze Chinese psychiatry in an optimal form. Unlike some elite hospitals in Beijing or Shanghai, however, the crowded space and the staff's heavy caseload at GBH made it similar to many other psychiatric hospitals in China. Furthermore, the large population of patients it attracted from the city of Guangzhou and the nearby region was socioeconomically highly diverse. My initial access to the GBH was facilitated by friends of friends, and by my bachelor's degree in psychology from one of the most prestigious universities in the country. Although the hospital itself was heavily biomedical, its administrators and doctors saw my presence as potentially beneficial to the patients. They also did not mind teaching serious psychiatry to a student from an emerging allied health profession. I was stationed on the adult psychiatry wards, which primarily housed patients diagnosed with schizophrenia and other psychotic disorders, along with some patients diagnosed with bipolar disorder or other mental illnesses. Every day I joined the staff for morning meetings and ward rounds, and observed psychiatrists as they wrote medical records or met with families in the office. When not much was happening in the office, I went inside the locked ward to chat with patients. Most of them liked talking with me, because no staff was interested in listening to their "ramblings," and because they were otherwise bored by life on the ward. Some patients were initially suspicious, but when they saw that I did not leak their peers' words to the doctors or the

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[11] Because of the uniqueness of my primary field sites, anonymizing them is meaningless. However, I use pseudonyms for every individual (staff, patient, family, and so on) who has not been involved in public policy debates. I also change some of their identification details. Because I have done supplementary fieldwork in other institutions of the same kind, I report my observation of these institutions as a whole when commentaries on a particular institution might jeopardize it.

visiting family members, and that my company could sometimes provide their peers with moderate comfort, they began to trust me as well.

I started out examining how doctors, patients, and families experience and explain schizophrenia. On the wards, I solicited people's illness narratives and explanatory models (Kleinman, 1980) through both semi-structured and unstructured interviews. Findings showed that some patients and family members used concepts from Chinese medicine or folk religions to supplement or resist the biomedical understanding of schizophrenia. I saw this tendency, at the time, as a way to reclaim a sense of agency and wholeness in their lives (Z. Ma, 2012). That pilot project was itself fruitful. Yet during fieldwork, I could not help but realize that almost all patients on the wards had been forcibly or deceptively hospitalized by their family members, and most of them were resentful of that experience. Some patients complained to me that their "symptoms" had been fabricated by their family members. There were other patients who might not question the validity of their diagnoses, but they feared being left by their families in the hospital forever. Because the hospital did not normally allow them to make phone calls, they often asked me to contact their families and urge their relatives to visit them. I initially hesitated, unsure whether that would jeopardize my status at the hospital, but I often eventually obliged. To my dismay, my phone calls did not change anything for the patients. When they silently sighed, it was hard for me to look the other way, focusing only on people's "beliefs" and their relationship with "Chinese culture."

Gradually, my focus turned to families' involvement in psychiatric care. I returned to the adult psychiatry wards and the outpatient clinic at GBH for brief follow-ups over subsequent summers and for longer-term fieldwork during 2013-2014. Through interviews and observation, I examined how patients and family members conceptualized and engaged in ethical practices towards each other, such as what it meant for a family caregiver to take responsibility for a patient, on what grounds the former claimed such a responsibility, and how this act of responsibility was performed and received. Attention was also paid to the power relations entailed in these ethical practices, such as whose voice was silenced, whose suffering went unrecognized, and the options that were open or foreclosed by particular family practices. Obviously, what patients and their family members perceived as ethical was often different, or even outright contradictory. Instead of adjudicating between these visions, I examined how the psychiatric institution (and allied institutions) conditioned such divergences by actively configuring the role of the family in relation to the patient.[12] I thus observed how doctors transformed family members' accounts into formal illness history records during intake interviews, how doctors taught patients the nature of their illnesses and the importance of medical treatment, and how family members were taught the proper ways to manage patients. I also recorded patients' and family members' understandings and challenges of such role configurations.

Note that because of this focus on institutional configurations of roles, in this book when I use identity terms such as "patient," I am following the customs of the field, instead of making any judgment on whether a particular person really has mental illness or not, or whether his/her illness warrants hospitalization. Similarly, "family members" or "relatives" (家属/*jiashu*) usually refer to members in a family who are not patients. While some patients would vehemently refuse to recognize what their family members did to them as examples of care, I will nevertheless use the term "family caregiver" here and there, because it was invoked in the psychiatric discourse in

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[12] Here I take a cue from Erving Goffman's idea of a moral career. By moral career, Goffman refers to a trajectory of internal—and intimate, I would add—inclinations that have evaluative connotations, and that are shaped by one's institutional position (Goffman, 1968, pp. 127-128). However, the word "career" implies an individual biography (as shaped by the institution), which does not apply to my case. Thus, I opt for the more encompassing term "configuration."

China. By using these potentially controversial terms, I also hope to destabilize what we commonly understand as mental illness, family relations, and caregiving.

Charting the Mental Health Landscape

My new interest in examining configurations of the family in its relations with the severely mentally ill patient inspired me to chart a broader landscape of institutions and settings that are involved in serving, monitoring, and challenging the family in psychiatric care. In China, most professional mental health resources are concentrated in psychiatric hospitals. However, in 2004, the Ministry of Health established a community mental health program, which seeks to manage severely mentally ill patients living at home through regular home visits by community mental health workers. Since 2010, the program has been gradually rolled out across the country. Thanks to an introduction from GBH staff, I shadowed some community mental health workers in Guangzhou during their home visits in urban and rural areas in the summers of 2010 and 2011, and then again during 2013-2014. I observed how health workers obtained information about patients' illnesses and levels of risk from family members, as well as their discussion with family members about the illness' nature, proper care practices, and domestic arrangements.

Note that the "severe mental illnesses" that the community mental health program manages include schizophrenia, bipolar disorder, paranoid disorder, schizoaffective disorder, epilepsy with psychosis, and mental retardation with psychosis. These disorders all have a clear psychotic component, and thus, according to psychiatrists and other policymakers, they make the patients prone to violence (Ministry of Health, 2012). This category "severe mental illness" has also appeared in other policy documents and institutional practices, serving as one of the threads that tie together the mental health landscape. In my fieldwork and in this book, I focus on patients included in this medico-administrative category, although most of the patients in the settings I visited were diagnosed with either schizophrenia or bipolar disorder. Because of my interests in the institutional configurations of family relations, I pay less attention to the fine distinctions between these illnesses; rather, I focus on the social experience these patients and their families held in common.

As a national and international commercial hub, Guangzhou has seen the emergence of many new social institutions. In the field of mental health, it houses one of the earliest, and still leading, social work centers across the country, the Likang Family Resource Center. As its name suggests, the center started by running support groups for family caregivers of psychiatric patients. Although it was aimed at providing a space for family members to become resources for each other, the center's services have expanded to include a clubhouse, vocational training classes, and a shelter workshop for patients.[13] During my long-term fieldwork in 2013-2014, I spent much time at Likang, participating in its activities as a researcher and volunteer, and observing how notions of family, mental illness, and care were imparted, discussed, and challenged. Besides the center's formal activities, I also accompanied some family members and patients outside the center, as they did chores, navigated healthcare and welfare resources, and gathered together for fun or for solidarity. From January to May 2014, I lived in a public housing community in Guangzhou, whose residents included over 300 low-income psychiatric patients and their family members served by a local branch of Likang. Such immersion in the everyday life of patients and family caregivers gave me a more comprehensive view of their social worlds, including how and to what extent these worlds were shaped by, and in turn reshaped, institutional forces.

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[13] In the center's terminology, they are to be called "persons in recovery" or 康复者/*kangfuzhe*.

Most cities in China do not have a social work center dedicated to mental health issues; nor are their community mental health programs as developed as those in Guangzhou. By looking at these emerging institutions, my study may perhaps be challenged as “not representative” of the situation in “China.” However, given the country’s internal diversities, it is hard to claim any local picture as representative of China as a whole. Instead of representativeness, I am more interested in potentiality; that is, how these emerging institutions may reinforce, destabilize, or remake the role of the family in psychiatric care as configured by the hospital. Meanwhile, in order to gain a more balanced view of different institutional and socioeconomic conditions, over the years I have visited various psychiatric hospitals, community mental health teams, and, where they exist, social work/rehabilitation centers in other parts of China, from metropolises like Beijing and Shanghai to other provincial capitals like Kunming, and to small cities and rural counties in Guangdong Province that are economically less developed. My visits ranged from a half-day tour for interviews with administrators or senior staff to days or even weeks of observation. This book will also draw on these visits to supplement my data from Guangzhou.

A historicized understanding of the present also involves looking back to the past. For this purpose, the city of Guangzhou again served as an advantageous starting point. In 1898, American missionary John Kerr established a refuge for the insane located where the GBH is nowadays. The Kerr Refuge is commonly recognized as the first psychiatric hospital in China. This long history has not been well recorded in the archives of GBH, and it is of no concern to most of the hospital staff, except for the conventionally shared memory that Kerr started the hospital out of a humanitarian spirit, hoping to save Chinese patients from their “barbarian families.” Nevertheless, I managed to learn bits and pieces of the history of Chinese psychiatry, as reflected in the institution's history, through reading the generations of books and hospital publications in its library, and through checking files on the hospital in the municipal archives. I also visited several other archives to search for materials on the Kerr Refuge and on the development of psychiatry in China in general, such as those at Yale Divinity School, the Needham Research Institute in the UK, and the Shanghai Library Bibliotheca Zi-Ka-Wei. These archival analyses reveal how the role of the family has been variously configured in the past, in relation to different socioeconomic conditions, as well as to different conceptualizations of psychiatric expertise, patienthood, rights and responsibilities.

Tracking the Mental Health Law

A common condition faced by all the established and emerging institutions mentioned above is the recent mental health legal reform. Just as I was turning attention to families' involvement in psychiatric care, including involuntary hospitalization, I began to notice news articles about people being wrongfully diagnosed with mental illness and hospitalized as a result. Some articles also mentioned the protracted course of the drafting of a national mental health law. Following this lead, over the years, I have travelled to Beijing, Shanghai, and Chengdu to interview senior psychiatrists who were centrally involved in the law's drafting. Interview topics included the proper role of the family in inpatient and community care, as set out in the law and as perceived by those leading psychiatrists; the state's responsibilities for and limits in intervening into family care; and how those leading psychiatrists have responded to public controversies about involuntary hospitalization by families or other agents.

In 2011, I met with an organization called the Equity and Justice Initiative (EJI), based in Shenzhen. As a leading human rights agency advocating for the users and "survivors" of psychiatry, EJI collected cases of psychiatric abuse, published reports for domestic and foreign readers, and engaged in public debates with psychiatrists on mental health legal reform. EJI was central in speeding up the protracted process of legislation leading to the 2013 law. When doing fieldwork in Guangzhou, I often went to Shenzhen and elsewhere to participate in workshops organized by EJI, either as a member of the audience or as a speaker. I also travelled with its staff to national and international conferences on mental health legal reform and disability rights. Through these frequent interactions, I became familiar with the EJI staff and its supporters' ideas about the relationship between mental illness, family guardianship, and human rights, as well as their plans, strategies, and obstacles encountered in promoting patient rights.

Conversations with leading psychiatrists and human rights activists reveal the struggles of ideas that went into making the Mental Health Law. Yet we also need to understand the everyday implementation and impact of the law. Fortunately, my prolonged fieldwork, running from 2008 to 2014, provided an ideal window of time for this purpose. As Michael Lipsky famous argues, "the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively *become* the public policies they carry out" (Lipsky, 2010, p. xiii). This is certainly true of the Mental Health Law in China, as court cases around it have been few and far between, and as they do not count as precedents to follow in the Chinese legal system. Therefore, instead of focusing on court cases, during my institutional fieldwork, I observed how hospital staff, community mental health doctors, social workers, and other street-level bureaucrats implement the law's provisions on patient admission and on discharge—the two most controversial areas in psychiatry—especially in relation to families' rights and responsibilities. These practices were compared to my observations before the law's implementation in 2013. Moreover, I paid attention to how people—patients, family members, health and social service providers—commented on the law, invoking it to discuss their concrete acts and desires. This examination yielded insight into how the legal discourse shaped, and was shaped by, people's everyday social worlds.

Making (Better?) Worlds

Chinese psychiatry is an ethically and politically riven world. Psychiatrists, patients, family members, human rights activists, and other stakeholders are often diametrically opposed to one other. During fieldwork, I needed to be careful not to identify myself with any one group, lest it would alienate me from the others. However, as I gradually earned the trust of my interlocutors, I started facilitating dialogues between different parties. For example, I was once invited by EJI to its workshop on deinstitutionalization. From previous interactions, I knew that EJI's notion of individual autonomy lacked a dimension that would acknowledge vulnerability and the needs for care. Therefore, instead of attending the workshop alone, I brought with me more than thirty patients and family members who were my interlocutors. They spoke about their horrific experiences with various institutions and the need for legal oversight, but rather than merely advocating simple deinstitutionalization, they also talked about ways in which institutions could be improved and how alternative services could be provided. Their powerful words shook not just the EJI staff, but me as well. Chinese psychiatry is a fragmented landscape in other ways. While new resources and services are emerging, few people—not even those in close contact with psychiatric hospitals—know of their existence. As a person who had the luxury of visiting different sites and organizations, I often referred my interlocutors to places that might benefit them.

Thus, rather than simply studying a pre-existing "field," the fieldwork that constitutes this book contains efforts from my various interlocutors and myself to build helpful connections and more inhabitable worlds together. By charting convergences and ruptures in the psychiatric landscape, particularly in its relation with families, this book hopes to generate more connections, dialogues, and collaborative endeavors to build better worlds among people and entities concerned with mental health in China.

Chapter Outline

After this introduction, the body of this book is divided into three sections, each with two chapters. Section One, "Insanity, Intimacy, and Institution," examines how figures of the family have been invoked in the history of Chinese psychiatry and the current legislation debate, and how these figures help construct forms of governance and care. Drawing on archival materials, Chapter 1 traces the historical lineages leading to the contemporary epistemological and social entanglements of insanity, domestic intimacy, and medico-legal institutions from late Imperial China. 18th-century imperial law began to require domestic confinement of the insane, thereby constituting the family as a private agent for public safety concerns. Ignoring its background in socio-political conditions, medical missionaries in the late 19th century saw domestic confinement as emblematic of Chinese culture. Efforts to identify and eliminate cases of domestic confinement legitimized the development of the psychiatric profession and institutions. However, liberatory psychiatry was soon changed into an apparatus of population control, constructing and collaborating with the eugenically minded family. The Maoist era saw a new emphasis on the parent-state over the rights and responsibilities of individual families, and on community care over institutionalized psychiatry. In post-socialist China, a biomedicalized and marketized psychiatry has tended to turn the families into consumers of and allies with psychiatric services, especially hospital psychiatry. An institution-family circuit has thus come to dominate mental health care. The figure of domestic confinement has reappeared, but as an apolitical imagination that serves to legitimize the expansion of the psychiatric institutions.

Against this historical backdrop, Chapter 2 details the making of the National Mental Health Law, especially focusing on the family's centrality in it. Here I draw on interviews with lawmakers and human rights activists, as well as media analysis of debates on the law. Findings indicate that in the last decade, human rights lawyers leveraged strategic litigation to promote a public fear of psychiatric abuse, arguing that such abuse was endemic to the authoritarian state. Conceding to this fear, psychiatrists who drafted the law championed patient autonomy on paper, withdrew the public sector from the process of hospitalization, and made risk the only criterion for involuntary hospitalization. Meanwhile, they argued that an overemphasis on autonomy would jeopardize patients' rights to health and public safety, resulting in a humanitarian tragedy, as—they intimated—had happened in the deinstitutionalized West. By concentrating the rights and responsibilities of psychiatric care on the family, the law thus simultaneously configures the family as a haven from the state and as an agent of *guan*, of medical paternalism.

Section Two, "Logics of Risk, Ethics of Paternalism," analyzes everyday psychiatric practices in the hospital and the community, especially before the passage of the Mental Health Law. A slightly anachronistic approach is taken, going back from the legislation process described in Chapter 2 to what happened before, in order to contrast the abstract legal language of risks and *guan* to the concrete ways in which psychiatric logics of risks have influenced families' ethics of *guan*. This will help us understand, in Section Three, the socioeconomic, political, and institutional conditions that have shaped the implementation of the Mental Health Law.

Drawing on participant observation in psychiatric wards, Chapter 3 looks at de facto practices of hospitalization and inpatient treatment. It shows that families commonly engage in practices of *guan,* including seeking hospital treatment as part of their toolkit, in order to restore order and hope in patients' lives. However, the psychiatric discourse inscribes patients into a chronic pathological trajectory of remission, risk, and relapse, thereby transforming practices of *guan* into the biomedical management of the chronically risky subject. Under this biomedical *guan*, families initiate cycles of hospitalization. This not only disrupts patients' lives, but also makes families themselves—especially female caregivers—vulnerable to emotional and financial harm. The resulting loss of hope then generates ethical ambivalence in terms of what counts as *guan* and how to *guan*.

Chapter 4 turns to family life with patients outside the psychiatric hospitals and explores how it may be gendered. Fieldwork shows that while male caregivers are more insistent on normalizing patients with psychiatric techniques, female caregivers are more compassionate for patients' nonmedical desires and more likely to experiment with hybrid ways of care. This chapter also examines how family life may be shaped by the state's recent community mental health governance efforts. Community mental health connects patients' risk of illness aggravation to the risk of violence they pose to the public, and reconfigures *guan* as the management of both. The discourse of community mental health expects family members to be invested in this biopolitical project of *guan,* and assumes that they have the authority to summon patients' compliance. However, my observation shows that in practice, community mental health workers often acquiesce to what they publicly denounce as improper care, such as hidden drug treatment and domestic confinement. Family members undertake these practices both as a response to the risk management pressure they face, and as compassionate engagement with patients. I thus argue that the biopolitical paternalism enshrined by community mental health requires but also conceals ordinary maternal practices.

Section Three, "Predicaments and Potentials of *Guan*," interrogates the collective re-negotiation of rights and responsibilities under the new Mental Health Law. Chapter 5 examines how the law has been implemented, particularly in regard to hospitalization and discharge. It shows that on the basis of existing hospital and community mental health practices, the law has further concentrated the rights and responsibilities of patient management onto the families, asking them to explicitly justify their demands for patient hospitalization with a language of risk. Family members complained that this language failed to recognize the actual vulnerabilities they and their loved ones faced, only serving to remove the burden of *guan* from public sectors. To help families seeking to hospitalize patients, psychiatrists twisted and expanded the legal notion of risk in turn. However, this overall expansion of a concept of risk adds to another kind of suffering. Although patients who have been subjected to long-term hospitalization by families hoped that the law would grant them freedom, their hope has been frustrated due to the reinforcement of private paternalism and the heightening of risk consciousness in the law's implementation.

Through fieldwork on caregivers' social lives and organizations within and outside social work centers, Chapter 6 examines how familial ethics of *guan* could be transformed into a politics of recognition and redistribution. Because the medico-legal regime of psychiatry placed almost all the burden of *guan* onto families, a condition called "the old nurturing the disabled" came to be recognized all over China. Realizing that their private work shouldered the public responsibility of *guan*, caregivers rejected the blame implicit in some health professionals' messages that it was they who had caused the mental illness or who were not sufficiently caring. Moreover, they started to organize and petition the government for more financial aid and recognition. Impoverished caregivers also taught each other to make the most of welfare and leisure resources, fashioning themselves as entitled citizens suffering from the demands of an unjust state. In so doing, they sought to transform family-mediated biopolitical governance into a different politics of *guan* or what I call "paternalistic citizenship": it envisions a benevolent governance that recognizes the vulnerability of both caregivers and the cared for, that demands the state to be a proper parent, and that values a complex ethics of mutual concern.

By way of reviewing the book's major arguments, the epilogue considers how biopolitical paternalism not only has shaped the ethical and political practices of *guan* in psychiatry, but also bespeaks the general tenor of governance in contemporary China. I will end by drawing on follow-up fieldwork to contemplate the potential future(s) of mental health governance and care in China.

SECTION ONE

INSANITY, INTIMACY, AND INSTITUTION

CHAPTER 1

INSANITY, INTIMACY, AND INSTITUTION: A HISTORY

A Century of the "Iron Cage"

On Feb. 28th, 1898, John G. Kerr, an American Presbyterian missionary doctor, opened the first refuge for the insane in China. In an often-cited document describing the Kerr Refuge's opening, Charles Selden, who directed the Refuge after John Kerr, vividly portrayed the family-induced suffering of the Refuge's first two patients:

> "In his home this man [the first patient] had been chained for three years to a stone in such a way that he could not take a single step, and had lost his power of walking. The second patient, a woman, was found sitting on the floor of a hut with a chain around her neck, the end of which was fastened to a staple in the floor behind her… she was sitting on the floor of a little hut built over water, with a chain around her neck and with a dejected expression of countenance."\

Staff at the Kerr Refuge immediately unchained the two patients upon admission, and in his writing Selden celebrated that "for the first time in the history of China a mind-diseased patient was to receive special care" (Selden, 1908).

The birth of psychiatry in the West is often symbolized by the image of Philippe Pinel ordering the chains to be removed from patients at the Paris Asylum for insane women (Harris, 2003), chains that represent the barbaric practices of the pre-modern custodial institution. In contrast, the arrival of psychiatry in China is marked by John Kerr removing the chains that symbolized domestic neglect and abuse, ill treatment that was associated with the merciless household. After the Kerr Refuge was shut down in 1926 because of a labor strike, missionary psychiatrists in other parts of China continued to talk about the insane being restrained in their homes with ropes, with chains, or in "an iron cage" (e.g. (Woods, 1929, p. 569)).

Today, most Chinese-trained psychiatrists celebrate Kerr's symbolic unchaining of the patient from the familial "iron cage" as the beginning of "*modern Chinese* psychiatry" (e.g. (J. Li, 2010; Lulu Zhang & Ning, 2010)). In the domestic and international media, they continue to deplore family confinement, taking up unchaining as one of their public health missions. In November 2011, *The New York Times* published two articles on the inadequacies of mental health treatment in China. In the first article, the authors discussed the "dearth of care" in the darkness of the Chinese household:

> "Left to their own devices, some relatives resort to heartbreaking solutions. In 2007, He Jiyue, a government psychiatrist, discovered a 46-year-old man locked behind a metal door in a stinking room in a rural Hebei Province home. The man was mentally ill, his aged parents told Dr. He. They had locked him up after he attacked his uncle.
>
> That was 28 years earlier. The man, a high school graduate, could no longer speak. 'I said to the parents: "How could you do this to somebody?"' Dr. He recalled. They replied, 'We had no choice.'
>
> In the past three years, Chinese mental health workers have rescued 339 other people whose relatives were too poor, ignorant or ashamed to seek treatment. Some, shackled in outdoor sheds, were 'treated just like animals,' said Dr. Liu Jin, of the Peking University Mental Health Institute." (LaFraniere, 2010)

Dr. He in the above news article was very likely a participant in the "Unchaining Movement (解锁工程/*Jiesuo Xingdong*)," part of the community mental health apparatus that has emerged since 2004. The movement proclaims that tens of thousands of patients with severe mental illnesses are locked up by their families in "iron cages" (Kong & Li, 2013). It thus aims at replacing domestic confinement with free or low-cost inpatient treatment. I will return to everyday practices of community mental health and unchaining in Chapter 4. For now I want to draw attention to the image of the Chinese family that these stories show has been circulating in psychiatry. The *New York Times* article portrays the family as a constraining and dehumanizing space, contrasting it with a liberating and humanitarian psychiatry. Unlike the image of the "iron cage" current at the advent of psychiatry, however, the family depicted in the recent article is made to seem less cruel than helpless: The patient is of course still a human, but he is also a troubling burden. In dealing with the patient, the article implies, the family should not be "left to their own devices," but should be educated in, helped by, and allied with psychiatry.

Insanity, Intimacy, and Institution: Genealogy and Dialectics

This chapter traces a genealogy of how medical and related discourses have configured the Chinese family in relation to insanity/mental illness from late imperial China to the early 21st century, just prior to the establishment of the Mental Health Law. Here the verb "configure" means both to represent by an image and to fashion or put together in a certain form, because how psychiatry represents the family also shapes how it interacts with, intervenes into, and regulates the latter. The image of the Chinese family as an "iron cage" has recurred in psychiatric discourses for over a century, and it has also dominated the historiography of psychiatry in China. Historians have written about "the dissemination of Western concepts of institutional psychiatry in China" ((Kao, 1979, p. 18), also see (Szto, 2002)), including the field's encounter with—and ultimate triumph over—domestic confinement. In these historical accounts, domestic confinement is treated as a timeless and essential feature of how Chinese society manages the insane. It eternally awaits reform by modern, scientific psychiatry, which also carries an unchanging essence of humanitarianism in its travel from the West.[1] Following this reading, one might say that this psychiatric essence has been well maintained in the profession's evolution throughout modern China. In contrast to this historiography of progress and continuity, however,

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[1] Yang Nianqun launched a similar critique of the impact-response framework in previous historical accounts of Western medicine in China (N. Yang, 2006, p. 8). However, Yang's own analysis perceives the Kerr Refuge as "basically a transplantation and copy of the York retreat in Britain" (pp. 79), and it also takes the missionaries' description of the constraining Chinese family at face value.

a more Foucaultian genealogy would urge us to heed the recurrence of “sentiments, love, conscience, instincts”—and images, I would add—in history, “not in order to trace the gradual curve of their evolution, but to isolate the different scenes where they engaged in different roles” (Foucault, 1984, p. 76). Consider the two similar images of domestic confinement and psychiatric liberation that I described at the chapter’s beginning: the subtle difference between the cruel family depicted in 1898 and the helpless family portrayed in 2011 emerges from a genealogical reading.

In this chapter, I trace a genealogy of how the putative essence, “the Chinese family,” has been “fabricated in a piecemeal fashion” (Foucault, 1984, p. 78) using diverse discursive and material techniques, including psychiatric techniques. The genealogical method requires us to see not only the discontinuous formation of knowledge, but also how knowledge is entangled with relations of power: on the one hand, power relations appropriate knowledges as instruments and apparatuses to dominate, to normalize individuals, and to constitute the subject; on the other, it is through the interlocking of powers that new concepts are produced, new fields emerge, and new kinds of authority arise (Foucault, 1977, p. 27). In what follows, I will trace how images of the family in psychiatry—or before psychiatry, Chinese medical understandings of insanity—have transformed from appearing as a hierarchy imbued with reciprocity and desire, to a space of confinement, to a subject of reproduction to be disciplined, and finally to a partner in care to be allied with/relied upon. These images emerged from, and contributed to, the legitimation and institutionalization of psychiatry, the medical profession’s relations with the police, the courts, and other institutions, as well as the political economic arrangements of the state over the 100 years since the founding of the Kerr Refuge.

When psychiatry repeatedly depicts the family as an "iron cage," it seems to forget the fact that the professional field itself also often operates with methods of control, constraint and confinement. Anthropologists recently reminded us that even for contemporary Euro-American psychiatry, which is supposedly in a post-asylum era, constraint still constitutes the profession's "rough edge of practice," where the interests of clinicians and patients diverge, and where care and control blur into each other (Brodwin & Velpry, 2014, p. 524). As Lovell and Rhodes put it, "it is through constraint that the larger social 'will' (to power, to social order) shows its teeth." And psychiatry's teeth "are most likely to be bared in disputes over the moral status of the patient and the legitimacy of the institution" (Lovell & Rhodes, 2014, p. 618). Psychiatric constraint in China is more widespread and perhaps more in need of analysis, as currently most psychiatric inpatients are committed without their consent. As Chapter 2 will show, in the recent mental health legislation reform, this issue of involuntary hospitalization was hotly debated, along with the rights of the patient and the responsibilities of the institution, the family, and the state.

Rather than seeing domestic confinement and psychiatric constraint as separate or opposed phenomena, I contend that they are intimately linked. Note that the image of the familial "iron cage" has been invoked most often in key moments of the expansion of psychiatric institutions—when the first asylum for the insane was established more than a century ago, when psychiatry recently sought to reach out beyond institutions into communities, etc. Here I take a dialectical approach to analyze how the unfolding of psychiatric knowledge/power in China has been centrally hinged upon its conceptualization of, and interaction with, the family. In *Dialectic of Enlightenment*, Horkheimer and Adorno point out that Enlightenment creates its "other" by measuring everything according to the law of rationality, reducing the multiplicities of objects, and "amputat[ing] the incommensurable." In doing so, it ensures the victory of rationality over the world. But the failure to recognize alterity beyond rationality and identity in turn transforms reason into a coercive law (Horkheimer & Adorno, 2002, p. 9). A similar story can be told about psychiatry in China: when psychiatry fashions itself as a modern, rational, and/or humanitarian discipline, it posits the family as its other, from which it then endeavors to rescue the patient and make him a sovereign individual. But in configuring the family as its other, psychiatry fails to consider the historical, political, moral, or even cosmological conditions active in certain domestic practices. This work of reduction facilitates and conceals psychiatry's collaboration with networks of power. In this process, contrary to the psychiatric ideology, the patient no longer appears as a sovereign individual, but is better seen as a disciplined subject.

Analyzing psychiatric configurations of the Chinese family, the dialectic method reveals how such configurations are central to the development of psychiatric institutionality and the disjuncture of psychiatric practices from the field's humanitarian ideal. At the same time, the genealogical method cautions us against "assuming a correspondence between elements referred to by the same abstract term" (Lovell & Rhodes, 2014, p. 620), and urges us to heed changing forms of psychiatric institutionality and diverse practices of constraint. Such a genealogical reading will reveal a historical palimpsest (Brotherton, 2012, p. 5) that still grounds and configures the insane subject, domestic intimacy, and broader social relations today. Specifically, the history of this process contains traces of erased or subjugated knowledges that haunt contemporary practices, and may offer resources for actors or the ethnographer to challenge the contemporary contrastive articulation between the familial and the institutional.

Insanity and Sociality in Imperial China

Chinese Medicine and Desiring Hierarchies

Let us begin by looking at how Chinese medicine in the imperial era understood insanity in relation to personhood and intimacy. The mind-body divide, on which the term *mental* illness is hinged, does not exist in Chinese medicine. The latter has terms for insanity, like 癫/*dian* and 狂/*kuang* (or 癫狂/*diankuang*), which, as their symptomatology crystalized in the 19th century, refer to non-manic withdrawal and manic, overtly disordered behavior, respectively. Rather than being located in the "mind," *diankuang* indicates dispersed physiological processes, in which the life force (气/*qi*) that normally should flow smoothly through functional systems is disordered. For example, in Song and Yuan dynasties, authoritative doctors argued that one became insane because mucus blocked the heart-mind,[2] the seat of one's spirit/vitality (神/*shen*), and the mucus in turn came from excessive heat and Fire in the body; in the 18th and 19th centuries, the mucus that caused insanity was often thought to result from a stasis (郁/*yu*), particularly stasis in the Liver (Simonis, 2010). Medical descriptions of insanity involved many physical experiences all over the body, such as headache, fatigue, hot flashes, congestion in the respiratory tract, and so on and so forth.

At the same time, Chinese medicine always pays attention to the role that excessive emotions (情/*qing*) play in conditioning pathological processes and giving rise to insanity. Particularly in the Ming and Qing dynasties, with the rise of the cult of *qing* among the literati

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[2] Using modern, dualist English, Simonis argues that 心/*xin* (which he translates as heart but many others translate as heart-mind) "referred to both the mind and to a physical structure, and could thus serve as hinge between physical and mental processes in descriptions of psycho-behavioral pathology" (Simonis, 2010, p. 129). So even though insanity in this etiology is located in the heart-mind, one still can't say that it is a *mental* illness.

and the general society, *dian* was commonly seen to be caused by emotion-inflicted depletion, and *yu* was often diagnosed as stasis caused by pent-up emotions. As historian Fabien Simonis points out, Chinese doctors assume that emotions, or what we today call "mental" activities, are accompanied by changes in physiological processes (if we have to separate them at all), so they often prescribe drugs to restore organic balance for the patient and to treat the symptoms of insanity induced by pathological emotions.[3] At the same time, the crux of Chinese medicine, as Judith Farquhar argues, lies in distinguishing the specific pathological process and determining treatment thereof (Farquhar, 1994, p. 55). The famous Yuan physician Zhu Zhenheng asserted that since the process of insanity ultimately hinged upon the emotions, a virtuous doctor should be able to analyze the specific emotion that causes insanity, pacify the patient accordingly, and resort to human affairs (人事/*renshi*) rather than drugs for treatment.[4]

So what were the human affairs undergirding the recognition of emotions and treatment of insanity? For doctors in imperial China, many of whom belonged to the Confucian literati class, human affairs arise from a world of "encompassed hierarchies," that is, a world that contains "many, unequally valued but equally necessary parts" (Zito, 1997, p. 29), such as lord and subject, parent and child, husband and wife. These hierarchies differentiate persons, but also put them in relation to—and, ideally, in reciprocity toward—each other. This hierarchical world is concerned with ritual propriety, through which excessive desire must be disciplined. Meanwhile, as literary critic Haiyan Lee argues, Confucianism sees emotion as "human nature, the material basis of heavenly principle, the fount of ethical conduct, and the origin of all virtues" (H. Lee, 2007, p. 34). It is through emotion—particularly emotion towards one's

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[3] Simonis calls the inseparable relation between the mental and the physical one of "supervention" (Simonis, 2010, p. 36).

[4] From Zhu's 丹溪心法/*Danxi Xinfa.* Cited from (Chen, 1934, p. 1739).

relational counterpart, such as a child's love for his parents—that ritual propriety is felt and properly enacted.

In this world of encompassed hierarchies, Chinese medical treatises often use the word 乱/*luan* or disorder to describe insanity, focusing on uncommon, wild, and socially improper behaviors or desires. A goal of treatment is to reassert the proper social roles and emotions.[5] For example, if a woman runs around naked, hugs any man she sees, and speaks lustful and filthy words, then she is considered to be afflicted by a disorder called "flower insanity" (花癫/*huadian*). The treatment is considered successful if she comes to feel ashamed and stops such behavior.[6] On the other hand, unlike modern biomedical psychiatry, which claims the psychotic patient's experience to be merely delusional, the Confucian approaches to emotion leads Chinese medical practitioners to some extent to sympathize with the patient's desire, and heed the social processes that produce excessive longing. In the case of flower insanity, the doctor usually understands it as afflicting women (and men) who are physiologically ready and emotionally longing for sexual life but for some reason cannot enter the legitimate institution of marriage.[7] Of course, the doctor might not be able to do much to change this untoward circumstance. But when possible, the sick woman's relatives would often try to find a spouse for the sufferer.[8] In less constricted relations, where the patient's longing can be satisfied, the doctor might seek to build a more reciprocal relation for the patient. For example, the Yuan physician Zhu Zhenheng recorded a case in which a young woman had stayed in bed day after day in a total daze,

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[5] For a discussion of *luan* or disorder in Chinese medical understandings of insanity, see (Simonis, 2010).

[6] From Chen Shiduo's 石室秘录/*Shishi Milu* in (Chen, 1934).

[7] Chen Shiduo's *Shishi Milu*.

[8] Simonis claims that this practice is also rare and, at least in the imperial era, was limited to male patients, whose families would sometimes get them a concubine. But I sometimes witnessed such a practice—or families considering such a practice—for contemporary male and female patients diagnosed with hebephrenia. This practice is also often reported (and denounced) by journalists and commentators, such as (H. Yang, 2001). The folk term for this practice is 冲喜/*chongxi*, or counteracting the bad luck with happiness.

responding to the fact her fiancé had been away on a business trip for two years. After alleviating her symptoms with drugs, Zhu told her father to call back his son-in-law. Upon her fiancé's return, the woman was completely cured.[9]

Interestingly, in Chinese medicine, at least as it existed in late imperial China, "the family" was never problematized.[10] Granted, families and other kin groups were the main agents that provided for the insane and sent for the doctor. But the doctor did not have to rely on the family to detect the patient's secret behavior or provide hidden illness history, because *diankuang* was seen as apparent disorders that could easily be identified by anyone. Even when they went unspoken, maddening desires could be clearly sensed in the physiological symptoms, and could be easily inferred from the adversities that the sick person faced. Besides, because both doctors and families saw insanity as *temporary* or *intermittent* aberrance from a proper organic balance, which could be quickly restored by medicine, families did not usually feel the need to provide long-term special arrangements for their afflicted member, nor would doctors instruct families to do so. Therefore the physician in imperial China did not have to configure the family as a relay of medical power or discipline it as a subject of care.

Cultivating the Filial or Confining the Dangerous: The Family in Imperial Law and Social Policies

Since patriarchy is commonly invoked in modern and contemporary discussions of Chinese families, such as in psychiatrists' critiques of domestic confinement, we need to get a sense of what patriarchy or parental rights might have meant in imperial China. One comparative

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[9] From Zhu Zhenheng's *Danxi Xinfa* in (Chen, 1934).

[10] Foucault defines problematization as "the set of discursive or non-discursive practices that makes something enter into the play of the true and false, and constitute it as an object for thought (whether under the form of moral reflection, scientific knowledge, political analysis, etc.)" (Foucault, 1988, p. 287).

point is Roman law, which granted the head of a family (*pater familias*) absolute power over the life and death of every family member (*ius vitae necisque*) (Harders, 2012). In classical Confucianism and Chinese customary law, parents in a sense also owned their children's bodies. According to the *Classic of Filial Piety*, "The body, hair and skin, all have been received from the parents, and so one doesn't dare damage them—that is the beginning of filial piety."[11] However, while this body appears to be a physical entity, it is in fact one that expresses love and respect for parents[12] through bodily disposition (Zito, 1997); in other words, it is a relational, filial body that parents own. By the 4th century at the latest, Chinese law prohibited parents from claiming absolute ownership over their children's physical body. Instead, they could take their children's life without being punished only when the latter were unfilial or disobeyed correct parental demands. Pre-modern law also granted parents the right to send an unfilial children to local authorities for punishment (Ch'ü, 1965). On the other hand, in the Ming Dynasty, if the father beat his wife or children rather than reciprocating their filiality with kindness, the local government would issue a placard writing "unjust someone (offender's name)" and place it on the house's gate to shame the offender, and exclude him from any community life (Dutton, 1992, p. 77). In a Confucian legal order, therefore, the family's sovereignty or patriarchal power hinged on cultivating filiality, and having the unfilial person punished. At the same time, it is precisely the principle of filiality that set limits to patriarchal power and allowed it to be policed.[13]

This divergence in Chinese patriarchal power from that of Western classical law partly comes from a difference in the public/private divide. In Greco-Roman thought, Aristotle

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[11] (S. Wang, 2004), Chapter 1.

[12] Hierarchies in the Chinese cosmology are relative and constantly shifting. A mother also has power over her children. When she outlives her husband to become the oldest in the family/clan, she becomes the matriarch who manages the patriarchal system (T. Lee, 2002; Mann & Cheng, 2001). So here I intentionally use the plural form to blur the gender in parental power.

[13] Dutton argues that in imperial China, the "family functioned both as a model to be exalted and a mechanism by which to police," and the latter works by strengthening the former (Dutton, 1992, p. 34).

famously distinguished the family (*oikos*), the private space where a household head ruled his wife, children, and slaves for the purpose of satisfying "the bare needs of life," from the city-state (*polis*), the public realm where household heads participated in political activities as free citizens (Aristotle, 2005, p. 13). As philosophers David Hall and Roger Ames point out, "[t]his division of the life of the individual into public and private dimensions is in no way echoed in early Confucianism" (Hall & Ames, 1987, p. 147). On the one hand, as Angela Zito points out, rather than a private virtue, filiality was an "organizing trope for connecting cosmic and social hierarchies," including the Heaven-human, lord-subject, and father-son relationships. "Filiality not only fell upon all Chinese human beings as a moral duty, it provided a ground for the civilizing of human beings at all" (Zito, 1997, pp. 58, 186-187). So there was no bare physical existence to be claimed or controlled by anyone in imperial China; instead, one was constantly cultivating oneself as, or being disciplined into, a filial person. On the other hand, the actual family was just one node in a world of encompassed hierarchies. Since the emperor, the local magistrate, and the clan leader could all be the father of a subject, they had different degrees of authority in determining crime and punishment, and their authorities were all legitimized by different concrete formations of filiality.

Following the logic of the universality and particularities of filiality, neither in theory nor in practice did families in imperial China carry the full burden of nurturing and providing for the vulnerable. Classical Confucianism constantly extols parents' birthing and nurturance of small children, and exhorts adult children to provide for and love old parents. While kin affects should be eternal, material nurturance between parents and children is seen as a time-bounded, rather than indefinite, duty (X. Zhao, 2011). Moreover, as a discourse that is often mobilized in modern Chinese regimes and social movements, the Confucian ideal of the Great Harmony (大同

/*Datong*) encourages people to partake in providing for the old, the young, the disabled, and the widowed in general, recognizing them all as one's own kin, and envisioning the world as a large family (X. Zheng, 2008). This may be a utopia, but by the 10th century there were in fact a wealth of charitable organizations to shelter the vulnerable members of the population, run mostly by clans, religious groups, and local governments. Particularly, if the human world is one large family, an emperor gains legitimacy not just through claiming patriarchal power over his subjects, but more importantly through performing as a filial son of Heaven and of his people; serving the vulnerable population is certainly a key way to perform filiality (Zito, 1997, p. 201). In the Tang Dynasty, for example, the central government endeavored to abolish Buddhist charity organizations and claim a monopoly over welfare provision. Later, in the Song Dynasty, with an even more prosperous economy and rising class inequality, the government built a more comprehensive welfare infrastructure, including the first official orphanages in the world, which in effect legitimized the transfer of child rearing responsibility outside the natal family (Leung, 2013). The delimitation and distribution of nurturing responsibilities under the principle of filiality serves as an important comparison for socialist and post-socialist welfare policies.

In late imperial China, the law began to require the family to discipline the physical existence of the individual, precisely by stipulating domestic confinement for the insane. According to Simonis, in 1667, Qing law made an explicit rule to exempt from punishment killings by the insane, as it saw insanity as a state completely devoid of intention. Alongside this exemption from criminal responsibility, the law required relatives of the insane to provide civil compensation for the victim's family. Now that Qing officials had begun to see insanity as a disorder that could bring about blind homicidal impulses, they began to fear the dangerousness of all insane people. In 1689, a new rule required families to keep precautionary watch over the insane (regardless of whether they had committed violence before), and it prescribed beatings for relatives whose carelessness allowed the insane to kill others. In 1732, another rule required families to declare any insane member to the local government. In 1762, for fear of the potentially homicidal person's relapse, the law stipulated permanent imprisonment for those who killed because of insanity. Finally, it was in 1766 that preventative confinement by families became a legal stipulation. The law now required relatives of the insane to manage (*guan*) and restrain the person in a safe room, and local officials were to issue locks and chains to the family so that confinement could be strictly implemented. If domestic confinement was not enforced well enough and the insane person committed homicide, the law stipulated that the relatives should be harshly sentenced (Simonis, 2010).

These legal provisions on domestic confinement of the insane had roots in the thousand-year-old neighborhood administrative system (保甲/*baojia*), where neighboring households were organized to perform mutual aid and mutual surveillance, and to share legal responsibilities in cases of transgression. Yet while *baojia* responsibility revolved around ensuring filial behavior toward the family, the community, and the state, the new provision on domestic confinement sought to control the physical existence of the individual, which, in the case of insanity, now could be seen as permanently disordered, constitutively devoid of intention, and embodying a potential danger to society. This legal notion of insanity differed dramatically from the existing medical and popular notion of insanity as a temporary, curable disorder that often reveals natural but socially frustrated desires. Moreover, the court mostly did not rely on the knowledge of the physician except when asking him to ascertain that the suspect's insanity was not faked. Yet by requiring the family to confine and constantly watch over the insane, the Qing law sought to turn the family into a disciplinary agent for the security-minded state. In this small but pathbreaking stipulation on domestic confinement, the individual's physical existence and threat, the state's concern with security, and the family's role in discipline came together, allowing the entry of the idea of *guan*, here meaning management/control, into sociopolitical arrangements for insanity,

Of course, even before the legal requirement of domestic confinement, some families had chained up their insane relatives to wait for an attack of disorder to end, because they had no money to send for a doctor, or because the medicine they had was not effective. And if the "fit" of insanity did not end as expected, the helpless family might have no choice but continue the confinement. But recorded cases of confinement were few, both before and after the Qing legal stipulation. In fact, as Simonis has pointed out, "[W]hat the government came to see as the most dangerous aspect of madness (its unpredictable intermittency) was precisely what many people considered the best reason *not* to declare a mad relative" (Simonis, 2010, p. 465). Many families ignored the legal stipulation and unchained their insane relatives whose insanity only flared up periodically, because they needed labor for agricultural work, because they saw the persons as having recovered from madness, or because they did not view chaining as a suitable method of care.

Missionary Psychiatry, the Chinese Family, and a Dialectic of Enlightenment

Domestic Confinement, Psychiatric Liberation?

In the 19th century, particularly after the Opium Wars, groups of Western physicians, most of whom were Protestant missionaries, began to practice medicine and establish hospitals in Chinese treaty ports, and then in inland cities. These medical missionaries established the first psychiatric hospitals in China, most notably the Kerr Refuge for the Insane in Canton (now Guangzhou). Their work laid the infrastructural and discursive ground for professional psychiatry in China, and it continues to be invoked by Chinese-trained psychiatrists as the glorious beginning of their profession. So although psychiatry before the People's Republic was established in 1949 had many ebbs and flows, here I focus on its early moments, particularly from the 1890s to the late 1920s—around the time when the Kerr Refuge was shut down and asylums in other cities took the lead in the development of the field.

From the very beginning, medical missionaries' concern with insanity and the family in China seemed to be equally an anxiety about Western civilization and scientific reason. John Kerr, an American physician and Presbyterian missionary who had been the director of the Canton Hospital since the 1850s, proposed to the Presbyterian Board in the 1870s to establish a refuge for the insane. To his surprise, his proposal provoked much opposition from his colleagues. Some of them doubted the feasibility of converting to Christianity insane people who lacked basic faculties of understanding. Some others, like Kerr's major opponent Charles Wenyon, wondered what Western civilization had to offer to the perfectly serene oriental mind: "Life generally here [in China] is free from the nervous strain which in the West so often destroys the balance of mind… Owing to the simplicity of life here and the clan system of society, many persons thus afflicted are able to do something for their living, and if not, they freely and safely go in and out among their relatives, and are, with few exceptions, kindly treated" (Wenyon, 1892, p. 6). Echoing a European medical understanding of "diseases of civilization," which stems from the 18th century (Porter, 1993), Wenyon's argument saw insanity as exacerbated by the complicated mentality, alienation, and high-strung society of the developed West; in contrast, the simple, traditional social structure of the Chinese clan system, including its natural unit of the family, served as a protective zone for the insane individual.

Unsuccessful in defeating this opposition, Kerr had to establish the Refuge mostly with his own financial resources (Szto, 2002). As an attempt to legitimize his resolve to establish the Refuge, Kerr told his assistants and others a traumatic story: although he had long known of "the lack of proper treatment by the Chinese of these patients in their own homes, how they were heavily chained, etc… it did not seem possible to take charge of these patients in a general hospital… [O]ne day when he turned an insane woman away, a concubine, the husband took her to the river just in front of the hospital and threw her in" (Harvey, 1920, p. 104). After the Refuge was founded, references to family abuse and graphic descriptions of it saturated the Refuge's annual reports and its staff's writings in the globally circulated *China Medical (Missionary) Journal*. For example, Selden wrote: "If a member of a household becomes insane and unmanageable or troublesome, the common custom is to chain the person to a post or heavy stone in the house so that he or she may not be able to go out into the street or do violence to men or things… Many bear the marks of fetters that have been on hands and feet" (Selden, 1908).

In insisting on establishing an asylum for the insane in China, Kerr and his medical missionary colleagues certainly shared a sense of "therapeutic optimism" prevalent among Euro-American psychiatrists since the late 18th century. These psychiatrists championed the curability of insanity, and they believed that the asylum could be therapeutic rather than merely custodial. Historian Edward Shorter points out that this notion of curability "was good Enlightenment thinking, part of a larger agenda of improvement through social, political, or medical engineering" (Shorter, 1998, p. 8). Yet here I contend that the specific unfolding of psychiatric Enlightenment in China was not simply a transposition from the West, but rather hinged upon missionaries' "discovery" of domestic confinement and their framing of the Chinese family as a barbaric other. Accounts of the suffering of insane Chinese marked the missionary as the modern self, the universal human. To borrow historian Dipesh Chakrabarty's words from his analysis of how British colonizers and Indian reformers documented widow sacrifice, the universal human so configured had the "capacity to notice and document suffering… from the position of a generalized and necessarily disembodied observer" (Chakrabarty, 2000, p. 119), and he was willing to jeopardize his own interest to rescue the victim even when he or she was in no way related to him.

At the same time, missionary psychiatry treated the chain, the iron cage, and other instruments of constraint as icons of the Chinese family. Kerr remarked, "A short method of getting rid of the hopelessly incurable has no doubt often been adopted *in a country where the father holds the power of life and death over his family*" (Kerr, 1898).[14] Here Kerr used the Roman *ius vitae necisque* to frame the Chinese family as a patriarchy, without recognizing that the patriarchal power over physical life had a Western home, or that Chinese patriarchal power operated on a different notion of life, a life of filial relations. In contrast to the missionary, a man who was capable of generalized empathy, the patriarch thus framed was a local and backward subject, a lesser human, who, plagued by a "blindness induced by custom and habit" (Chakrabarty, 2000, pp. 121-122), inflicted cruelty on the insane person even or especially when she was a blood relative. In this dialectic between universal psychiatry and local patriarchy, the conditions of the insane became "an index for measuring the quality of a civilization" (Chakrabarty, 2000, p. 118), and the patriarchal family became an unquestioned index of the oppressive Chinese culture.

This dialectical positioning also severed the insane person from his relational constitution and made him an *individual* to be enlightened, a universal human: medical missionaries saw

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[14] Italics added.

insane Chinese as having the same physicality and susceptibility as a Westerner, and inscribed them in the same disease typology then nascent in European psychiatry. For example, using Emil Kraepelin's diagnostic categories, Dr. J. Allen Hoffmann at the Kerr Refuge reported in 1913 that "we have just the same kinds of psychoses here as in the homelands, and the symptoms of the different groups are identical with the symptoms of similar groups at home" (Hofmann, 1913, p. 370). Moreover, as a universal human, the insane was now able to incite empathy, was worthy of respect, and, despite being presently insane, was capable of regaining reason with the help of humane medical care. One of the Refuge's principles was: "Though insane, these patients are yet men and women—not beasts" (Selden, 1909c). Because of the universality of human nature, Western psychiatry was applicable to the Chinese insane. Treatment in the Kerr Refuge combined evangelical work with the two core features in Euro-American therapeutic asylums and "moral treatment":[15] for one, a structural daily regimen in a calmative setting, including "rest, warm baths, out-of-door life, exercise, employment"; for another, the therapeutic relationship in which doctors used persuasion rather than force, mixing kindness with firmness, in order to excite gratitude and affection in the patient (Selden, 1909c). Meanwhile, the threat of the oppressive family made institutional isolation all the more legitimate and necessary. The asylum was a home away from, and better than, home, and was able to protect "the insane from inconsiderate outsiders" who made fun of or even harassed the patients (Selden, 1908, p. 83). The discourse of psychiatry liberating the insane from domestic confinement soon gained dominance among medical missionaries, who established similar asylums in several other Chinese cities.

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[15] Shorter argues that founders of therapeutic asylums in the early 19th century "envisioned two aspects of life in an asylum as therapeutic—the setting itself with its orderly routines and communal spirit, and the doctor-patient relationship" (Shorter, 1998, p. 18).

As discussed in the last section, domestic confinement had become a legitimated practice only slightly more than a century before, when Qing law had displaced the state's concern with public security and recast it as the family's liability. We have also seen that many families secretly resisted this legal regulation and did not permanently confine their insane members, for reasons like economic necessity or a different understanding of insanity. In reading domestic confinement of the insane as an ahistorical, naturalized essence of the Chinese family, medical missionaries not only made the mistake of overgeneralization, but also failed to see how socio-political concerns and legal regulations could constitute a public/private divide and configure the family as a disciplinary agent, and how people resisted and engaged in tactical negotiations with such official mandates. Therefore, in the process of constructing an evolutionarily backward, morally corrupt, and dehumanizing patriarchy as the other of Enlightenment, missionary psychiatry carried out a work of reduction and elision.

This elision facilitated missionary psychiatry's strategic alliance with the police and local elites. While the Kerr Refuge, in its first several years of existence, only admitted family patients (i.e. patients who were brought by their families), in 1904 a policeman sent in an insane man and asked whether the Refuge would admit the man at the expense of the Police Department. Staff at the Refuge remarked with excitement that this incident was "a new departure; the first occasion of official recognition" (Selden, 1910). Although missionaries saw the institution as curative whereas the police saw it as custodial, both parties shared the technique of spatial segregation. They were thus able to establish a strategic alliance: the police handed over to the medical mission responsibilities for control and confinement that they had previously imposed upon the family; the missionaries willingly took on the responsibilities, ignoring the socio-political dimension underlying both domestic and hospital confinement. With the inauguration of this strategic alliance, more people were sent to the Refuge by the police, to the extent that by 1909 half of the patients in the Refuge were supported by officials, and half of this group had been picked up from the street by the police.[16]

While allowing for an alliance with the police, missionary psychiatry's reductionist reading of familial practices gave the doctors a hard time attracting family patients. In an age before mass produced psychopharmaceuticals, staff at the Kerr Refuge acknowledged "*no specifics* for insanity" (Selden, 1909a, p. 228), offering only careful nursing, discipline, and removal of the patient from existing conditions. To their dismay, patients' families and friends often "place all dependence upon the medicine which the patient is supposed to be taking, and they come to see its effect" (Selden, 1909a, p. 226), seeing no value in the enlightened routines and evangelical therapeutics of the asylum. Families and friends even brought medicines to the Kerr Refuge, such as anti-mucus emetics, along with food, wine, and tobacco. Moreover, some relatives even insisted on living in the Refuge to keep the insane person company (Kerr, 1898). Rather than relations of oppression, relatives and friends' gestures of this kind suggested not so much a cruel "chaining" of the insane as ties of intimacy binding a group who cared for each other and who viewed their fates as intertwined. But medical missionaries simply brushed off relatives and friends' concerns and requests as irrational, choosing instead to maintain their own symbolic and spatial demarcations between the humanitarian refuge and the bestializing household. This may explain why family patients did not increase at the same rate as police

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[16] The other half was transferred from the Government Lunatic Asylum in Hong Kong. See (Selden, 1909a).

patients did, and why China for most of the early twentieth century did not have mass confinement of the insane (Diamant, 1993).[17]

Besides being depicted as irrational, operating as a blind power over the life and death of its members, the Chinese family was also framed as a subject of instrumental rationality, a "bad" rationality at odds with psychiatry's ideal of human liberation. Examples abound in comments and reports by Kerr and colleagues. In one of Kerr's famous remarks, that the Chinese patriarchal family has adopted "*[a] short method* of getting rid of the hopelessly incurable,"[18] domestic confinement was seen as an effective and expedient means to an oppressive end. Later when discussing the rise of "police patients," doctors at the Kerr Refuge believed that it was because many families considered the insane a nuisance and "put [them] into the street for the police to pick up and bring to us."[19] In fact, the doctors only recorded several cases like this (Selden, 1909c), and this comment reveals less about domestic practices at that time than it does the doctors' view of the Chinese family as not only cruel but also calculative and cunning. Moreover, in a photograph from the 1916 report of the Kerr Refuge (Figure 1.1), a new patient lies bound to a pig's feeding trough, the condition in which his relatives carried him to the hospital, while in the background other hospital patients, free from constraints, are visible. With the pig's feeding trough and the rope tying the insane, the missionary author portrayed the Chinese as dehumanizing the insane person, treating him as a beast to be managed or a waste object to be disposed of with recycled domestic resources (other pictures show the use of a ladder, a chicken coop, and a pig basket). Using the word "resourceful" to connote economic, instrumental

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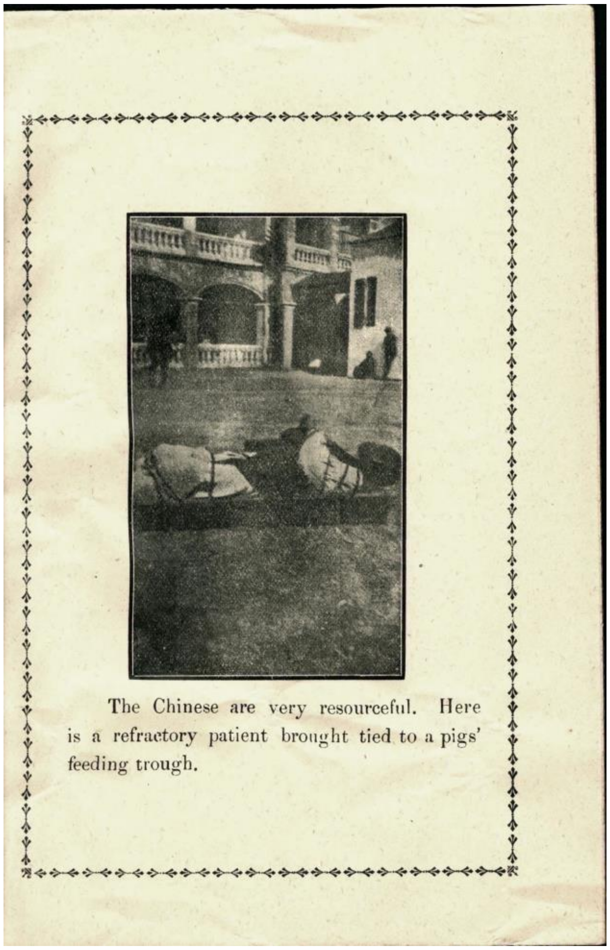
[17] In contrast, when discussing Euro-American psychiatry in the late 19th century, Shorter attributes the rise of the asylum population partly to families' increasing willingness to commit patients to the asylum (Shorter, 1998).

[18] Italics added.

[19] Hospital Reports, the John Kerr Refuge for the Insane, 1909. Missionaries themselves used the word "belief."

rationality, the author effaced legal, medical, or other possible concerns that might lead to confinement, and depicted the family as an agent calculating every action and the value of everything, including an individual's life, in terms of its own survival.



The Chinese are very resourceful. Here is a refractory patient brought tied to a pigs' feeding trough.

Figure 1.1 Image 1 from Hospital Reports, the Kerr Refuge for the Insane, 1916-1917.
SOURCE: Special Collections, Yale Divinity School Library.

When missionary psychiatry posited the insane person as a universal human amenable to be enlightened, it simultaneously demarcated a norm from which the insane would deviate, only to be subjected to discipline. Or in Horkheimer and Adorno's terms, "because that self never quite fitted the mold, enlightenment throughout the liberalistic period has always sympathized with social coercion" (Horkheimer & Adorno, 2002, p. 9). While the space of the Kerr Refuge was initially constructed to prevent outsiders from harassing the insane, by 1909, five years after the Refuge willingly took on responsibility for confining police patients, the director decided to build thicker doors to prevent the insane from breaking them down and escaping.[20] In correspondence with the editor of the *China Medical Journal* in 1920, Robert Ross, then the director of the Kerr Refuge, recommended that all general hospitals be provided with at least three articles for handling the insane patient: a bath-tub, a wire restraining frame, and a straight jacket (Ross, 1920). If we compare Figure 2.3, portraying the wire restraining frame the staff at the Refuge devised for "humane restraint" of the patient, to Figure 2.2, showing the pig basket the natives used to transport the patients to the Refuge, we see a very interesting parallel in the equipment's shape and use: provided, that is, that we take on the missionaries' perspective and see the pig basket as a "resourcefully" employed tool of constraint (Ross, 1920, p. 581). It could well be that missionaries appropriated this bit of "Chinese wisdom" for their own resourceful use. In any case, the pig basket picture still shows the struggling body of the insane, the relatives who simultaneously constrain and connect with the insane, and the spectator who could not close his/her senses to the noise, sweat, fear, and hope of the intimate bond. In contrast, every trace of human connectedness has disappeared from the picture of the wire restraining frame; the recalcitrant body is completely silenced and excluded. When missionary psychiatry characterized the family as an agent of instrumental rationality and a force of discipline, it dialectically held up a mirror to itself.

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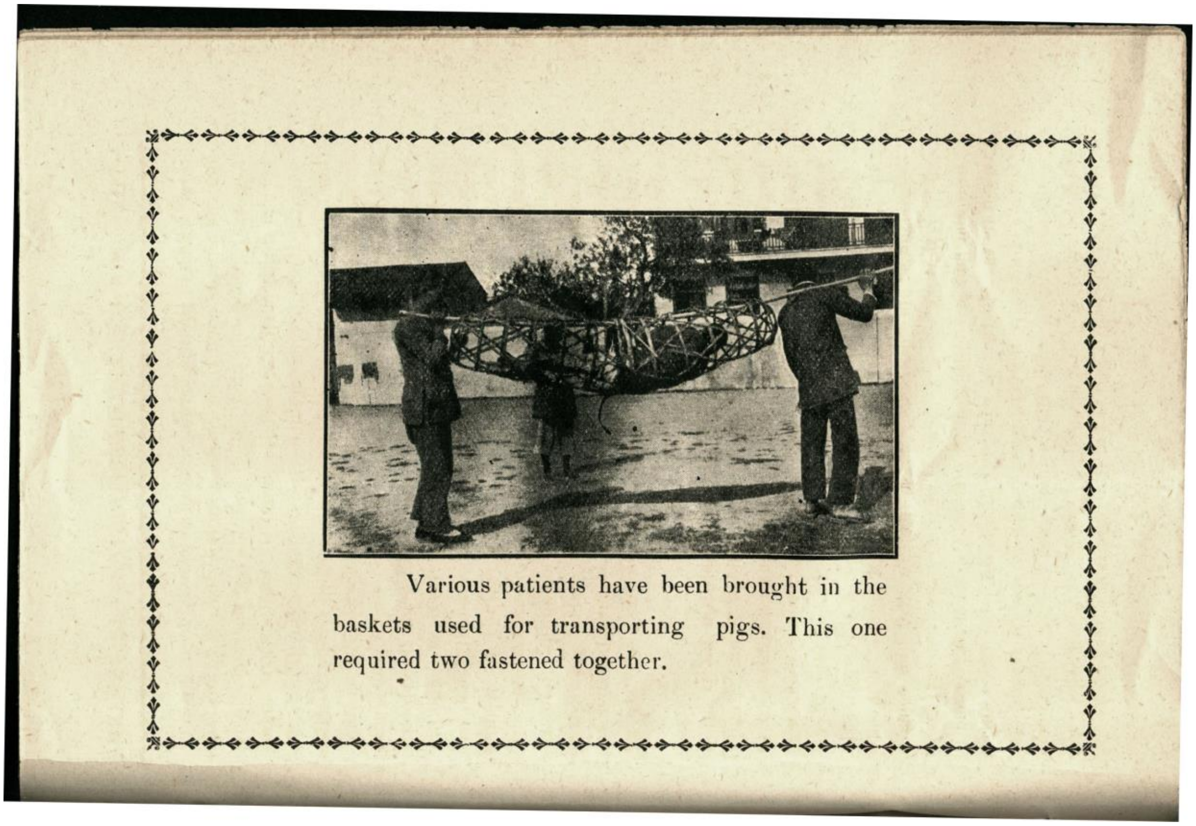
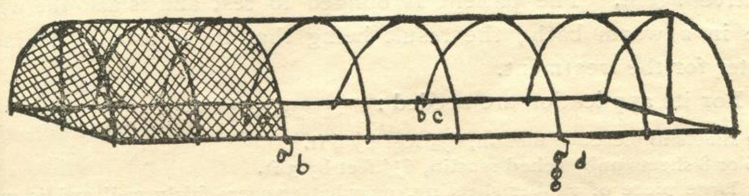
[20] Selden also writes that "One reason for having a hospital for insane surrounded by large grounds and quite removed from the abodes of men, is that the patients may be allowed to make a certain amount of noise and need not be continually drugged in order to prevent them from disturbing others" (Selden, 1909b, p. 382).



Various patients have been brought in the baskets used for transporting pigs. This one required two fastened together.

Figure 1.2 Image 2 from Hospital Reports, the Kerr Refuge for the Insane, 1916-1917. SOURCE: Special Collections, Yale Divinity School Library.



Backbone and ribs partially covered with netting.

Figure 1.3 Image from Charles C. Selden (1909c). "III. Treatment of the Insane," in *The China Medical Journal.* 373-384. SOURCE: The Center for Research Libraries.

The Chinese Family at the Crossroad of Eugenics and Psychoanalysis

In the late 1910s and 1920s, missionary psychiatry bifurcated into two new epistemologies of insanity and subjectivity: psychoanalysis and eugenics. In different ways, both discourses furthered the dialectical relation between universal psychiatry and local patriarchy. In

1913, the concept of heredity appeared for the first time in publications from the Kerr Refuge. Noting the hereditary taint borne by many patients, Dr. J. Allen Hoffman and other medical missionaries now saw the insane person not so much as a universal human capable of rationality, but more importantly as a biological body carrying and spreading hereditary defects and moral degeneracy, thereby needing institutional discipline (Hofmann, 1913).[21] Moreover, missionaries now saw the Chinese family as instantiating evolutionarily backward marriage customs: by compelling every male—even the insane—to reproduce, these customs could only worsen the heredity of future generations (Harvey, 1920, p. 104). Some doctors noted in passing that at least in some cases relatives took the patient out of the hospital for marriage "in the hope of curing the insanity" (Ross, 1926, p. 10). But the doctors, again, dismissed the families' hopes as merely irrational, and disregarded the possibility that relatives might arrange marriage for the insane in order to satisfy the latter's excessive yearning for love. The doctors thus sought to prevent families from taking the insane back home, so as to contain the sexual and reproductive danger that the insane posed to society.

However, missionary psychiatry operating under the eugenics discourse quickly changed from seeing the Chinese family as an irrational other obsessed with reproduction to deliberately configuring it as a reproductive machine. Based on this configuration, psychiatry sought to recruit the family to manage the insane. In the 1920s, the Kerr Refuge held two mental hygiene campaigns aimed at educating the public on issues like "heredity and feeblemindedness," "segregation of [the] feebleminded," and "the relation of feeblemindedness to crime, to prostitution, to the spread of venereal disease" (Ross, 1926, p. 13). Most importantly, the campaigns exhorted:

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[21] For the rise of the eugenic subject and its accompanying moral discourse in the U.S., see (Kline, 2001).

> “In this land where agricultural methods have been so highly developed along certain lines it is surprising that there is so little evidence of the appreciation of the importance of stock and seed selection. In this land where posterity is so much desired it is surprising that there is so little evidence of the appreciation of the importance of eugenics. Where children are so greatly desired it seems strange to see how little attention is given to the antecedents of the concubine. Among the most enlightened one very frequently finds the concubine who bears children into the family, has been a slave, or even a prostitute, whose parents are unknown” (Ross, 1926, p. 10)

Interestingly, while knowledge of eugenics and heredity that arose in the U.S. at the turn of the century aimed at erasing the “depravity” of polygamy that “fell outside the bonds of prevailing middle-class standards” (Kevles, 1985, p. 107), in China the missionary psychiatrists, most of whom had been trained in the U.S., no longer sought to defend these particular middle-class morals. Instead, in framing the Chinese polygamous family as a reproductive machine, psychiatrists redefined it as naturally interested in producing the biologically fittest offspring to continue its bloodline, and thus urged it to heed “stock and seed selection,” to investigate the reproductive history of the concubine (Ross, 1926, p. 10), and to calculate and monitor its own reproductive risks. Psychiatry’s critique of patriarchy was now lost, and the family’s instrumental rationality, which it once “discovered” and deplored, now became its own instrument in promoting eugenics.

On the other hand, in the late 1920s, missionary psychiatrists also began to adopt a psychosocial language to critique the pathogenic dynamics of the Chinese family. In a 1926 article on mental hygiene, Robert Ross from the Kerr Refuge systematically discussed the “cause[s] of irritation and strife [in Chinese family life] that we [Westerners] are free from.” These predisposing pathogenic causes included “the unreasonable authority vested in the mother-in-law,” “the concubinage system” that brought fear to wives and concubines who could not bear sons, and in general, “the cramping restrictions upon social exchange between the two sexes”

(Ross, 1926, p. 11). Soon, physicians from other medical facilities started writing on these topics in a full-blown psychoanalytic register. For example, Andrew Woods from Peking Union Medical College wrote:

> "The sexual life of the Chinese is different from ours [i.e. Westerners] in its superficial exhibitions, but obviously has under it the same deep instinctive and emotional forces. They are driven by strong cravings, and these are inhibited by equally vigorous regulative and protective devices on both the instinctive and the intellectual levels. Hence, there are repressions, out of which conflicts arise, causing stormy emotional disturbances." (Woods, 1929, p. 565)

With the language of psychoanalysis, Woods and other missionary psychiatrists thereby started to depict the Chinese individual as a subject with sexual instincts, and Chinese family life as a field of intensities and inhibitions of desire. Exactly like Freud's European families, one might note.

Understanding the Chinese insane in a psychoanalytic register involved a delicate play of universalities and particularities, which, again, was hinged on an analysis of the family. The psychoanalytic discourse saw familial life and sexual exchanges in both Chinese and Western families as suffused with "erotic coloring," such as longing, fixation, disappointment, and antagonism. According to psychologically/psychoanalytically-minded clinicians, this universal eroticism ran counter to the "average Occidental" view that "the Chinese betrothal and marriage customs are without emotions" (Woods, 1929, p. 565), and thereby legitimized the application of psychoanalysis to the desiring Chinese. However, medical missionaries never forgot to locate disturbing cultural particularities in the Chinese family. Following the emancipatory discourse that lamented the drowning of a concubine for her madness, and the eugenics discourse that advised the patriarch to heed the impurity of the concubine's heredity, physicians writing in a psychoanalytic register also discussed the Chinese concubinage system and its toll on women's emotional life. Woods wrote: "Jealousy is as fierce in the Chinese as elsewhere when coveted love strays to superior attractions. Herein is *one of the greatest of the drawbacks to polygamy…*

it becomes the groundwork of subtler conflicts when its control is disturbed by the pressure of passion" (Woods, 1929, p. 566). In this psychoanalytic account, jealousy highlighted women's desire for love and obsession with its objects, casting them as universal libidinal subjects, but this emotion also marked the frustration and repression brought on by the fierce competition, power hierarchies, and demands for propriety that were characteristic of Chinese polygamous families.

Although emancipatory, eugenic, and psychoanalytic discourses often intermixed in missionary writings of the late 1920s, these discursive apparatuses later had different fates, which can only be very roughly sketched out here. The nascent psychoanalytic discourse brought about new therapeutic techniques and gained some social and institutional importance. Since "neuropsychosis is a form of reaction which can only be interpreted if the history of the development of the individual is known" (McCartney, 1926, p. 83y), analytically oriented physicians called for uncovering patients' past sexual and emotional lives through conversation. In addition, medical social service workers were also sent to investigate the intricate history of a patient's family life. The professionals would sometimes suggest rearranging the family's relations and cohabitation pattern, so that what they perceived as the sovereign and dysfunctional extended family could be changed into a nuclear family serving the interests of the individual, including his survival and libidinal satisfaction.[22] In the mid-1930s, psychoanalysis enjoyed a brief period of development in Chinese psychiatry. At Peking Union Medical College, Bingham Dai, a U.S. trained sociologist and analyst, set up a clinic seeing patients and teaching psychoanalytically-oriented therapy to residents (Blowers, 2004). Surveying the social situations that precipitated the patients' disorders, he argued that mental disturbances reflected social ills in

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[22] See (Woods, 1928) for a case study.

China, such as concubinage and tensions with in-laws (Dai, 1941). But after Dai's return to the U.S. in 1939, the voice of psychoanalysis in Chinese psychiatry basically fell silent.[23]

Meanwhile, the eugenics discourse furthered missionary psychiatry's collaboration with police and legal power in terms of reproductive control and bodily discipline. For example, the 1923 provisional criminal code of the Republic of China made it illegal for anyone to have sexual intercourse with persons of unsound mind. As Woods put it, the goal was to prevent the insane person from injuring "Chinese society by marriage and the propagation of undesirable offspring" (Woods, 1923, p. 204). The 1923 law required that a psychiatrist determine whether people suspected of insanity were actually so and to provide testimony to the court, while the Police Regulations of Peking stipulated that the insane be detained and accommodated in an asylum.[24] With this intermeshing of medical and legal apparatus, psychiatry in Republican China gradually leaned toward the eugenics discourse, fashioning itself as a tool of population management.[25]

Because of the continuous political and military crises (warlord regimes, the Sino-Japanese war, and the civil war), psychiatry's subsequent development in Republican China was largely halted by the late 1930s. Around 1949, when the People's Republic was founded, there were only 600 psychiatric beds and less than 50 psychiatrists across the country, for a population of 450 million people (Bowman, 1948). Most of these resources were concentrated in 5 (some

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[23] Outside of psychiatry, psychoanalysis led to the development of psychotherapies focused on the talking cure and mental, emotional aspects of psychopathology. In the reform era, psychoanalysis has certainly experienced a strong revival in clinical psychology in China. Moreover, during he New Culture Movement in the mid 1910s and 1920s, psychoanalysis's "repressive hypothesis was an effective weapon in challenging the prohibition of sexual effectiveness within the terms of Confucian orthodoxy," and therefore "it is fervently embraced by modernizing and modernist intellectuals alike for its emancipatory promises" (H. Lee, 2007, pp. 191, 216).

[24] The Commission on Extraterritoriality (1923). *The Provisional Criminal Code of the Republic of China Embodying Presidential Mandates, the Provisional Criminal Code Amendment Act, the Revised Draft of the Law on Offences Relating to Morphine, Revised Regulations Governing Military Criminal Cases, Regulations Governing Naval Criminal Cases*.

[25] Of course, as with most laws in the Republican period, this provision was probably scantily enforced.

report 9) major municipal psychiatric hospitals (Pearson, 1995, p. 11), all in a state of disrepair. Treatment used in these hospitals was barebones, including insulin shock therapy, metrazol, electroshock treatment, and, more commonly, methods of routine constraint (Bowman, 1948).

Psychiatry in the Maoist Era:

State Paternalism, Revolutionary Spirit, and Community Mobilization

The Maoist regime fashioned itself as what Judith Stacey calls a “public patriarchy” (Stacey, 1983, p. 227), or similar to what Katherine Verdery describes for Eastern Europe as a “parent-state,” a “socialist paternalism” (Verdery, 1996). That is, by nationalizing the means of production, creating urban work units, rural communes, and other mass organizations to arrange, mobilize, and intervene into many parts of people’s lives, the Communist Party assumed the symbolic role of the father. Individuals, through identifying with, working for, and even sacrificing for the state, were guaranteed a widened and more equal access to collective resources. This socialism valorized national and collective prosperity, while denouncing interests that were presumably limited to the individual or the family. It would be wrong to claim that socialism eliminated parental power; in fact, in areas like urban housing distribution, work point accounting in rural communes, and land distribution (the latter before 1956), state policies maintained the family as an economic unit and to some extent further entrenched parental power. However, as most people were recruited into the labor force with the egalitarian identity of “working people,” young adults, women, and other individuals who once occupied lower positions in familial hierarchies now gained more bargaining power with their elders. In addition, with socialist redistributions of wealth, major differences in wealth and privilege between families were reduced or even eliminated.

What sort of life did the Chinese socialist "parent-state" give birth to? It promised a life as part of a working people, with improved health due to easy, inexpensive access to health care. The state's commitment to health led to renewed development in psychiatry during the first decade of the People's Republic. By 1958, there were 46 mental hospitals and clinics in 21 provinces and municipalities across China, equipped with 11,000 beds in total. The number of psychiatric specialists had increased to 400 doctors, including 30 doctors of traditional Chinese medicine, as well as 4600 mental health workers, psychologists and nurses, which was 16-20 times the number in 1949 (Kao, 1979). Treatment costs were minimal for the patients, as most of them were covered by urban labor insurance or rural cooperative health insurance, both of which also provided coverage for non-working dependents. For people with mental illness who had no home, no support, and no means of livelihood (the "three have-nots"), the Civil Affairs Department announced in 1958 that it would provide them with free hospital treatment (Pearson, 1995). Moreover, in contrast to the rejection of Chinese medicine on the part of medical missionaries and the Republican government, Mao in 1956 famously praised Chinese medicine as "a great treasure house" and advocated for an integration of Chinese and Western medicines. During this period, psychiatrists often used herbs, acupuncture, and moxibustion alongside insulin, electroshock therapy (which was, however, banned during the Cultural Revolution), and psychopharmaceuticals like chlorpromazine (Y.-C. e. Chao, 1965).[26] This highly eclectic and flexible approach ensured the provision of cheap and personalized treatment.

In 1958, the Ministry of Health organized the First National Conference of Psychiatric Specialists in Nanjing and issued the National Mental Illness Prevention Work Plan of 1958-1962, the only such five-year plan for psychiatry to appear during the Maoist era. This key

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[26] For the use of acupuncture, see for example (L. Wang, 1956). For the ban of electroshock therapy and its underground use in Cultural Revolution, see (Pearson, 1995, p. 20).

document defined mental illness as “one in which the higher nervous activities of the human body are chaotic and there is a mental block. It brings not only pains and distress to the patient but also brings certain perils to industrial and agricultural production as well as social security” (Pearson, 1995, p. 17). Although this definition emphasized the harm mental illness posed to social order, the Plan did not seek to exclude the patient from the social. Rather, psychiatry at this period saw patients as an integral part of the politicized category of “the (working) people”; they were afflicted by, but were also able to overcome, mental illness, an “enemy” of the revolution.[27] A central task for psychiatric institutions, therefore, was to prepare the patient for his reintegration into revolutionary society. So besides medical treatment, the Plan also advocated labor therapy through organized sports and cultural entertainment, and systematic educational therapy. As John Kao, a Harvard psychiatrist who was often invited to Chinese psychiatric hospitals during the late Cultural Revolution, commented, “the intersection of politics with therapy has insured that the therapeutic community will be suffused with the values and concerns of the surrounding social milieu, and that the goals of therapy in China have been indistinguishable from the goals of society, namely to attain a maximal state of productivity and to contribute to the growth and progress of the Chinese nation” (Kao, 1979, p. 92).

While the Plan’s definition of mental illness may seem to focus only on the biological, psychiatry during the socialist era was in fact imbued with a specifically Maoist dialectical materialism. That is, consciousness was taken to reflect historical material conditions, but it also reacts on the material world, giving people agency to grasp the laws of nature and to change the objective world. According to this view, mental illness was produced by the oppressive conditions of the pre-revolutionary bourgeois society, or by an obsession with a bourgeois

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[27] For an analysis of people vs. class enemy as the central political contradiction during the Maoist era, see (Dutton, 2005).

worldview in the new revolutionary society. While disordered thoughts were neurological activities that required pharmaceutical treatment, their change also necessitated thought liberation. In the hospital, once the patient's symptoms were relieved by medicines, he would be expected to attend collective education, in which all patients and the hospital staff sat together to learn Mao's political writings, to talk about the social changes they had experienced and their roles in the new society, and thereby to recognize problems in their thoughts and attitudes. Because of revolutionary egalitarianism and Mao's increasing mistrust of expert knowledge, the hierarchical relation between doctors and patients was largely leveled. Doctors were encouraged to labor with, live with, and communicate in-depth with patients as proletarian brothers and sisters. During the Cultural Revolution (1966-1976), the importance of thought education, leveling institutional hierarchies, and patient agency was further intensified.[28]

After a decade of development in the 1950s, psychiatry as a profession and institution was deemphasized (though not discontinued) for the rest of the Maoist era. Psychiatric periodicals ceased to be published in 1959, and from then on the state spent little effort garnering data on epidemiology or healthcare resources. Because of the shortage of first-hand data and the unwillingness of most contemporary psychiatrists to comment at length on this period,[29] we could only speculate on the conditions of this period of de-emphasis, conditions from which post-socialist psychiatry would depart. The most sympathetic analysis has been offered by Kao. He argued that if we saw psychiatric patients as victims of oppressive conditions or incorrect ideologies in the pre-revolutionary society, then an explicit connection could be made "between social changes resulting from the revolution and the level of mental health prevailing in the

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[28] For a characteristic domestic report during Cultural Revolution, see (Reporter, 1971). Kao (1979) also discussed dialectical materialism and thought work (he called it psychotherapy) at length.

[29] Psychiatrists' unwillingness to comment on this period is an observation shared by me and some other social scientists working on psychiatry in China.

general population." From his multiple trips to China, he observed that this was indeed the consensus shared by professionals and the public (Kao, 1979, p. 63). Kao also appreciated the ability for the hospitals' social and ideological work to orient patients to "the cohesive and collectively held canon of values" (Kao, 1979, p. 91), thereby to cure many patients. In this reasoning, it only made sense for the state to deemphasize psychiatry given the perceived high cure rate and the relatively low occurrence of mental illness.

One could also trace the de-emphasis on psychiatry to a valorization of community care over institutional medicine. Maoist healthcare policies, including the 1958 Mental Illness Prevention Work Plan (Pearson, 1995, p. 17), always emphasized disease prevention and accessible community treatment. A three-tier referral system was put in place in the regime's early days, in which primary healthcare workers in work units and village communes served as the major contact points for residents, referring them to county- or city-level hospitals if necessary, and these primary care practitioners followed the patients throughout the treatment process. Despite the three-tier system, however, in 1965, Mao announced that he was shocked to discover a huge urban-rural disparity in healthcare resources. In a famous directive to the Ministry of Health, Mao deplored the fetishism of book knowledge in medical education, ordered the Ministry to send most urban doctors "down" to the countryside, and advocated for training grassroots health workers in practice (Pearson, 1995, pp. 77-78). Mao's directive was quickly followed, and from 1968 to 1977, over a million barefoot doctors practiced in rural areas. They were part-time doctors who received a few months of training, but they were generally able to mobilize local material resources and social networks to treat common diseases, including common mental illnesses.[30] Therefore, despite its poverty and political instability, the People's

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[30] For media reports at that time, see for example (Reporter, 1969). For scholarly discussions on barefoot doctors, see (N. Yang, 2006).

Republic greatly improved its citizen's health during its first 30 years of reign, increasing the average life expectancy from 35 to 68 years (Hsiao, 1995). Urban hospitals might have been eviscerated when most practitioners were sent down to rural and urban communities, but on a positive note, the widely accessible primary care probably prevented many patients from requiring intensive inpatient treatment in the major hospitals.

Finally, if psychiatry was a tool to exercise and restore revolutionary reason, we may understand its expansion or contraction through looking at how the counter-revolutionary other was displaced in relation to psychiatry. In 1957, Mao initiated a series of political campaigns to combat the party-state's bureaucratization and maintain its revolutionary character, often by means of discovering and struggling against the "counter-revolutionary elements." The logic of this policy orientation finally led to nation-wide tragedy when, during Cultural Revolution, "counter-revolutionary" became a label to stigmatize and exclude many (H. Wang, 2008).

In retrospect, forensic psychiatrists have estimated that during the late Cultural Revolution, over half of the people undergoing judicial appraisal for mental illness had conducted crimes of a political nature, such as making reactionary speeches or putting up reactionary posters.[31] After being diagnosed as severely mentally ill, these people, exempted from criminal responsibility, were put into hospitals. It might be that the revolutionary ideology had become so hegemonic that any attempt of resistance could reasonably be deemed as completely insane or foolish; or it might be that these people were following a long intellectual tradition, known from ancient times, to fake insanity when making potentially dangerous political claims. While pointing out this "hyper-diagnosis" of mental illnesses, Robin Munro, a former Director of the Hong Kong Office of Human Rights Watch, argued that much more

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[31] Zhong and Shi estimated 54% of the cases they appraised in 1977 were anti-political(Zhong & Shi, 1987). Robin Munro quoted Zheng Zhanpei as saying that 72.9% cases appraised in the Shanghai Municipal Mental Health Center during 1970-1971 were of political nature (Munro, 2000, p. 29).

common were cases of “hypo-diagnosis”; that is, people with genuine mental illnesses, whose symptoms included random political ravings and who might otherwise be hospitalized, were sometimes punished as counter-revolutionary criminals (Munro, 2000, pp. 25-26). In a most dramatic case quoted by Munro, when the Red Guard struggled against the then Minister of Propaganda in 1966, they accused his wife, who had been diagnosed with paranoia for several years and treated with frequent insulin coma therapy, of faking insanity, because she had often lashed out at some Party leaders and their families. All the psychiatrists who had been responsible for her treatment were then charged with “counterrevolutionary conspiracy” in helping her escape punishment (Munro, 2000, pp. 36-38). Of course, in assuming the existence of a stable and unquestionable diagnostic standard from which Chinese practices deviated, Munro’s terms “hypo-diagnosis” and “hyper-diagnosis” draw a false dichotomy between science and politics. Nevertheless, his analysis reminds us that in the late Maoist period, the concatenation and distinction between medical and legal powers, and therefore the expansion or contraction of psychiatric authority, required demarcation by revolution, a powerful notion that was constantly working itself out.

The Making of an Institution-Family Circuit in the Post-socialist Era

From State Paternalism to Family Nurturance

If state paternalism in the Maoist era required people to embrace the party-state as the symbolic father and the source of life, then the post-socialist era has reconfigured the family as the default symbolic and material source of life. Much of this transformation has been driven by the market economy. In 1981, the central government started to promote the household contract responsibility system for rural areas, which allowed household members to band together as a production unit and benefit from any surplus they could generate over government quotas. This policy spurred immediate economic growth, but it effectively dissolved the communes and destroyed the rural cooperative health insurance system. Market reform in urban areas did not emphasize the family as a production unit. But when the state-owned enterprises went through market-oriented adjustment in the mid-1980s and went into bankruptcy en masse in the 1990s, many people became unemployed, especially those who were relatively old, chronically ill, or disabled. Labor health insurance was unavailable for many people working in the rapidly emerging private sector; even for those lucky enough to continue in state-owned enterprises, healthcare coverage became much more limited, requiring workers themselves to shoulder a significant portion of the costs, and insurance was not able to cover dependents as it had in the Maoist era. During 1993-2003, only 30% of the general population was covered by any medical insurance scheme. And the proportion of out-of-pocket expenses to overall healthcare spending rose from 20% in 1978 to 58% in 2002 (K.-Q. Li, Sun, Zhang, Shi, & Kolstad, 2012). Pressured by public outcry against the broken safety net, in 2002 the state started to rebuild the public insurance system in urban and rural areas (Blumenthal & Hsiao, 2005), but so far many people with chronic or life-threatening illnesses are still being left behind. During fieldwork, I often saw retired parents using their own insurance to pay for treatment for their mentally ill adult children, in effect cheating the insurance system with the help of cooperative doctors. In the market economy, where expanding opportunities go hand in hand with increasing wealth disparity and precarious social security, the family is thus being configured as a primary economic unit. Families seek to maximize their opportunities to survive and thrive, while simultaneously having to gather together extraordinary resources to care for the vulnerable (Phillips, 1993).

Besides being an economic agent, the family is also configured by welfare policies and laws as a natural and normative source of life. Remember that in 1958, the Civil Affairs Department (later Ministry of Civil Affairs) instituted a policy providing hospital treatment for the destitute. After that, the Ministry built its own system of psychiatric hospitals dedicated to this population; it eventually provided over 20% of all psychiatric beds in China.[32] In 1987, however, the Ministry broke away from this policy and ordered its hospitals to shift to a self-paying care (that is, fee-for-service) system. Vice Minister Zhang Dejiang stated at that time:

> "We must face reality and develop self-pay care. With the increase in living standards of the people and the continuous development of society there are fewer and fewer mental patients who have no family to go to, no financial resources and no supportive network. There are more and more who are doing nothing productive for society but who do have family support. To work with this reality and to cope with the need of society and expectation of the people we broke the old way of working and shattered the original idea of the 'three have-nots'." (D. Zhang, 1987)

This authoritative pronouncement measured a person's social value against the labor productivity expected by the market, implying that the state is only responsible for economically valuable persons. What was left for the newly valueless patients was their biological life, the maintenance of which was seen as the natural task of the family; and family was presumed to be actually available to most, if not all, patients. This force that naturalized the nurturing family was accompanied by another force that configured familial nurturance as a moral/legal imperative. In 1980, the central government revised its 1950 marriage law. While the 1950 law only stated generally that parents should provide for their children (CPCG, 1950), Art. 13), the 1980 law explicitly stipulated that parents should provide for adult children who could not live independently ((NPC, 1980), Art. 21). This legally stipulated responsibility for nurturance has

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[32] This is the statistics from 1995, published by the China Health Annual, quoted from (Phillips, 1998, p. 22). In this survey, 67.4% of all psychiatric beds are in specific hospitals supervised by the Ministry of Health, 3.5% in hospitals supervised by the Ministry of Public Security, and only 0.7% in urban general hospitals.

weighty implications for families with chronic psychiatric patients, who are the most stigmatized and least likely to be employed among all people with disabilities.

The post-socialist state does not, however, simply retreat from family life and leave it to the questionable mercies of the market economy. Rather, in the Reform era it has intervened even more deeply into the family's reproductive activities. In 1982, family planning (*jihua shengyu*)—or what English speakers usually call the "one-child policy"—became a basic national policy. By taking control of the couple's, especially the woman's, body, the state hoped to control the quantity and quality of children born, so as to alleviate the economic burden of rapid population growth and raise the productivity of the population (Greenhalgh, 2008). This sweeping policy has dramatically reshaped the desires of the family. Married couples now devote the utmost financial and emotional investment into their single children so that the children can develop great biological and intellectual "qualities" (Anagnost, 1995). When a single child—often already an adult—is diagnosed with mental illness, it is with this same desire that parents continually search for a cure, monitor their child's everyday behavior, and feel great disappointment and shame if all hope becomes exhausted.

Anthropologist Charles Stafford has argued that Chinese kinship ties are constituted by practices of *yang*, that is, raising, nurturing, and caring, between parents and children (Stafford, 2000). Yet he doesn't point out the historical and institutional conditions that make *yang*, even parents' *yang* for their adult children or families' *yang* for the vulnerable, an imperative. As we have seen, before the 1980s, neither in theory nor in practice was providing for the vulnerable the sole and unlimited responsibility of the family. When the post-socialist state encourages or even requires the family to take up all the responsibilities of *yang*, it makes the family an isolated economic unit of survival, a biopolitical agent for governing the individual for the sake of the population, and a consumer of biomedical techniques. Configuring the family as such, then, allows the state to withdraw its safety net while extending its channels of intervention.

Professionalization, Institutionalization, and Commercialization of Psychiatry

The post-socialist state has summarily repudiated the Cultural Revolution and everything it represented, turning instead to a putatively value-neutral and apolitical science to chase the dream of wealth. Accordingly, Maoist psychiatry seems to be the "anything but" other for post-socialist psychiatrists, who have busied themselves with reconstructing a professional identity that is independent from state or Party ideology. Young Derson, a prominent Chinese psychiatrist and WHO-appointed expert, has commented: "We do not believe that you can get a disease from a wrong idea—nor will a 'correct idea' cure a patient. We try to teach the meaning of illness, based on scientific knowledge" (Achtenberg, 1983, p. 373). In 1979, the Chinese Society of Psychiatry published the Chinese Classification of Mental Disorders, which over time has increasingly been shaped by American and international diagnostic standards (S. Lee, 2001). From then on, psychiatry has come to be dominated by the biomedical model, which sees mental illness as ultimately resulting from neurochemical imbalances. As I observed during fieldwork, most psychiatrists now criticize traditional Chinese medicine's understanding of insanity—which as we saw above is symptom-focused and takes seriously the interaction between physiological, emotional, social, and even cosmic processes—as superficial, unable to grasp the neurological foundation of mental illness. So they either refuse to use Chinese medicine at all, or merely use it to ameliorate the side effects of psychopharmaceuticals.

Related to the professional pursuit of scientific/biomedical identity is psychiatry's effort to build a strong institutional presence. In 1982, a team in the Ministry of Health collaborated with the World Health Organization to conduct a 12-region epidemiological survey. It found that schizophrenia affected 6.06 out of 1000 population in urban areas and 3.42 out of 1000 population in rural areas (Phillips, 1998, p. 5). These numbers are comparable to the global lifetime prevalence of schizophrenia, 0.30–0.66% (van Os & Kapur, 2009). They have thus become authoritative figures for the morbidity of severe mental illnesses in China, making psychiatric patients a stable and alarming presence, and thereby helping psychiatry get attention from the general public and resources from the government. In 1987, almost three decades after the first national mental health conference, a second one was held. The meeting issued *Opinions about Strengthening Mental Health Work,* which portrayed psychiatry as the victim of underdevelopment and the state's neglect. According to the document, the government allocated only half the funds to psychiatric hospitals that they gave to general hospitals at the same grade. And there was a grave shortage of psychiatric beds: at that time there were only six beds for every 1000 psychiatric patients; 80% of patients were not able to receive treatment and 95% of patients could not be admitted to hospital (Pearson, 1995, pp. 84-85). By constantly invoking these statistics in media and policy reports, psychiatrists limit mental health services to those grounded in institutions, thereby calling for government investment in building more institutions, while ignoring other aspects of mental health services that might be more needed and/or less developed. This use of statistics has been quite effective: from 1978 to 2009, the number of psychiatric hospitals in China was increased from 219 to 637, the number of psychiatric beds was increased from 42,000 to 191,000, and the number of psychiatrists was increased from 3,128 to 18,800 (K.-Q. Li et al., 2012).

In the Maoist era, families were just nodes in a vast social network that barefoot doctors and other primary healthcare workers mobilized. Yet in the post-socialist era, with radical commercialization of health care and the state's uneven (dis)investment, the community healthcare system crumbled. From 1978 to 1999, the central government reduced its share of national healthcare spending from 32% to 15%, while relegating much responsibility to lower levels of governments (Blumenthal & Hsiao, 2005). Because higher-level governments—provincial and municipal, and especially metropolitan, authorities—have better financial situations, their support for large, tertiary care institutions within their jurisdictions is much better than the support received by county- and village-level hospitals/health stations (K.-Q. Li et al., 2012). Community healthcare workers are thus poorly paid, and most former barefoot doctors are unemployed in an era that requires them to "wear shoes," that is, to have formal schooling and credentials. To survive, many of these grassroots doctors have abandoned their devotion to community health provision, and instead resorted to selling drugs or providing for-profit services. At the same time, as patients and families have now become the main payers for healthcare services, they come to desire services of as high a quality as their money can buy. Sharply aware of the low quality of primary care, they often go directly to large tertiary hospitals for even small ailments. The three-tier referral system has in effect collapsed. In psychiatry, patient flow is even more concentrated in specialized hospitals, because only 1.54% of all secondary and tertiary general hospitals across the country have psychiatric beds (Gong, Feng, & Wang, 2005).[33]

Although provincial and municipal psychiatric hospitals are in a better financial situation than lower-level hospitals/health stations, government support still only accounts for less than 30% of their total income (Gong et al., 2005). This financial support is mostly spent on infrastructural expansion (such as purchasing new equipment) and hospital staff's basic salaries,

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[33] Psychiatrists whom I interviewed attribute this uneven institutional arrangement to the stigma associated with severe mental illnesses, and to the fact that psychopharmaceutical treatment is not as profitable as surgical or other treatments.

which are meager and relatively unchanged compared with the skyrocketing prices for consumer goods. Hospitals shoulder their own everyday expenses and the staff's bonuses, the latter being increasingly unrestricted by government policies. Hospitals in turn put the pressure of revenue generation directly onto departments and individual physicians. At the same time, although the government tightly controls the prices of routine medical procedures and basic medicines, it permits facilities to collect profits from new drugs, new tests, and technologies. As a result, physicians excessively prescribe expensive drugs and procedures, for which they often receive kickbacks from pharmaceutical and medical technology companies. From 1978 to 2002, annual per capita spending on personal health services increased from CNY 11 to 442 (or roughly USD 1.35 to 55), and half of this expenditure went to drugs (Blumenthal & Hsiao, 2005). In specialized psychiatric hospitals, physicians also tend to promote inpatient treatment. It allows them to prescribe and charge for larger dosages of drugs, a wide variety of machine examinations, and diverse therapies (music, sports, handicraft, etc.), which last often become the only means for patients to enjoy a short period of freedom outside the closed ward. During my fieldwork in 2008-2014, the standard course of inpatient treatment recommended by psychiatrists in Guangzhou Brain Hospital lasted for 3 months, and the cost was CNY 6,000-10,000 per month (other less famous hospitals charged slightly less, but all above CNY 4,000). Meanwhile, Guangzhou residents' average annual income in 2012 was CNY 5952.1 (Consumer Committee, 2013). Hospital bills thus drained the resources of many families, especially the families of the half of the patient population who had come from small cities or rural areas outside of Guangzhou. In order to keep their family members under treatment, parents, siblings, and spouses often had to run around borrowing money from relatives and friends to pay the bill.

In short, families in the post-socialist era have taken on heavy responsibilities for caring for persons diagnosed with severe mental illnesses, mostly by arranging for psychopharmaceutical and inpatient treatment. I have traced the intensification of family responsibilities as such to the retreat of state welfare, the expansion of eugenic policies, the naturalization and moralization of family nurturance, the rapid institutionalization and pharmaceuticalization of healthcare, and—undergirding all these—the dominance of a market economy that measures an individual's value according to his labor productivity and wealth. In Chapter 2, I will examine the psychiatric discourse that grants the family *de facto* and, most recently, *de jure* rights to decide upon a person's commitment to and release from the psychiatric hospital. I will argue that such family rights cannot be seen as a mere repetition of Confucian patriarchal power, which hinged on a relational, filial personhood; instead, they are conditioned by an idea of a biological *individual* who should be protected and disciplined by the joint force of psychiatry and the family, for the sake of himself and of the population. While the family's rights in hospitalization and its desire for "magic pills" to cure (and control) may spark many legal and everyday controversies, creating much anguish in inpatients who disagree with their commitment, Chapter 3 tells us that expensive hospitalization and the psychiatric discourse of *chronic* mental illness also entrap families—no matter what their initial intention is—in a life of chronic responsibility and uncertainty. As the story unfolds, we can see what I call an "institution-family circuit" being formed in post-socialist China. In this circuit, the psychiatric institution and the family work together to shape and manage the biological individual who is perceived as a chronic source of risks, who indeterminably depends on and struggles against psychopharmaceutical care (Z. Ma, 2014a). In this circuit, the family is no longer the other of psychiatry, but psychiatry's closest ally and biggest consumer.

The Return of the “Iron Cage”

In 2003, the SARS (severe acute respiratory syndrome) epidemic led the Chinese state to own up to the grave disrepair of the public health system and to start investing in its reconstruction. Psychiatrists were eager to jump onto this bandwagon, out of a strong fear of falling behind: after all, they had never received direct financial support by the central government in the reform era, and they felt they were being looked down upon by the state and their medical colleagues, because of psychiatry’s quasi-scientific status and relative unprofitability compared to other disciplines that trafficked in expensive treatments like surgeries. This time around they were able to turn the tide. In 2004, the "National Hospital-Community Integrative Treatment and Management Program for Severe Mental Illnesses" was established, and it received CNY 6.86 million from state revenue for the first year. Meager as the amount was compared to the state’s overall public health investment, the psychiatrists concerned were overjoyed; since then they have been calling the program “the 686 Program” (PKU6, 2012).

Interestingly, one of the most publicized components of the 686 Program, or oftentimes the only component reported by the press, is “unchaining.” The Program requires community mental health workers to visit households that have, or are suspected to have, persons with severe mental illnesses. If the worker discovers any “chaining,” that is, “the patient’s freedom of mobility being restricted by ropes, chains, or iron cages for non-medical purposes” (Ministry of Health, 2012), he should report it, have the ropes, chains, or iron cages removed, and, if necessary, send the patient to the psychiatric hospital for free inpatient treatment. The common media depiction of domestic confinement is not unlike that current more than a century ago: the confined patient has a strong smell, is covered in filth, wounded by chains, cannot walk or even stand up, and lives in a state of total abjection and disorientation. Meanwhile, the story after the patient is unchained and receives inpatient treatment is almost always one of miraculous deliverance: the patient is clean, stabilized, and clear-headed; he can walk, talk, and take care of himself; in some cases he even goes back to work (Kong & Li, 2013)!

No doubt, domestic confinement exists, and I encountered several cases when following community mental health workers to patients' households. In Chapter 4, I will recount these encounters, reflecting on the conditions that make possible and continue to entrench such domestic confinement. For now I am concerned with what the discourse of domestic confinement posits and mobilizes, or in other words, its effects beyond the actual unchaining moment. One central question is: if, in the post-socialist era, the family becomes psychiatry's friend rather than foe, how can psychiatry remain obsessed with faulting the family for confining the patient?

The answer is, simply, that psychiatry does not really find fault in the family, or rather, it is a fault not of malice, as missionary psychiatrists a century ago would have it, but of helplessness. Remember that in the *New York Times* article I quoted at the beginning, the parents who had locked away their son for 28 years had done so because they had been "left to their own devices" and thus "had no choice." If the institution-family circuit requires a smooth flow of patients between the institution and families—that is, the family should immediately hospitalize the patient in crisis, receive him in remission, and closely monitor him for signs of relapse and readmission—then the flow as psychiatrists see it is often blocked. According to psychiatrists, the flow of patients is stuck because the collapse of the public medical insurance system and the overemphasis on fee for service has made inpatient treatment unaffordable by a growing number of people (Phillips, 1998). From 1991 to 2001, the occupancy rate of psychiatric beds across the country decreased from 98.6% to 75.16% (K.-Q. Li et al., 2012). The flow of the institution-family circuit is stuck because the state has not invested enough in building psychiatric hospitals, training psychiatrists, and making services easily accessible to people in remote areas. It is stuck also because, unaware of the urgency of psychiatric care, families miss the best timing for inpatient treatment and wait until things get out of control.

The sensational image of domestic confinement has thus allowed psychiatrists to make a strong case for institutional expansion and increased government support. For instance, since 2002, the state has been trying to rebuild the public health insurance system, partly by systematizing and widening the list of insurance-covered essential medicines. A growing number of psychopharmaceuticals has recently been included in the list. Thanks to the more affordable medicines and available health insurance, the occupancy rate of psychiatric beds climbed back to 95.2% in 2009. The new Mental Health Law that came into effect in 2013 requires county-level governments to arrange for medical institutions to serve patients with severe mental illnesses ((NPC, 2012c), Art. 68). In many cases, this has come to mean establishing a psychiatric hospital or a psychiatric department in a general hospital in every county. Moreover, domestic confinement's tragic consequences for the patient and the family have served as a negative lesson for the general public, reminding them to be constantly on the watch for their loved ones' potential symptoms and willing to secure timely inpatient treatment. The focus on the evils of domestic confinement has also allowed psychiatry to gloss over its own use of constraints in inpatient treatment, or justify these practices as serving medical purposes. This was particularly evident when human rights activists took issues with involuntary hospitalization in the recent debates on legislation.

More than a century ago, medical missionaries deplored the familial “iron cage” because it entrapped the universal human; now, psychiatrists often sympathize with the family, because they see it as living with a danger, a source of immanent violence. In other words, rather than a dehumanized person, what is now in the cage is likely to be seen as a real beast. For example, the *New York Times* article quoted above does not mention why exactly the parents had no choice but to lock away their mentally ill son. But it does describe, before this story, a series of incidents reported by Chinese psychiatrists, in which untreated psychotic patients committed horrid violence, such as random killings of strangers. The reader is thus led to suspect that the parents locked away their mentally ill son in order to prevent his violent outbursts (LaFraniere, 2010). In Chinese domestic media, depictions of violent psychiatric patients have become even more prevalent. In recent years, whenever an apparently senseless crime like a public slaughter happens, a psychiatrist is quoted by the media speculating about whether the perpetrator is mentally ill. If actual incidents of patient violence are numerically rare, the current portrayal of domestic confinement can make people’s fear of it more pervasive. Thanks to their nature of being hidden from the outside, cases of helpless families confining the putatively violent patient could be innumerable; one publicized case can stand in for an indefinite number. In a recent report published by the state’s official news agency, and clearly endorsed by the 686 Program, the authors first lament the difficulty of calculating the number of cases of domestic confinement, but then claim that over one million patients across China are under domestic confinement. (The latter assertion is based on a rough estimate from Hebei Province, which in turn seems to be based on a small sample in one region.) The authors argue that these families confine the patients out of a sense of responsibility to protect the public, implying that other families who cannot bear the responsibility may simply let the patients roam free (Kong & Li, 2013). The report thus uses domestic confinement to connote the looming danger of both mental illness and homelessness.

This emphasis on patient violence, aided by the portrayal of domestic violence, has again facilitated psychiatry's entrance into public health: If mobile germs and viruses could kill a large number of people, the mobile psychotic patient could also inflict harm on not just his immediate surrounding but also the general public. With this logic, psychiatry has inserted itself into the public health apparatus, which has traditionally focused on infectious diseases, and also into the public security apparatus, becoming a key link between the two. The 686 Program now requires community mental health workers to evaluate the risk level posed by the patient during regular home visits. It also requires local health departments and police departments to regularly share information on dangerous patients. All these techniques serve the key motto of the 686 Program, that is, to manage (*guanli*) the dangerously mentally ill.

Conclusion

We have come a long way to achieve a simple goal: to denaturalize the image of the family as it is deployed in Chinese psychiatry. In the discipline's 117 years of official history, it has often been centrally concerned with the Chinese patriarchal family that confines the patient with mental illness in an "iron cage." Alternatively, especially in the last 30 years, Chinese psychiatry often exalts the family as a basic unit that should provide spontaneous, altruistic care for the patient. Drastically different as they are, the two images both presume a certain timeless essence of the Chinese family. Anthropologist Michelle Rosaldo once contended that an assumption that patriarchy or the public/private divide are universal would inevitably lead to a conclusion of primordial human need, and thus preclude critiques of power relations; as a solution, she advocated examining how a certain sexual division of labor "is bound up with extremely complex forms of interdependence, politics, and hierarchy" (Rosaldo, 1980, p. 412). Similarly, to make room for a critique of Chinese psychiatry, I have traced a genealogy of how, in different eras, various forces have come together to configure the family, how such configurations are shaped by, and in turn condition, certain power relations and subjects of insanity.

For most of the imperial era, the family was not problematized, that is, not constituted as a central object of thought, in the treatment of insanity. Medical practitioners saw insanity as a manifest and temporary disorder of the physiological processes, which could express socially frustrated desires. Practitioners might recruit family members to discipline or satisfy the insane's desires, but they did not need families' help to detect some secret disorder or constantly monitor the insane. At the same time, since Confucian filiality manifested itself as both a universal principle and in particular hierarchies, the family could claim patriarchal power only over the filial person, but not over the individual's total physical existence; relatedly, the family's responsibilities to provide for the vulnerable were circumscribed, particularly by the filial state. However, when Qing law required families to confine the insane, whom it was beginning to see as permanently dangerous, it started to turn the family into an agent of the state, required to manage the individual's physical existence.

When missionary psychiatrists established the first asylum for the insane in Canton in the late 1890s, they saw the Chinese family as a patriarchal power over the life and death of the individual, and thus defined their task as rescuing the insane from domestic confinement. In eliding the historical and political conditions for domestic confinement, and refusing to recognize families' concerns for patients, missionary psychiatry was able to collaborate with the police, but failed to gain support from families. Ironically, missionary psychiatry's strategic alliance with the police gradually turned the asylum into a space of constraint, coinciding with what it had deplored in the family. The subsequent rise of eugenics exacerbated missionary psychiatry's tendency to control and manage, this time by recruiting the family to calculate the reproductive risk posed by the insane.

The Maoist regime fashioned itself as a parent-state that gave birth to the healthy life and revolutionary spirit of the working people. The state's commitment to health initially spurred the development of institutional psychiatry, which combined pharmaceutical treatment with rehabilitating the patient into the revolution. However, institutional psychiatry was deemphasized in the later Maoist era, probably because the regenerated society had reduced people's distress and their need for psychiatry, because the state's all-out effort to develop community health care prevented many people from requiring intensive inpatient treatment, or because the revolutionary ideology central to psychiatric epistemology marked a growing group of "counter-revolutionaries" off the list of mentally ill patients.

Turning away from socialist paternalism, the post-socialist state has whole-heartedly embraced a market economy that measures people's value according to their wealth and labor productivity. The unproductive and valueless psychiatric patient is now left to the family, which is configured as an economic unit of survival, a natural and moral source of life and care. The population quality discourse promoted by the state has shaped families' desire for "magic pills" that cure the patient. Meanwhile, biomedicine's effort to rebuild a professional and institutional identity has coincided with the state's uneven disinvestment in health and the ensuing collapse of community care. Together, they make expensive inpatient treatment almost the only option for families with psychiatric patients. An institution-family circuit has thus been formed in post-socialist China, in which the chronically ill patient is constantly shuffled between the family and the total institution, while the family—now the major ally and consumer of psychiatry—carries chronic responsibilities for care, management, and payment. To insert itself in the state's recent attempt to rebuild public health, psychiatry has again turned to discovering and eliminating domestic confinement. As an alleged symptom of the blocked institution-family circuit, the image of domestic confinement now serves to justify the expansion of psychiatric institutions. Compared to the similar image mobilized by missionary psychiatrists a century ago, the patient confined is now seen as a real danger. This new image has thus allowed psychiatry to insert itself in the state's growing security apparatus.

While tracing a genealogy of different configurations of insanity, intimacy, and institutionality, I have also endeavored to explain Chinese psychiatry's continual obsession with the family. Max Weber famously distinguished three types of authority, including traditional, charismatic, and rational authorities (Weber, 1958). In their efforts to define abnormality and govern life, the family and psychiatry seem to fall into two separate categories, that is, traditional authority and rational authority. However, using a dialectical method, I have shown that psychiatry legitimizes itself as a rational authority precisely by configuring the family as an ahistorical tradition and then taking issue with it. The family could be a blind and malicious power, or a well-meaning but ignorant and helpless caregiver. Either way, it is by positing the traditional family as a lack that psychiatry fashions itself as a modern, rational discipline and justifies its institutional development. When this dialectic plays out in networks of power that seek to discipline the dangerous individual and defend the social, it has allowed the putatively humanitarian psychiatry to grow teeth and then hide them from plain view.

The historical overview of psychiatric configurations of the family also reveals the emergence and transformation of the ideology of *guan* in the ethics of care and the politics of governance. The ideogram *guan* initially referred to a wind instrument made of a jade or bamboo tube, or a key to a lock. Probably shaped by these initial references, *guan*'s subsequent verb form almost always carries a sense of ordering and orchestrating, like directing the air that flows through the tube, or assuming responsibility to open a horizon, like handling a key. Specifically, before it had anything to do with insanity, *guan* as a verb had meant to administer, control, discipline, and restrain; or to concern oneself with, be responsible for, guarantee, or provision. Qing law introduced *guan* to the social arrangements for insanity by requiring the family to confine and control, or *guan*, the insane. Since then, bodily disorder has become tied to social disorder, and different medical or legal apparatuses often try to restore the latter by containing, managing, or eliminating the former, whether or not the notion of *guan* is explicitly invoked. The idea of putting the psychiatric patient under *guan*/management, along with the connection of bodily disorder and social disorder, has been highlighted in the post-socialist era, when, as Michael Dutton points out, the socialist struggle between the revolutionary people and the counter-revolutionary enemy has given way to the policing of the people themselves by discovering and disciplining dangerous elements (Dutton, 2005). Yet in this medicalized context, *guan* also takes on an explicit ethic of care: first, the family is assumed to have a natural proclivity and moral responsibility to provide (biomedical treatment) for the patient; next, the state has renewed its commitment to public health precisely by closely monitoring the risks posed by patients in the community. Care and management thus become entangled to give birth to and orchestrate a biomedicalized life, a life that does not just connect to spaces of confinement, but more importantly unfolds in the flow through the institution-family circuit.

How is the entanglement of care and management legitimized and contested? How do specific entanglements hinge on and transform family affects and emotional labor? These are the questions I will explore in subsequent chapters.

CHAPTER 2

CONSTRUCTING RIGHTS, CONTESTING PATERNALISMS: THE MAKING OF THE MENTAL HEALTH LAW IN CHINA

A Legal Vacuum Called "The Family"?

On a cold winter day in 2013, Chen Dan, a female engineer in her early thirties, met with me over a hot-pot dinner. This marked the tenth day since she had lost her case against a model psychiatric hospital in Beijing for violating her rights to personal freedom, a case that had culminated in the recent mental health legislation debate. On June 5, 2012, Chen's Beijing apartment was broken into by four male strangers. The assailants were followed by her parents, who, according to her, hated her boyfriend and wanted her back home in Northeast China. They snatched her from her boyfriend, put her in a van and drove her to the hospital. At the outpatient clinic, a doctor met with her parents. He noted a diagnosis of "agitation" on Chen's medical records, and processed the paperwork for her hospitalization. At the same time, watched by one of the assailants in the hallway, Chen furtively texted her friends for help. A moment later, she found herself in a locked inpatient ward, her cell phone confiscated by a nurse.

Initially scared, Chen collected her thoughts. She told doctors on the ward about her estranged relationship with her parents, insisted that she was not sick, and threatened to sue the hospital if she was not released immediately. Alerted, psychiatrists of various ranks came to question her. They made five different diagnoses in three days. At the end of the third day, she received the final diagnosis of "recurrent depressive disorder, remission stage," because her parents had said she felt unhappy about a previous breakup and had once sought counseling. Against the objections of her parents, the hospital then discharged Chen to her boyfriend, claiming that she was "in remission" and thus did not need hospitalization. But as Chen later told me, the doctors knew that they had wrongly committed her; they made up the diagnosis, placing her in an indeterminate state of remission along a chronic illness trajectory, in order to justify both the detention and the discharge.

Immediately after she was released, Chen contacted Huang Xuetao, a prominent human rights lawyer and activist on mental health issues. Huang quickly summoned the press, which then fiercely attacked the hospital for wrongfully committing an innocent, "normal," and capable young woman, thereby violating her right to autonomy and self-determination. News headlines that sent shockwaves through the public included "Female engineer hospitalized by parents because of free love?" (P. He, 2012)[1] and "72 hours of being mentally illed (被精神病/*bei jingshenbing*)" (Xi, 2013). As we will see in this chapter, "being mentally illed" has been a keyword in the mental health legislation debate since 2010. It usually refers to the process in which an individual who appears to be "normal" in the public eye is accused of being mentally ill, and forcibly hospitalized in the interest of political, familial or other kinds of control (EJI, 2010).

In response to the media outcry, the hospital held a press conference with the theme "Being mentally illed is not as easy as you think." In the conference, the hospital staff reported Chen's illness history as it had been collected from her parents, including her "suicidal behavior" and "paranoid" view that her parents would harm her. The hospital staff argued that the decision of hospitalizing Chen followed the Beijing Mental Health Regulation's stipulation on "medical protection hospitalization." This stipulation allowed guardians to hospitalize patients with severe

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[1] In Chinese, the term "free love" emerged from the May Fourth Movement in the 1910s. Denoting a modern form of intimacy based on the couple's free will and passion, it is often invoked to resist marriage arranged by the traditional, patriarchal family (H. Lee, 2007).

mental illnesses against their will. Accordingly, the decision had been made in order to protect Chen's "right to health" (P. Wang & Li, 2012).

Shortly after the press conference, Chen filed suit against the hospital. In court, Chen's attorney argued that the Beijing Regulation was inapplicable, because she did not have severe mental illness,[2] and because as an adult with full legal capacity, she should not be placed under her parents' guardianship. Yet in the end, the court, which Chen suspected to be biased toward the hospital because of local ties, found for the defense. The verdict said if Chen's parents had provided inaccurate information to the hospital, then they, and not the hospital, would have been responsible for any violation of rights. Furthermore, it was ruled that although the outpatient doctor did not diagnose Chen with severe mental illness, the "complexity and diversity" of the ways mental illness can manifest justified the inpatient observation (D. Chen, 2013).

When we met, Chen was eager to recount to me not just the hospital's wrongful treatment and the court's biased ruling, but more so her indignation towards the oppressive family, as well as the legal and popular culture that is blind to its abuses. As much as she hated being called mentally ill, she did not hesitate to tag her parents as "nuts." She told me that her parents were paranoid, antisocial, and were preoccupied with her. They thought all of her friends, including her boyfriend, intended to harm her, and were concerned that life in the city was corrupting her. To avoid their control, she had had to move often. She said that this was why they had had her kidnapped and taken to the hospital: it was the only way they could make her a stable target, and eventually move her back to her hometown. According to Chen, this kind of parental control and family conflict is pervasive in China. While controlling and hurting others, people often claim "I'm doing this for your own good." In order to cure this pathological culture, Chen argued, "The Mental Health Law should be concerned with the sick adults, not the bullied children."

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[2] In the current medico-administrative system, depression does not count as a severe mental illness.

Yet to her dismay, nobody seemed to recognize these conflicts. Not only did the psychiatrists continue to take her parents' word at face value, the whole bureaucracy seemed to have a blind faith in "the family." In order to find the kidnappers, who had disappeared after the hospitalization episode, Chen filed a criminal complaint of illegal detention to the police. This implicated her parents as accomplices, because they were the ones who had hired the kidnappers. Upon hearing her case, the police shrugged, "There can be no illegal detention between parents and children. Your parents broke into your apartment, so what?"

As Chen saw it, domestic relations are a vacuum in the Chinese legal system, where parents (or other family members in control) have natural immunity no matter what kind of injuries they have brought about. More than a mere lack, this legal vacuum allows for a culture of paternalistic control that prevails not just in the family, but for the entire state. Chen said,

> "State paternalism is like that of the family. When you oppose the state, even if the state is wrong, it will deprive you of rights, because it wants to control you. The same goes with the family. Parents may be wrong, but they want to control you, because they are the ones in power."

Splitting Rights, Scaling Paternalisms:

An Ethnography of Lawmaking

Sensational as it is, Chen's case reflects a mundane and widespread phenomenon in contemporary China: most psychiatric inpatients are hospitalized against their will by their family members. According to a survey of 17 flagship psychiatric hospitals across China in the early 2000s, more than 80% of all psychiatric patients in China were involuntarily committed—60% by families, and another 20% by police or other public sector agents—a rate much higher than in most other countries (Pan et al., 2003). In Chapter 1, I outlined the politico-economic conditions within and beyond the medical system during the reform era that have concentrated responsibilities of healthcare onto the family, and that have made expensive institutional treatment the most desirable form of care. In this chapter, I will briefly examine the psychiatric discourse that legitimates or even necessitates involuntary hospitalization by this modern family. In particular, I will show how the biological individual that is envisioned by psychiatry requires a paternalistic intervention that weaves together certain forms of ethics and knowledge drawn from both the medical profession and the family.

While it was typical of the commitment process, Chen’s case caused a sensation partly because it happened on the eve of the passage of the first national Mental Health Law in China. Here is a brief chronology of the long-drawn-out legislation process: In 1985, the Ministry of Health (MoH) commissioned Dr. Liu Xiehe, a forensic psychiatrist in Sichuan, to draft a national mental health act. Dr. Liu summoned help from his colleagues, consulted experts from the World Health Organization (WHO), and solicited opinions from relevant government sectors on the legislation. But the draft he submitted to the MoH in 1990 strangely sank into oblivion, until nine years later, when the MoH convened younger psychiatrists from Beijing and Shanghai to revive the legislation drafting process. Then in the early 2000s, as test runs for the national legislation, several cities passed municipal mental health regulations, starting with Shanghai in 2001. Yet outside of the small group of drafting psychiatrists, these processes and products were largely unknown. It was not until 2006 that cases similar to Chen’s turned people’s attention to problems involved in involuntary commitment, igniting public discussion about the legislation. Among the agents who propelled this discussion were human rights activists like Huang Xuetao, who were well versed in Chinese and international law, along with self-proclaimed survivors of psychiatric abuse (“survivors” hereafter) as well as some members of the journalistic community. Their mobilization significantly accelerated the legislative process. In 2009, the Legislative Affairs

Office of the State Council took over the law's drafting from the MoH, which marked the entrance of the legislation into the central government's purview (psychiatrists were still closely consulted). Drafts were released in order to solicit public opinion, and were reviewed by the National People's Congress. Finally, in Oct. 2012, the national Mental Health Law was passed, and it came into effect in May 2013.

This chapter traces the making of the Mental Health Law, especially the public discussions that took place over the last few years of the legislative process. It addresses two empirical questions: first, what were the discursive strategies deployed by interested parties—particularly human rights activists and psychiatrists—to define the issue and to recruit the public's interest to their campaigns? Second, although the legislation debate started with controversies around family-initiated hospitalization, even earlier than that of Chen Dan, the Mental Health Law ended up emphasizing the role of the family in psychiatric care. While recognizing the psychiatric patient as a sovereign individual with the right to autonomy in principle, the law curiously also subjects the patient to the family's guardianship. It grants family members the right to consent to patients' treatment and to decide upon involuntary commitment of those who pose a risk to themselves. It also stipulates that families have the responsibility to provide for, look after, and monitor the patients. Why is the family so valorized in the law?

Rather than trials invoking the Mental Health Law, which were seldom open to the public, my analysis draws on media reports, online discussions, face-to-face debates (such as conferences) between activists and psychiatrists, and my interviews with key stakeholders. My answer to the first question about discursive strategies highlights two techniques, namely scaling and splitting. As sociolinguist Jan Blommaert puts it, scales present social phenomena in "a stratified, non-unified image of social structure," and scale-jumping or scaling is a "vertical move within a stratified social meaning system, enabling and mobilizing the various forms of indexical reordering of the statement" (Blommaert, 2007, p. 4 & p. 7). Using keywords like "being mentally illed," activists *scaled up* the handful of cases they had to index a type of psychiatric abuse that could reveal the general conditions not just of the Chinese family, but also of the biomedical profession, and even of law and governance of the Chinese state. The object of critique that cut across these different scales was the culture of paternalism. Activists and their supporters like Chen Dan saw paternalism as abusive control in the name of care, and sought to replace it with a culture of rights that respects the individual's autonomy and limits the power of the family, the medical profession, and the state. By scaling up cases of psychiatric abuse to a matter concerning the nation-state's entire past and future, activists broadened the scope of their legislative campaign, making it cognitively and affectively relevant to the general public.

If "being mentally illed" portrays a "normal" individual being wronged by psychiatry, then it inadvertently implied that a "truly" mentally ill person might be properly subjected to hospitalization. It is in this normal/pathological split that psychiatrists found ways to defend their professional practices and legislative vision: if activists sought to protect the "normal" individual's right to autonomy, then psychiatrists were promoting the right to health for the "pathological." Along this divide, they redefined paternalism as a valued ethic of care for the pathological individual. Psychiatrists also scaled up the normal/pathological divide, including their emphasis on a caring paternalism, from the individual level to the population level. In so doing, life as it is conceived and contested in post-socialism has become a fractal dualism.[3]

This semiotic analysis of lawmaking leads us to the second empirical question of this chapter, that is, why the family is so valorized in the Mental Health Law. I argue that this is not a

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[3] Judith Irvine and Susan Gal define fractal recursivity as "the projection of an opposition, salient at some level of relationship, onto some other level" (Irvine & Gal, 2009, p. 403).

simple failure to comprehend patient rights or an unproblematized continuation of paternalistic Chinese culture, as Chen Dan might put it. Rather, I hope to show that in the law, and in contemporary Chinese biopower in general, the family is positioned to mediate the normal/pathological divide that is central to how the individual subject and the population are conceived, as well as to negotiate the contesting visions of rights and paternalism.

Ultimately, as the chapter's conclusion will discuss in detail, analyzing these empirical questions about the mental health legislation can reveal the forms of life—including the rights of citizens and the responsibility for them—that come to matter discursively and institutionally in contemporary China. A close look at how people define paternalism and scale it across different domains will show us how intimate, biopolitical, and state powers intertwine with each other in post-socialism. After all the discursive contestation, the paternalism that is enshrined in the Mental Health Law is a neoliberal one. It conjoins a biomedical quest for the normal, a human rights fear of the state, and a rising security concern with risks, loading them all onto the shoulders of the family. Because in the legislation debate, paternalism was often referred to as the guiding ethic of *guan*, the Chinese praxis of governance, this chapter also begins to unfold the social and psychic implications of *guan*. Finally, attending to frictions between scales and to gaps in the normal/pathological divide, the conclusion will also discuss the blind spots, vulnerabilities, and disparities that the post-socialist structure of care might produce.

Insight, Intimate Knowledge, and Involuntary Hospitalization

Contemporary Chinese psychiatrists whom I have observed or interviewed often emphasize the importance of having a "normal self" for mental health. Its characteristics were explained at a free public lecture on psychopathology I attended: "First, self-ownership. This behavior is mine; I'm the person who does this, not others. Second, my behavior has intentions and motivations. Third, one's thoughts, emotions and behaviors are integrated. For example, I feel happy when I eat my favorite food." Psychopathology, in particular schizophrenia, destroys these characteristics and is thus a "disorder of the self." For example, a patient with schizophrenia may believe that others are imposing thoughts on him and acting through him, and feel that he is alienated from himself. Psychiatrists attribute this self-disorder to neurochemical imbalances in the patient's brain, and endeavor to treat it with psychopharmaceuticals.

Underlying all the characteristics of the self is the idea of self-knowledge or insight (自知力/*zizhili*). In the field of psychopathology, key psychiatric texts in Chinese define insight as "the ability to realize, understand and describe one's abnormal mental status and pathological behavior" (SMPC, 2001). A lack of insight could make the patient unwilling to accept treatment. Of course, in China and elsewhere, psychiatrists have long seen the lack of insight as a feature of severe mental illnesses. Yet it is only in the post-socialist era that the *self*-conscious, physically bounded, biologically based individual has gradually become the ideal form of personhood in psychiatry. Rather than aligning the patient with collective revolutionary life, as their socialist predecessors did, psychiatrists now focus on making the patient recognize that he is sick, his self is out of bounds, and that he needs to comply with biomedical treatment. Therefore, the patient's insight (or lack thereof) qua biological individual has become crucial for the psychiatrist to make a diagnosis, gauge the illness's severity, and determine the patient's prognosis.

Now that mental illnesses are seen as widespread, often hidden, and in need of early detection, psychiatrists have to co-construct an illness history that recounts the tiniest behavioral anomalies in the dusty corner of a potential patient's distant past. If the patient lacks insight on his illness, who can narrate the illness history for him? Since post-socialist life is structured by a practical emphasis on and an ideological exaltation of private life (Yan, 2003), according to many psychiatrists the only suitable parties for this function are the family members who spend countless days and nights living with the individual, and who thereby have intimate knowledge of him. Thus psychiatric textbooks in this period often ask the doctor to collect illness histories from family members, even without the individual's knowledge, lest the "truth" recounted by the family would provoke the patient (Z. Zhao, 2008). In Chen's case, the doctors' reliance on the parents' account during the intake and diagnostic processes was nothing other than the common practice of the trade.

Since inpatient treatment at tertiary institutions has become the most sought-after treatment mode—or as many people see it, the only quality option—in the post-socialist era, involuntary hospitalization is often imposed on patients who putatively lack the insight to perceive their need for treatment. As I have noted, rather than the psychiatrist, it is the patient's family members who are usually the ones to decide upon hospitalization. (Sometimes the patient's work unit or residential committee also makes the commitment decision, especially when the family is not available. However, their involvement has become increasingly controversial and rare.) Money is an important factor here: the fact that the family is responsible for paying an astronomical hospital bill often grants it the last word on whether an individual is to be admitted into—and discharged from—the hospital. Before the passage of the Mental Health Law, many psychiatric hospitals would, upon the family's request, send staff to "escort" a suspected patient to the locked ward.[4] As I witnessed during fieldwork, psychiatrists from time to time would frown upon a family's decision to keep the patient in the hospital against medical advice. "But what can you do? The family is the one who pays," sighed a doctor.

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[4] It is similar to what Chen experienced with the assailants, except that with all the controversies of psychiatric abuse, the hospital in her case had stopped providing this service, and the four men were freelance "go-betweens."

More often, however, psychiatrists genuinely respect family members' decision-making power in hospitalization. They see family members not only as possessing the truest knowledge of the patient, but also as having the patient's best interests at heart. Sun Dongdong, a forensic psychiatrist who was long involved in drafting the Mental Health Law, once commented, "Familial affection (亲情/*qinqing*) is the kindest of all human emotions."[5] So undergirding the family's involvement in psychiatry is a moral economy as well as an epistemic authority.[6] This moral economy is reinforced by the political economy of healthcare: For most psychiatrists, the fact that a family is willing to shoulder the high medical costs for the patient can only suggest the family's deepest care for and concern with the patient; psychiatric abuse of one's kin is seen as only the rarest exception to this tendency.

Long before the Mental Health Law went into effect, involuntary hospitalization had been sanctioned by local mental health regulations. When WHO experts came to China in 1987 and 1990 to help Chinese forensic psychiatrists design the mental health law, they insisted that psychiatric hospitalization should be as voluntary as possible. Many Chinese psychiatrists had trouble with this principle, however, and asked, what if a patient had no "insight" and did not want treatment?[7] Then in the early 2000s, when municipal mental health regulations were passed in several cities, they each included a procedure called "medical protection hospitalization," in which "a certified psychiatrist's duty is only to advise that the patient be admitted. The patient's family member or guardian was to have the right to decide whether to accept the advice or not, and when to finish or withdraw from the hospitalization and treatment." Lack of insight on the

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[5] Comment at the 2013 National Conference on Ethical and Legal Issues of Psychiatry in Beijing, which I also attended as a speaker.

[6] In his study of therapeutic citizenship of AIDS, Nguyen has also noted the moral economy that shapes the social form of healthcare (V.-K. Nguyen, 2010).

[7] Personal interview with Dr. Liu Xiehe, Apr. 1st, 2013.

patient's part was a criterion for this procedure to take place (Shao, Xie, Good, & Good, 2010, p. 5).[8]

As its name suggests, medical protection hospitalization was legitimized because it was supposed to protect and enhance the patient's wellbeing, following the basic medical ethics principle of beneficence. It was not that consent was out of the question in the municipal regulations. After all, the normal biological individual should be able to own his own body and make rational decisions about it. Yet psychiatrists explained to me that lack of insight deprives patients of the capacity to consent, and that, when he is possessed by a mental illness, the patient's refusal of treatment is not an act of autonomy. In fact, they often contended that after the patient was cured, he was most likely to change his mind and come to appreciate the family's decision.[9]

Here, psychiatrists assume a biological individual who is normal and desires normality as both the standard of measurement and the goal of treatment. In the medico-legal discourse of psychiatry, it is from this biological subject that attributes such as self-ownership, rational self-knowledge, and right to consent emanate. And it is against this presumed biological subject that a lack of insight, incompetence, and a need for treatment are defined.[10] Biomedicine in the post-socialist era thus works to distinguish the normal, sovereign individual from the pathological,

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[8] The name "medical protection hospitalization" is most likely a translation from a Japanese legal procedure called "hospitalization for medical care and protection," or what was called "consent admission" before 1987 (Nakatani, 2000). A detailed comparison between the Chinese and the Japanese procedures cannot be made here. One point to note, however, is that Japan's 1987 Mental Health Law placed more weight on voluntary admission, and established a psychiatric review board to review all ongoing hospitalization and patients' requests of discharge. As a result, the rate of hospitalization for medical care and protection among all admissions dropped from more than 80% before the law to less than 40% in 1991 (Asai, 1992).

[9] For a written argument, see (Yue Wang, 2014).

[10] Similarly, Foucault argues that the modern bourgeoisie produces and distinguishes the "juridical individual"—the ideal self—through whom "the bourgeoisie claimed power," and the "disciplinary individual" —the abnormal person alienated from the ideal—on whom the bourgeoisie exercised power (Foucault, 2006, p. 58)

disciplinary subject, and it seeks to bring the pathological back to the normal. Because so much hinges upon the family's—or other family-like figures'—narration and decision, human rights activists criticized psychiatry as relying on unsubstantiated or tautological arguments potentially driven by ill will. Yet for psychiatrists who endorse the intimate knowledge and moral legitimacy of the family, their collaboration with the family is an expression of caring paternalism.

Types of Abuse, Scales of Paternalism

> "Rule of law, or being ruled by psychiatrists? There is not much time for fellow countrymen to choose."

On Oct. 16, 2010, Huang Xuetao opened an account on Sina Weibo (the Chinese counterpart of Twitter, literally meaning "microblog"), and the above was her first entry. Huang's microblog would soon become a key site for public discussion on psychiatry and on the mental health legislation reform. As of Sept. 2015, it had over 6,000 entries and more than 12,000 followers. As her first entry foresaw, Huang would frame the legislation as a battleground between medical and legal authorities. Addressing the public as "fellow countrymen (国人/*guoren*)," a term that had been used by modern Chinese intellectuals to address the masses during wartimes, she would frame the legislation battle as one that pertains to the fate of the nation, to the rights and freedom of everyone rather than just the patients, and would use every case about psychiatric abuse polemically to convey a sense of urgency.

Huang's animosity toward medical authority dates back to the case of her friend Zou Yijun in 2006. Zou, then a thirty-year-old woman with a college degree, had recently experienced her father's death and her own divorce. Her father had intended to bequeath his house to his beloved daughter, and her divorce had left her with a large indemnity award. Zou, a Buddhist devotee, wanted to use the money for a study tour, but her mother and brother wanted to rent out her father's house and use her indemnity for down payment on a new apartment. After a serious fight with the family, Zou felt an impending threat to her personal safety. She signed a power of attorney document with Huang, then a corporate lawyer, authorizing Huang to exercise her civil rights on her behalf if she lost her freedom. In a family visit to her father's grave, Zou was taken away by male assailants, tranquilized, and sent to a psychiatric hospital. There she was registered under a pseudonym and diagnosed with bipolar disorder. In her frantic attempts to rescue Zou, Huang called the police in order to force the hospital to disclose Zou's admittance, and she gathered a crowd of journalists in front of the hospital in order to pressure the hospital administration to allow a meeting between her and Zou. Even so, her power of attorney was brushed aside by the hospital staff, who claimed that a patient did not have legal capacity, including the capacity to entrust representation to a lawyer. A psychiatrist said to her: "This is a hospital. We don't talk law here. Go elsewhere if you want to talk law."

Finally managing to get Zou released, Huang began to work on human rights for psychiatric inmates, and later established an NGO called the Equity and Justice Initiative. She continues to work with people who believe they were wrongfully hospitalized by their families. One of the key advocacy strategies that Huang and her supporters developed over time was to coin or promote a keyword that could transform a case into a token of a type of psychiatric abuse, capture its essence,[11] and index the institutional conditions that make such abuse possible. As an earlier example, Huang and Zou diagnosed the psychiatric hospital as a "prison by contract." They argued that because the hospital had to finance itself, it would willingly serve the

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[11] Here I follow Latour's idea of an essence as lying in "a situated, material practice that ties a whole range of heterogeneous phenomena in a certain specified way" (Latour, 2010, p.12).

interests of whoever pays, even if they incarcerate a person without legal grounds. Their campaign was thus aimed at relocating this "prison by contract," a space apparently beyond the law, within the bounds of a law that would respect a citizen's autonomy. As in Zou's case, the primary contracting party for the psychiatric prison was the family. So, going beyond institutional reform of psychiatry, Huang and Zou also advocated for changing the paternalistic familial culture that enabled such psychiatric abuse. After being ordained as a Buddhist nun—or as is said in the Chinese idiom, "leaving home" (出家/*chujia*)—Zou heatedly remarked in an interview, "I want people to talk about something else beyond the institution. What should this be? Humanistic care for every citizen's rights. We cannot deprive the citizen of all her rights and freedom in the name of love."

Although the term "prison by contract" accurately pointed out some economic conditions of institutionalization, it failed to enter the public parlance. This is probably because in the post-socialist era, a time when market freedoms are highly valorized, it is difficult for people to associate the exalted term "contract" with any kind of abuse. In any case, Huang's advocacy continued, as she soon found out that psychiatry was prone to be abused not just by families, but also by public institutions. There were scattered cases in which work units—especially large state-owned enterprises—were charged with wrongfully committing staff members to hospital or having them diagnosed without their knowledge.[12] Moreover, from 2008 to 2012, the mainstream media reported dozens of cases in which persons who brought grievances against

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[12] According to Liu Xiehe, in 1980s a teacher in Hangzhou was suspected by her school to have hysteria. The school's principal thus committed her to a psychiatric hospital for treatment. The teacher's family did not think she was mentally ill, and took their complaints to court. The school lost the case. But I have not been able to find any news articles reporting that case.
There have been several more publicly known cases since 2008. For example, in 2010, a hospital in Shenzhen asked a psychiatrist to come and diagnose a nurse without her knowledge, and then demoted her based on her diagnosis. The nurse later sued the hospital and won the case. See (Ying Wang, 2011).

local governments to higher authorities or to Beijing in appeals for justice were arrested by police and thrown into psychiatric hospitals. For centuries, Chinese peasants have used petitions and appeals to the central government to resist local injustice (Ocko, 1988). Decollectivization and marketization in the post-socialist era have made people less dependent on local governments. It has also made them more aware, in local policy implementation, of frictions with their personal interests and lapses in the rights discourse that the central government promulgates (O'Brien, 1996). As more and more people have turned to petitions and appeals to register their grievances, the state has legalized such political actions, but it has also become concerned with any tendency that could threaten its political legitimacy and social stability. State representatives have thus relegated to the local governments ever heavier responsibilities for keeping any potential social disturbance in check (C. K. Lee & Zhang, 2013). In the last decade, there have been numerous reports that local governments have used oppressive and even violent measures, including psychiatric hospitalization, to prevent aggrieved citizens from appealing to Beijing, or, if they do so, to snatch them back from the capital.

An increasingly rights-conscious public has much sympathy for such petitioners. So when reports of psychiatric abuse by local governments began to come out, psychiatrists found themselves in the very troubled waters of state politics. In a 2009 interview, a journalist asked Dr. Sun Dongdong why many apparently “normal” people, such as Zou Yijun and several petitioners, were forcibly hospitalized. He answered:

> “The public often thinks that only those who are disheveled, crazy-looking and violent people are mentally ill. But in fact many mentally ill patients look completely normal except for their psychotic symptoms. As for those veteran petitioners [whose grievances are unfounded or have been solved, but who insist on petitioning all the same], I can reliably say that, if not 100%, then at least 99% of them are mentally ill, with paranoid psychosis.”

He thus insisted that these "veteran petitioners" be hospitalized, because paranoid psychosis would by definition disturb the social order (J. Wang, 2009).

Sun's "99%" comment spurred an outcry online. Many liberal netizens saw it as an insult that denigrated the wretched petitioners and their rightful appeals. Although there were only a handful of cases where psychiatric hospitalization had been reportedly imposed on petitioners, Sun's sweeping claim about petitioners enabled human rights activists to scale up their criticism of psychiatry and link it to an ideological critique of the state. Activists likened Chinese psychiatry to Soviet psychiatry, which had used diagnoses such as "sluggish schizophrenia" as excuses to incarcerate substantial numbers of political dissidents.[13] This comparison not only portrayed compulsory hospitalization of Chinese petitioners as a potentially widespread phenomenon. It also attributed wrongful hospitalization not to local bureaucrats who had made the decision, often in the face of a complicated array of interests and pressures, but to the totalitarian state wielding the oppressive tool of psychiatry against all opposition.[14]

By working with petitioners who had survived involuntary hospitalization, and critiquing the political mechanisms that had engendered their mistreatment, Huang and her supporters were also able to scale up their critique of patriarchy and paternalism. Modern Chinese intellectuals have often invoked the Confucian idea of "family-state isomorphism" (*jiaguo tonggou*) in their political analysis. That is, the family and the state tend to be seen as structured by the same

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[13] Besides Leng's article cited above, Huang also made this comment on several occasions, including her microblog entry on Apr. 30, 2011. This comparison had been made as early as 2000 by human rights monitor Robin Munro in his controversial article on political abuse of psychiatry in China (Munro, 2000). Although it scandalized China in the international psychiatric community, Munro's article did not have much impact within China.

[14] Here I follow Sharma and Gupta's advice to see what the activists saw as "the sate" as "culturally embedded and discursively constructed ensembles" (Sharma & Gupta, 2009, p. 27). As will be clear later, the activists' discursive imagination of the state is a set of bureaucracies (or what they call "public power") that are organized in a hierarchical fashion, emanate smoothly from the center, and oppress "the society" or the private realm.

ontological principles. Therefore, a critique of the familial culture can—and very often does—become a critique of the political culture as a whole (Glosser, 2003). This intellectual tradition was followed by some human rights activists. In an online commentary on Sun's "99%" remark, activist Leng Feng likened the Chinese state to a feudal family in which the patriarch holds absolute power over other members, especially women. Moreover, if paternalism, as Zou Yijun defined it, means depriving people of rights and freedom in the name of love, then it arguably applies to both the family and the state. In the case of hospitalizing petitioners, the state's "love" would be expressed both to cure the mentally ill petitioner and to protect the social order. Huang used *guan* (management) to denote this common kind of undue intervention, and on her microblog she warned China's rulers not to let their paternalistic desires run wild or to try to *guan* everything.[15] She also commented, "State paternalism and cultural paternalism [in the family] are isomorphic…Paternalism is boundless in China, but the doctor-patient relationship is the area most hard hit."[16] According to Huang, biomedicine can serve the interests of both paternalism in the family and state paternalism because it becomes a hegemonic standard by which to evaluate our life and subjectivity: "we have the right to choose only when [biomedicine sees our choice as] rational and correct."[17]

"Being Mentally Illed"

Although cases of psychiatric abuse were able to bring about a temporary uproar, and although Huang and the activist community were able to use media interviews, online commentaries, and microblogging to scale up individual cases to rather global critiques of paternalism in the family and the state, these voices often failed to last in a world of information

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[15] Huang's microblog entry, May 21, 2011.
[16] Huang's microblog entry, June. 7, 2012.
[17] Huang's microblog entry, Dec. 19, 2012.

overload. After all, while sympathy exists, it is difficult for middle-class consumers of media to fully identify themselves with wretched petitioners or psychiatric inmates. Meanwhile, if a social movement needed an interest group to represent itself and struggle for recognition (Fraser, 2009), Huang was concerned that there might not be one for human rights in psychiatry, because psychiatric patients were denied by the medical discourse of the capacity of self-representation, and because they were often too stigmatized to "come out." As a solution, Huang decided to mainstream the issue and broaden the base, by arguing that it is the general public who needs to seek legal recognition and protection.

In 2010, in a news report on Peng Baoquan, a man who was forcibly hospitalized by the police apparently because he had taken pictures of a petitioners' demonstration as an onlooker, the journalist coined the term *bei jingshenbing,* or "being mentally illed" ("Petitioning "psychiatric patient" in Hubei narrates his experience, forced to take medications," 2010).[18] As we have seen in Chen Dan's case, it usually refers to the process in which a "normal" individual is accused of being mentally ill and is detained in a hospital. "Being mentally illed" was an instant hit, largely because it resonated with a group of neologisms that had been emerging online since 2008. These neologisms each start with the word "被/*bei*," a preposition functioning as the passive voice in English, followed by a word that isn't normally used in the passive voice, and that usually signifies some undesirable situation (Hou, 2010). For example, the phrase "being suicided" (被自杀/*bei zisha*) emerged in a case where a whistle-blower about local government corruption was found dead, apparently having hanged himself. The public however believed it had been retaliatory homicide (L. He, 2009). For many social commentators, this

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[18] Like every case of alleged psychiatric abuse, there are different versions of "truth." Peng himself later admitted that he was not a bystander, but was a regular petitioner, this time commissioned by the demonstrators to take the photos.

group of neologisms signifies the advent of “an era of passivity,” in which people are increasingly aware of their individual rights being taken away, usually by abusive public power (公权力/*gong quanli*) (Yuan, 2009). By “public power,” critics refer to a realm of governmental and semi-governmental institutions that control power to regulate, or worse, repress people in society. Society, on the other hand, is thought of by critics as a pristine domain of private rights, consisting of individuals, families, and corporations.

When “being mentally illed” joined the vocabulary of the “era of passivity,” human rights activists finally found the key to sustaining broad, continuous public attention. As previous sections suggest, there was a wide array of agents who decided upon involuntary hospitalization, but families were the primary ones. Or in Huang and colleagues’ terms, there were various scales of paternalism. Yet the intertextual association of the passive “*bei*” directed people’s attention to, and concentrated almost all critical weight on, abusive public power without having to be specific about particular agents. That is, every case of psychiatric abuse is now represented as an instantiation and reminder of the vaguely omnipresent authoritarian regime, the paternalistic state. By implying the victim’s complete innocence and passive victimhood, the intertextual “*bei*” also scaled up the number of potential victims to include every single citizen, not just psychiatric inmates. Among all forms of passivity a citizen could face, “being mentally illed” could arguably be the worst, because psychiatric hospitalization denies a person his rationality and the truth-value of his words. “Being mentally illed” thus invited everyone to participate in the legislative debate, not out of a commitment to ultimate social justice, but because we all have a stake in protecting our own rationality and rights from being encroached upon by the state.

When the phrase “being mentally illed” was coined by her journalist ally, Huang Xuetao saw its evocative potential and put it to use. On her microblog, there are over 300 entries that mention this term, making it one of her own keywords. In her organization's first legal analysis of the psychiatric hospitalization system, published shortly after the term was coined, Huang and colleagues argued that with hegemonic and illegal/illogical standards like "lack of insight," the psychiatric system made everyone vulnerable to being mentally illed. The report was widely circulated in the media, generating heightened fear toward psychiatric institutions. It thus became a text that psychiatrists felt obliged to address. Huang also endeavored to make all of us feel that "being mentally illed" was not a distant potentiality, but an impending reality. When in 2011 the Chinese National Center for Disease Prevention and Control announced the epidemiological estimate that there were over 16 million people suffering from severe mental disorders in the nation, Huang took this statistic as psychiatrists maliciously trying to label everyone with a diagnosis, and thereby subject us all to hospitalization. Forget about preventing ourselves from "being mentally illed" and from being associated with the downtrodden, Huang said. We are already seen as mentally ill and lacking insight. So we should fight to have the patient's rights realized. Only then can our own rights be realized.

The Normal and the Pathological

By allowing activists to scale up the phenomenon of psychiatric abuse as well as people's fear of it, this rhetoric of "being mentally illed" brought the legislation debate to its most heated phase. Yet while helping us see and discuss reality in a certain way,[19] the keyword also created blind spots and schisms. For one, with all fingers pointing to abusive public power, critiques of the family now faded into the background. In Peng Baoquan's case, and some other cases in which petitioners were hospitalized by police, Huang and other activists argued that the

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[19] As Raymond Williams suggests, people use keywords to make semiotic connections and "formations of meaning—ways not only of discussing but at another level of seeing many of our central experiences" (Williams, 1985, p. 15).

procedure was illegal precisely because it was not the families’ decision, and because the families were often not even informed. The family was thus imagined at times as a safe haven that could protect the individual’s safety and integrity in the face of an over-reaching public power.

Additionally, the passive voice of “being mentally illed” implies that the victim of such processes is an innocent, that is, a biologically normal individual who has been wronged by a diagnosis, and who should therefore be distinguished from the truly mentally ill. This term could thus further stigmatize psychiatric patients. Besides, it was not always clear to the public whether the human rights campaign, structured by this term, was defending the “normal” citizens’ right to autonomy or the psychiatric patients’ rights (or even what the latter might be). These indeed were some of the deep-running ambiguities one often encountered in attending to the rhetoric of the human rights campaign.

In 2013, I attended a conference of Chinese users and survivors of psychiatry, which Huang’s NGO had organized as a community building effort. Although some participants showed symptomatic behavior, which a psychiatrist would readily notice, almost all of them asserted that they were absolutely “normal,” and that they were “survivors” rather than willing “users” of psychiatric services. They were there to seek Huang’s help to file lawsuits, hoping to have their diagnosis removed and their reputation restored. At the same time, similar to what Chen Dan would do in my interview later, they were not hesitant to use psychiatric diagnoses to characterize those who had forcibly hospitalized them. These were the people who should really be hospitalized, they thought. Yet Huang’s NGO was mostly funded by international donors to promote disability rights, and the conference discussion had been planned to focus on how to promote patient rights, deinstitutionalization, and community inclusion. While Huang hoped that the common experience of hospitalization could become a basis for participants to reflect on and become self-advocates for patient rights, none of these agenda issues appealed to the participants at all. Most of them did not want to be associated with labels like “patients” or “persons with disabilities.”

Moreover, in implying that the victim of hospitalization is a biologically normal person who is “illed” but not ill, in a sense “being mentally illed” reinforced the biomedical logic that human rights activists were fighting, and it opened up cracks where the psychiatric profession could exert their own pressures. When defending themselves against charges of psychiatric abuse in court, for example, hospitals usually asked that the plaintiffs be re-diagnosed. Such requests stemmed from the psychiatric view that mental illness is mostly chronic, with an unpredictable cycle of remission and relapse, and that hospitalization at any point of the illness trajectory is therefore justified. Accordingly, a newly ordered diagnosis could trace the existence of the illness back to the patient’s time of admission, defeating the charge that anyone had “been mentally illed.” In contrast, human rights activists argued that mental illness, at least the condition that requires hospitalization, is acute and temporary. Requests for re-diagnosis were judicially problematic, because it could not show the person’s mental status during admission, but would only reinforce the authority of the paternalistic medical profession. Yet with the psychiatric view prevailing in people’s imagination of mental illness, the court often granted the hospital’s requests, miring the case in endless forensic examinations.

Acknowledging these conceptual and practical difficulties, Huang increasingly tried to distance herself from the concept of “being mentally illed.” Yet a complete disavowal might have seemed disingenuous, so Huang sought to provide a legal redefinition of “being mentally illed”: those who have the legal capacity of decision-making—whether they are mentally ill or not—are diagnosed, hospitalized or treated against their will,[20] and are subjected to substitute decision-making.[21] Huang supported this redefinition with reference to the United Nation's *Convention on the Rights of Persons with Disability* (CRPD), which had been ratified by the Chinese government in 2008, which explicitly recognizes the autonomy and legal capacity of persons with disabilities ((UNGA, 2007), especially Article 12). According to the CRPD, a person's capacity is multifaceted rather than "all-or-none," as the psychiatric distinction between normal citizens and pathological subjects, commonly used in China, would seem to proclaim. For example, the fact that I lack the capacity of controlling my emotions does not mean I necessarily lack the capacity of giving or refusing informed consent to psychiatric treatment. Moreover, instead of making judgments on my general incapacity and limiting my rights accordingly, society should do its best to support my positive capacities.

With "being mentally illed" reframed as "being subjected to substitute decision-making," the line that Huang and colleagues drew was no longer between the normal and the pathological. It was now between the sovereign individual, mentally ill/disabled or otherwise, whose legal capacity and right to autonomy should be respected and facilitated, and the incapable subject whose rights could probably be circumscribed. This is a constantly shifting line that should always be demarcated by legal authorities, and should be moved far to the right, leaving much fewer people subject to institutional constraint. But how should the line be drawn? When does facilitation stop and constraint begin? The activists' answer again folded back to the political ideology undergirding "being mentally illed." Given that any external standard of capacity could be manipulated by the authoritarian state, then in order to ensure the subject's absolute

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[20] For example, see Huang's microblog entry on Jul. 5, 2012. Huang also made this statement in the 2013 Annual Meeting of Psychiatrists in Guangdong, where she was invited to have a face-to-face conversation with the province's leading psychiatrists about the Mental Health Law.

[21] Huang's microblog entry on Oct. 25, 2012.

sovereignty and liberty, his freedom should only be limited when he endangers others—and by extension, himself. According to the activists' vision, the post-socialist state should copy the history of radical deinstitutionalization, on the model of Italy and the U.S. Only with such institutional reform could China evolve from a paternalistic state to a regime based on the liberal social contract.

The vocal human rights campaign made remarkable headway in the legislation process. In 2009, shortly after several cases of psychiatric abuse appeared in the media, the State Council took over the drafting of the Mental Health Law from the MoH. Since then, the central government formally began deliberating the legislation, and it solicited public opinion on three drafts. Altered from previous drafts and existing municipal regulations, the concept of insight disappeared from the 2009 draft of the national law. Instead, the 2009 draft emphasized the voluntary principle, and set up two criteria for involuntary commitment: either the patient presents a danger to himself or others, or there is medical necessity—"the lack of hospitalization is not conducive to treatment."[22] Starting from the 2011 draft, moreover, doctors may only diagnose and treat patients in the hospitals, and psychiatric examinations should in principle be voluntary, thus banning the hospital "pick-up" service many families had previously relied on ((NPC, 2011), especially Art. 20 & 21). Although the medical necessity criterion has been adopted in many democratic countries, including the UK, Japan, and Taiwan (D. Li, 2014), activists reminded people that this was an instance of medical paternalism, one that easily usurped patient rights and exerted unwarranted control. Therefore, this criterion was taken out of the Aug. 2012 draft of the national law (NPC, 2012a). Moreover, when the 2011 draft expanded the danger criterion to include patients who "disturb the public order" (NPC, 2011), activists

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[22] This is a similar expression one could find in the Oct. 2011 draft reviewed by the National People's Congress. See (NPC, 2011).

immediately associated this phrase with potentially politicized abuse. After another round of media pressure, this phrase also disappeared from both the final review draft (NPC, 2012b) and the official law. In the end, what was left was an apparently extremely liberal dictum: No danger, no commitment.

Reframing Rights, Reclaiming Paternalism; Or Competing Chronopolitics of "China"

Scholars have pointed out that translation, especially transfer of a linguistically registered phenomenon between scales, can locate the phenomenon in a particular "historical TimeSpace" (Blommaert, 2007, p. 5), and can construct a common sense of time for all agents involved.[23] For one, scholars have used the term "chronopolitics" to refer to motivated work on actors' time-perspectives, especially by sketching broad trends in language; these time-perspectives in turn shape individuals' and groups' political orientations and actions. For another, situated chronopolitical projects are intertwined with perceptions of geopolitical order.[24] In China's mental health legislation debate, for example, with their discursive work that scaled up cases of psychiatric abuse to a matter concerning every citizen and the nation, the activists articulated a linear history of global human rights, depicting China—an "authoritarian" state and a "paternalistic" culture—as backward in time, and they demanded that it catch up with modern Western democracies and accord with rule of law.[25] To realize this chronopolitics of progress,

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[23] In *The Pasteurization of France*, Latour writes: "[I]nstead of explaining the movements of the actors by time and dates, we would explain at last the construction of time itself on the basis of the agents' own translations." (Latour, 1993, p. 51)

[24] Sociologist George Wallis defines chronopolitics as "the relationship between the political behavior of individuals and groups and their time-perspectives" (Wallis, 1970). For a more recent discussion of chronopolitics, particularly its relationship with geopolitics, see (Klinke, 2013).

[25] In her microblog entry on June 6, 2012, Huang wrote: "Because rationalism is not omnipotent, paternalism will eventually be abandoned by modern society."

legal and institutional reforms aimed at protecting the sovereign individual's right to autonomy became an "obligatory point of passage" (Latour, 1993, p. 43). On the other hand, compared to some of her activist peers who fiercely demanded a regime change, Huang Xuetao repeatedly emphasized that she was only demanding a *reform* on the technical and procedural level. This somewhat depoliticized position eventually won her the support of the central government. In June 2011, *People's Daily*, the official newspaper of the Chinese Communist Party, published an editorial celebrating the development that after so many discussions and revisions, the Mental Health Law was finally able to "think rights" (J. Chen, 2011).

With their profession under constant attack, and with the law that they and their colleagues had drafted according to their practice continuously revised, psychiatrists came to feel a sense of defeat. (Many psychiatrists admitted to me, however, that the tightened criteria of involuntary commitment would help them stave off undue pressure from the local authorities and thereby protect their professional independence.) In the last several years of legislative debate, prominent psychiatrists have often spoken in public and written in the popular or academic press in defense of their professional practice and their visions of personhood/patienthood. Yet simply in order to be legible, they had to work with the terms that had already been set by the activists, seeking only to redefine, rescale, or re-evaluate them. In other words, they had to turn terms such as rights and paternalism into what Star and Griesemer call "boundary objects,"[26] objects that would grant them the same legalistic legitimacy as human rights activists, while allowing them to depict a different, but no less progressive, chronopolitics of "China."

Although Huang and her team tried to offer a legal redefinition of the term "being mentally illed," the normal/pathological divide it implies made a strong impression on people's

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[26] Star and Griesemer define "boundary objects" as those "have different meanings in different social worlds but their structure is common enough to more than one world to make them recognizable, a means of translation" (Star & Griesemer, 1989).

minds. Psychiatrists did not directly reject this term, but they tended to rescale the two sides of the normal/pathological divide to their own advantage. True, they repeatedly said, there may be normal people who are wrongfully hospitalized by ill-intentioned family members, bosses, or police, but such cases are rare. If the focus of the Mental Health Law was on protecting normal people from being mentally illed, asked the psychiatrists, how do we take care of the millions of mentally ill patients who are truly vulnerable, who should be the real subjects of concern in the law?[27] To scale up the need for psychiatric care to the population level and scale down the problem of "being mentally illed" to the level of a few individuals, psychiatrists drew on statistics and did the math. According to Dr. Tang Hongyu, a forensic psychiatrist and drafter of the Mental Health Law, in 2010 there were more than 16 million patients with severe mental illness in China, among whom 10% had a tendency toward violence and therefore required involuntary commitment. Yet in 2008, there were only 740,000 people who received inpatient psychiatric treatment. This meant that the psychiatric beds weren't even enough to treat all the violent patients! "The vast majority of persons involuntarily hospitalized," Tang thus argued, "are real psychiatric patients" (Tang, 2010).

Here, Tang ignored activists' attempt to uncouple the existence of mental illness and the need for hospitalization. He assumed that China's meager mental health resources *had already been* distributed in an ideal gradient, concentrated where they were needed most. More importantly, by vastly "outscaling" (Blommaert, 2007, p. 6) the number of those "mentally illed" with the number of the "truly mentally ill," and by contrasting the size of the latter group with the meagerness of the hospital resources they putatively needed, Tang and other psychiatrists also portrayed China as in a state of lack. In the legislative debate, psychiatrists often invoked the

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[27] Similar arguments were voiced by nearly every psychiatrist I encountered. Hence the indirect reported speech. For a high-profile written record, see a blog entry by Dr. Xie Bin and Dr. Ma Hong (leaders of the 686 Program) (Xie & Ma, 2011).

data collected by the WHO Mental Health Gap Action Program (mhGAP), which uses per capita income to segment the world, and treats services available in the “developed” countries as global standards to which the rest of the world should measure up (Bartlett, Garriott, & Raikhel, 2014). mhGAP’s world mental health atlas shows that as of 2011, China had only 1 psychiatric bed in general hospitals per 100,000 population, which was slightly better than the low and lower-middle income countries (0.6 and 0.4 respectively), but fell far behind the upper-middle income countries (2.7)—to which China as an economic entity belongs—as well as the high income countries (13.6) (WHO, 2011a, 2011b). Note, however, that the world mental health atlas does not present data on involuntary admission. And even within the atlas’s framework, the country profile on China gathered by China’s Ministry of Health fails to include the percentage of patients receiving long-term care in psychiatric hospitals, and it does not consider the availability of community facilities. With this selective data presentation, Chinese psychiatrists argued that rather than having too much institutionalization, China does not have enough. There is a “treatment gap” in this area that needs to be closed.

In pointing to the existence of a “treatment gap” in hospitalization, Chinese psychiatrists have joined the recent global mental health movement in defining health as a basic human right, with mental health as a key component (Bemme & D’souza, 2014). Global (mental) health advocates often cite Article 25 of the *Universal Declaration of Human Rights (UDHR)* and Article 14 of the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* to argue that everyone, including those in poorer countries, has the right to the highest attainable standards of health. In so doing, they seek to shift the focus of (and funding for) international human rights from eliminating abuses of civil and political rights to safeguarding socioeconomic rights through healthcare development (Farmer & Gastineau, 2002). In China, psychiatrists’ claims about the right to health served to turn "right"—a key term in China's contemporary legal reform—into a boundary object, for which they could offer their own legitimate definition that applied to the real target group of the legislation, namely the mentally ill.

In June 2013, I attended a workshop in Beijing where lawyers and psychiatrists discussed legal and ethical issues pertaining to mental health. At the workshop, Dr. Sun Dongdong argued that involuntary treatment is a means to protect the patient's right to health. Therefore, it is a fundamental human right preceding and indispensable to the provision of other human rights. After his speech, Huang Xuetao asked, "Well, what do you mean by the right to health? According to the ICESCR, it means that the state has the responsibility to provide adequate healthcare services to its citizens. However, it also means that the citizen has the freedom to control his own health and body, and to consent to healthcare services given[28]—that is, one has the right *not* to be healthy!" Dr. Sun Dongdong shrugged and responded, "Well, you've got the concepts wrong. According to tort law, the right to life refers to the maintenance of the integrity of life, and the right to health refers to raising the quality of life. Tort law does not say whether it is the state's responsibility or the citizen's to defend the right to health."

The point of dispute was not so much between international and domestic law, as it was between different translations of the same concept that produced different (bio)political subjectivities. Huang sought to construct the right to autonomy as a prerequisite to the right to health, and her emphasis on the state's responsibility reinforced the idea of a sovereign individual facing a public power that could protect—but could also harm. In contrast, Sun's translation highlighted an objective standard of health that has to be met with medical services and a normal biological individual that has to be fostered, while remaining deliberately vague on

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[28] The United Nation's general comments on the ICESCR, published in 2000, states that "The right to health contains both freedoms and entitlements" (ECOSOC, 2000).

who should bring this into being and how to do so. Indeed, in this workshop and other venues, when activists pushed for the strictly danger-based involuntary commitment modeled after American legislation, psychiatrists often responded with an elaborate comparison of diverse criteria adopted in other Western countries, only to reach the conclusion that the means to realize the right to health and the threshold for constraint should be left in the indeterminate domain of culture (Xie, Tang, & Ma, 2011).

As many psychiatrists saw it, the right to autonomy was not just irrelevant to the realization of the right to health, but potentially antagonistic to it, and the "progressive" history of human rights as depicted by activists was in fact a regression. From their numerous trips to the United States and Europe, and from academic exchanges with "the West," prominent psychiatrists had brought home the message of social ruin resulting from deinstitutionalization: many patients were left homeless and many others jailed, all were living miserably and many posed risks to society. In media outlets, academic conferences, and personal interviews, Chinese psychiatrists and their allies recounted the story of Joyce Brown, a homeless woman who had sued New York City for imposing involuntary psychiatric commitment on her and had won, but who ended up "dying with rights." They told the story of psychiatric hospitals in Japan, where new French doors and windows erected along with an open-door policy were soon shattered by violent patients. They related first-hand experiences of desperate overseas Chinese families who had brought their patients back to the motherland for treatment, and who were indignant about American psychiatrists' apathy toward patient welfare in the name of protecting human rights (Jia, 2010). If human rights activists had scaled cases of abuse up to a critique of China's socialist (read authoritarian and paternalistic) regime, then psychiatrists also scaled cases and anecdotes up to refer to a vision of the gloomy capitalist future. Capitalism's idolization of radical individualism had brought humanitarian tragedies for both individuals and the public, a phenomenon of which the West had only gradually become aware and now frantically tries to reverse by "bringing back the asylum."[29]

To forestall this humanitarian tragedy, psychiatrists prescribed a form of "state paternalism" in the mental health law. According to Dr. Xie Bin, a forensic psychiatrist who drafted both the Shanghai regulations and the national law, "state paternalism" refers to the way society provides "care and love for the sick, the vulnerable, and the disabled," even against their own will (Xie & Ma, 2011). When prescribing paternalistic measures, psychiatrists also perform paternalism.[30] They fashion themselves as visionary technocrats who can distinguish real historical progress from fake, who were global enough to lead China's biomedical advancement while sustaining a socialist legacy to serve vulnerable people rather than bourgeois individuals, and who, with a deep dedication to care, were willing to deliver the unwelcome message of constraint. The people whom they claimed to serve, and the people whom they sought to recruit as allies in the legislative debate, were not just psychiatric patients. They were also the "normal" public who could be harmed by patients' violence, and those concerned with the rising economic power of the state that could be heavily burdened by the disorder. In other words, although psychiatrists emphasized the divide between the normal and the pathological, arguing that only the latter should be the legislation's focus, the right to health that they valorized had the power to reverberate across the divide, to be scaled up from a matter of an individual's welfare to one concerning a nation's future.

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[29] Unlike what Chinese psychiatrists described, this call for re-institutionalization is only a minor voice in Euro-American psychiatry. See (Sisti, Segal, & Emanuel, 2015) for a rare example.

[30] Wortham reminds us that a narrative always contains both a representational text and an interactional text. The narrator uses the representational text to position himself vis-à-vis the interlocutors, and often there is a parallel between the two texts (Wortham, 2001).

Guan, Risk, and a Legal Pivot Called "The Family"

When Sun Dongdong refused Huang Xuetao's definition of the right to health as an individual's unforced access to healthcare services provided by the state, he was not only refusing to prioritize individual freedom, but was also faltering in the prospect of securing state provision of care. Indeed, an irony of the psychiatrists' advocacy of state paternalism is that the state wanted no part of it financially. In my interview with him, Dr. Liu Xiehe said that the key issue in the legislation, as he and many colleagues perceived it, was to bind the government to a policy of providing free treatment for impoverished patients. However, when he had started drafting the law back in the 1980s, "somebody from above" told him not to mention anything about money or governmental provision. According to Sun Dongdong, the fact that the Mental Health Law was more likely to "burn rather than earn" money for the government partially explains why the legislation process dragged on for 27 years. Although by the time the law was finally passed in 2012, the state[31] had begun investing in reconstructing community mental health infrastructure, it still did not want to make any financial commitment on paper, thus leaving in the law's stipulations many unenforceable "shoulds" concerning different public sector responsibilities.

At the same time, the state was increasingly concerned with the potential danger and violence that patients with severe mental illnesses, particularly those with psychotic disorders, might pose to society. This anxiety was in keeping with the rhetoric psychiatrists used in their

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[31] What I mean by "the state" here is somewhat different from its previous meaning as cultural and discursive constructions. As Sharma and Gupta remind us, while the state is constituted in everyday cultural representations and bureaucratic practices and thus has no universally fixed form, it nevertheless sets up its boundaries precisely through the bureaucratic practices (Sharma & Gupta, 2009). In the mental health legislation process, this bureaucratically bounded state is the central legislative and administrative (including financing) structure. It marks itself by having the final say of the law. Obviously, through consulting mechanisms or advocacy strategies, psychiatrists and activists had different influences on the state, but neither could be equated with it.

efforts to frame mental health as a public health crisis, and it also accorded with the state's heightened concern for maintaining social stability. As a result, the idea of *guan,* already a central mandate in the 686 program, was highlighted in the new legislation. The official Mental Health Law lists as a general principle the establishment of a comprehensive management (*guanli*) system. It involves the cooperation of families, work units, and governments in the prevention, treatment, rehabilitation, and community surveillance of mental illness ((NPC, 2012c), Art. 6).

How did the psychiatrists' valorization of the right to health and the state's preemptive concern with danger/violence come to terms with the activists' struggle for the right to autonomy? In other words, how did the law mediate between the individual legal subject whose sovereignty needs to be respected and the biological patient whose pathology requires discipline? Through the concept of risk, the law answered. From the law's 2009 draft to its 2011 draft, there was a small but consequential change. While the 2009 draft required the presence of real or manifest impending danger for involuntary commitment, the 2011 draft put it more vaguely and broadly, stating that a patient might be committed if he had already injured himself/others *or* "was in danger of endangering" himself/others. Since this awkward term "danger to endanger" serves to bring the indefinite and uncertain future into assessments of the meaning of present action, I argue that it is in fact what sociologists have called "risk" (Dean, 1998). While an actual danger, such as an act of violence against others or oneself, demarcates, but also highlights, the sovereign individual's right to autonomy, the vast and as yet unrealized potentiality of risk can incorporate many different—and often intertwined—calculi of governance, including the state's desire to detect, prevent, and manage disturbance, as well as psychiatry's paternalistic wish to eliminate all vulnerability, defined as biomedical abnormality. As we will see in later chapters, the subtle expansion of the danger criterion into a risk criterion serves to maintain the law's liberal appearance while allowing negotiations or even struggles between different visions of rights, responsibilities, and subjectivities in the law's implementation.

Once the risk criterion has divided the sovereign individual and the disciplined subject, incorporating both into the law, who should be responsible for safeguarding the former's right to autonomy and the latter's right to health, or to bring a person from one side of the divide to another? The state wanted to oversee the work but did not want to be left holding the bag for its costs. Therefore the law limits direct intervention by public sector agencies (mainly police) to sending risky suspected patients to the hospital for diagnosis, and to deciding upon commitment for patients who pose risks to others. With their liberal sentiments, the activists had no qualms with this arrangement, except that, to their dismay, their request for establishing mental health tribunals to review involuntary commitment was rebuffed by psychiatrists with the same anti-state argument: Not only are there not enough financial resources to set up such tribunals, as Tang Hongyu said in an interview, but given that China's legal system is not independent from executive government powers, how can we be so sure that these tribunals won't collude with local governments and use psychiatry to illegitimately "maintain stability"?

Once again, everything reverted back to the family. On multiple occasions, the psychiatrists who drafted the law remarked with sympathy that family members caring for mentally ill patients in China were a group of people "bearing the heaviest responsibility and blame" (忍辱负重/*renru fuzhong*) in the world (For example, see (Xie et al., 2011, p. 724)). This was because of the heavy financial and emotional burdens they undertook to provide for the patients, and because of all the injunctions they received to monitor the patients. Yet absent any other resources, the psychiatrists could not draft the law in a way that might alleviate the family's burden. In fact, the law further exacerbates this burden by requiring the family to not abandon the patient (without explaining what "abandonment" means) and that the family bears legal liability if it refuses doctors' suggestions for treatment and if this refusal leads to the patient's injury of others. All that psychiatrists could do, as Tang said in my interview, was to grant certain rights to the family so that its rights and responsibilities could be balanced. The psychiatrists wrote in a semi-final draft that the family may commit the patient who poses risks to himself. The Legislative Office and the National People's Congress not only approved this stipulation, but in a final review they also took away from previous drafts the redress procedure designed for family-committed patients. That is, a patient who is committed by his family would not be able to request a re-diagnosis to overturn the decision of commitment, whereas a patient committed by the police could still do so. From this semi-final draft on, the family-committed patient also was not allowed to request his own discharge. So in the 2013 workshop, Tang Hongyu joked:

> "When the law came out, we psychiatrists were like, 'Shoot! Now you can beat up others, but for god's sake you must not injure yourself. If you do, you'll hand all your rights over to others…' What a rare provision in the world!"'

Note, however, that the law does not envision the family as merely taking over the patient's autonomy in order to discipline him into acting as a proper biological subject. It also conceptualizes the family as advocating for the patient and exercising rights on his behalf. When the law makes the historic announcement that the psychiatric patient is a sovereign individual entitled to dignity, freedom, and property ownership, it simultaneously subjects him to the guardianship of "those who may become guardians according to the Civil Law" ((NPC, 2012c), Art. 83). This sequence goes from spouses to parents to adult children to other close relatives to other relatives or friends willing to take responsibility. In Civil Law, only adults adjudicated by the court to be lacking or limited in legal capacity are assigned guardians to protect their legal rights ((NPC, 1986), Arts. 17&18). In Mental Health Law, however, not only is guardianship automatically granted to family members, but it becomes a central concept. The word "guardian" and its synonyms "family" and "(close) relatives" appear 52 times in total, more times than any other agents (Z. Ma, 2014a). The law concatenates the guardian and the patient with conjunctions "and" and "or," as if the former was an equivalent of the latter. The guardian is thus entitled to exercise informed consent to treatments as well as to seek legal redress for any abuse that the patient endures. Contrary to Chen Dan's complaint that family occupies a legal vacuum in China, the family is in fact deliberately made into a pivot in the 2013 Mental Health Law, protecting the sovereign (but incapable) subject's liberty and personal integrity, fostering the normality of the biological individual, and mediating the transition between sovereign rights and managed health.

Conclusion

The debates surrounding mental health legislation started with activists questioning the intimate politics of involuntary institutionalization, and yet they ended with the law institutionalizing and strengthening the power of the domestic group. How did it come full circle? In this analysis, I have shown that the mental health legislation debate—or the post-socialist imagination of citizenship in general, I dare say—is structured by a fractal divide between the normal and the pathological, but also by a conjuncture between an anti-state liberalism and a paternalistic neoliberalism.

Anthropologists have recently reminded us that constraint constitutes psychiatry's "rough edge of practice" (Brodwin & Velpry, 2014), through which "the larger social 'will' shows its teeth" (Lovell & Rhodes, 2014). Mental health legislation in China has sought to regulate psychiatric power, in particular institutional constraint, on grounds of legitimacy, especially the legalistic legitimacy of rights.[32] Yet the legislative debate has been fractured among opposing visions of what kind of social will needs to be regulated/legitimated, and what rights are at stake for whom. For human rights activists, cases of psychiatric abuse have shown that the normal individual can sometimes be wrongfully taken for the pathological (or in their revised term, the legally capable being wrongfully taken for the legally incapable). Such abuse has been a sign that the pristine private realm was being oppressed by the paternalistic state or public power. Therefore, activists have struggled to have the law recognize the sovereign individual's right to autonomy against any form of state intervention. For psychiatrists, however, the Mental Health Law needed to promote patients' rights to health, by which they meant professional medical care. This is in keeping with both the socialist legacy and the global development agenda to provide for truly needy populations, and to put the socio-economic right to subsistence ahead of the civil-political right to freedom.[33] For the post-socialist state, moreover, the people are riven by a normal/pathological divide, for they are both the self-interested public that the state represents and the source of potential disruption that the state has to guard itself against. In this view, care through constraint serves not only to realize the patient's right to health, but also to protect public security and to ease the disease's financial burden on the population. All these desires for provision, protection, and prosperity thus demand an expansion of state paternalism. In other words, if the post-socialist system of *guan* signifies an entanglement of care and management of

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[32] Max Weber provided a famous classification of sources of legitimacy, including traditional, charismatic, and legal legitimacy (Weber, 1958). Following this tripartite classification, it should be clear by now that the Mental Health Law didn't just seek to affirm the traditional legitimacy of the family, but rather the legal legitimacy of rights.

[33] For the socialist valorization of subsistence over freedom (a putatively bourgeois concept), see (Kent, 1993).

the biomedical life, then this entanglement is ideologically unstable: Activists saw *guan* as unbridled state control dressed up as paternalistic care. Meanwhile, psychiatrists and the state legislature that closely consulted them saw *guan* as proper state management and provision supported by an ethics of caring paternalism.

To mediate these different visions of rights and governance, the Mental Health Law eventually found it convenient to adopt a risk criterion for involuntary hospitalization. While the language of risk paints the law in liberal terms thanks to the affinity of risk to danger—a boundary marker of the social contract—its multiple and vague potentialities allow for diverse calculi of governance. Moreover, the conjunction of liberal and neoliberal logics has relegated the concrete responsibility of securing and mediating these divergent legal visions onto the family, a primary subject in the 2013 Mental Health Law. On the one hand, the strong anti-state sentiment invoked by the catchphrase "being mentally illed" led the public (and sometimes the activists themselves) to focus on state intervention, at the cost of ignoring the intimate politics of everyday life. Therefore, it did not raise a lot of eyebrows when the Mental Health Law granted family members automatic guardianship, and asked that they represent and protect the patient's sovereign rights. On the other hand, although the state claimed to have achieved much through ensuring (involuntary) treatment for psychiatric patients, it did not want to commit any financial resources or take on any legal/political liability for doing so itself. Thus, the "state paternalism" envisioned by psychiatrists came down to the state acting as a mere broker of the family's paternalist care. The different regimes of rights that have been structured along the fractal normal/pathological divide have thus produced a "structure of conjuncture" in the family, that is, "a set of historical relationships that at once reproduce the traditional cultural categories and give them new values out of the pragmatic context" (Sahlins, 2013, p. 125). Here the new value that the family has obtained is linked to their new powers as a biopolitical agent, a pivot on which biomedical knowledge, techniques, and policies turn to shape individual life and that of the population. The new value can be rendered because the family can shift seamlessly from protecting the private realm and the sovereign/normal individual against state incursion to carrying the public responsibility of caring for and managing the vulnerable/pathological family member.

It would be unfair to claim that Huang Xuetao and her activists-peers forgot about the intimate politics of institutionalization. In fact, especially since 2012, when she redefined “being mentally illed” as “substitute decision-making” and refocused her campaign on affirming patients' legal capacity, Huang has been advocating for an overhaul of the guardianship system. She has argued that guardianship should never be automatically granted, but rather should be adjudicated and conferred in only a limited number of cases. The ward should be able to choose and change his guardian. Moreover, Huang has pushed for the state’s responsibility in building a safety net for the individual outside of his home. Yet these nuanced arguments have received little attention from the public (at least not by the time the law passed), because it was too successfully fixated on the individual-state dichotomy pictured by the keyword “being mentally illed.”

Yet even if one realizes that the state isn’t always the problem, the human rights campaign still falls short by imagining its subject as a lone individual, by failing to recognize the shared human conditions of dependence and vulnerability, as well as human needs for care. While it is commonplace to encounter disputes regarding involuntary commitment between patients and family members, both within and outside of the psychiatric ward, these disputes have seldom become lawsuits, let alone made national headlines. In the few cases that did, thanks to Huang and her colleagues' facilitation, the plaintiffs usually did not live with their families, and they all had independent incomes or promising careers. One of them, Zou Yijun, even made the radical symbolic gesture of "leaving home" and joining a monastic order. The figure of the lone and sovereign individual leaving and resisting the domestic order has thus become the dominant, and perhaps the only conceivable, form of victimhood associated with psychiatric abuse by families. Yet this is a vision hard to fulfill by most of the people traumatized by family-initiated commitment. This is because they are emotionally and financially entangled with their families. Moreover, the most legible cause of complaint was that the family allegedly had committed psychiatric abuse for control of property. In such cases the family as a cultural institution had been conceived of as oppressing the quintessential sovereign individual in capitalism, the naturalized homo economicus. Yet in many other everyday family relations, family members negotiate their social, moral, and even ontological expectations toward each other, using discursive knowledge and technique from fields such as psychiatry, law, and policy. In Chen Dan's case for example, both she and her parents experienced and expressed their dissatisfaction with and expectations for each other in psychiatric terms. In such relations, the guardian's disciplining often emerges from her duty to care, and the ward's resistance is entangled with his demand for financial provision or emotional connection. In other words, *guan*, as it is practiced in everyday intimate life, is shot through with incalculable desire and multifaceted ambivalence.

As Martha Nussbaum has pointed out, by assuming subjects as free, equal, and independent individuals coming together to seek mutual advantage, classical social contract theories fail to consider justice, dignity and care for vulnerable people (including persons with disabilities) as moral and political goods in and of themselves (Nussbaum, 2006). This pitfall is shared by Huang Xuetao and her peers, who follow the international human rights tradition (Lord & Stein, 2013) and the liberal Chinese tradition to conceive of power only as a kind of substance, owned by the state and its institutions, which can be used to oppress the sovereign individual. Huang has even argued that claims to vulnerability were a tactic of the subservient to beg paternalistic authority for charity.[34] Yet vulnerabilities do exist, although their relationship with biomedicine is more complicated than what psychiatrists tended to claim. And in a socio-economic structure that tasks the family with everything, yet leaves it with few resources, the arrow of injury, suffering, dependence, and vulnerability within the domestic sphere might not run just one way. To conceive of and critique family dynamics in mental illness, it is not enough to simply think of the family as an institution (although as this chapter has shown, it very much is). The family is also a form of discursively conditioned *intimacy*. To take this intimacy seriously, Foucault's notion of power as micro-physics (Foucault, 1978) is more apt, but it too needs to make room for an ethics of care and duty, to encompass the complex affects, desires and ambivalences within the domestic. It is with the hope of analyzing the intimate politics of *guan* that I now turn to everyday practices of the family.

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[34] Huang's microblog entry, Sept. 9, 2012.

SECTION TWO

LOGICS OF RISK, ETHICS OF PATERNALISM

CHAPTER 3

CRUEL HOPE:

HOSPITALIZATION, RISKS, AND ABDUCTIVE COMMITMENTS

From 2008 to 2014, I paid countless visits to the adult psychiatry wards—two male and one female[1]—at the Guangzhou Brain Hospital (GBH), a flagship psychiatric hospital in Southern China. Each ward had about 90 patients, the majority of whom had been diagnosed with schizophrenia, and the rest with other ailments such as bipolar disorder or severe depression. The wards were all securely locked and barred. At night, most patients slept in crowded ten-bed rooms, and the rest either paid a higher price to live in double or triple rooms, or were put in monitored rooms, hands and feet under restraint, because of their florid symptoms or overt disobedience. In their waking hours, all patients, except for the restrained ones, were asked to stay in the large activity room, which placed them directly under the gaze of the nurses station outside. Staff led limited activities on the ward. After all, each ward had only one director, four resident psychiatrists, about ten nurses (working in shifts), and several care workers. Not much happened in the daily lives of most patients, other than short ward rounds conducted by doctors and nurses in the morning, possible visits by families and friends in the afternoon, and the collective dispensation of meals and medications at fixed points in time. They just chatted with each other on and off, sat on benches staring blankly at the TV, or paced back

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[1] I asked doctors on the wards why there were more male wards. The doctors' usual answer was that male patients' families were more eager to seek medical help for them, because of men's higher status at home and in society.

and forth, talking to themselves. While busy metropolitan life took place right outside the hospital, on the ward, time seemed to have stopped for the patients.

Rong, a thirty-year-old woman, was one among many patients who felt isolated, and who said that her life trajectory had been interrupted by hospitalization. A practicing Buddhist, she told me that she had converted shortly after her first hospitalization two years before. Back then, her difficult relationship with her boyfriend had made her irritable. She saw ghost-like shadows flying in her room, heard voices talking about her, and felt so scared that she couldn't help screaming. Therefore, she checked herself into another psychiatric hospital in the city. To her dismay, the pills that the doctors prescribed did not chase away the ghosts, but only disturbed her menstrual cycle, an important sign of natural femininity and bodily regeneration for many female patients.[2] So she stopped taking the pills after being discharged. Then one day, she saw the image of the Buddha flying in front of her, and heard the Almighty's voice telling her how to deal with the ghosts and the daily tasks. After that experience, she became a Buddhist, and had been learning to control her temper with prayer.

A migrant in the city, Rong had long been living with and supported by her elder sister. Despite her confidence in her own healing practices, Rong's pharmaceutical noncompliance and occasional irritability made her sister worry that she might be relapsing. Her sister suggested that she see a doctor, but she protested this idea. With the excuse of driving her to a family dinner, her sister tricked her into entering GBH. Weeks into her second hospitalization, Rong was still upset about this arrangement. She complained to me:

> I asked her [my sister] to give me a chance, to allow me two or three months without taking pills or being hospitalized [to see if I could control my temper with Buddhist discipline]. Every time I made this request, she refused by saying: "What if you end

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[2] For discussions on the cultural experience of femininity, blood, and madness, see my paper (Z. Ma, 2012).

> up like last time?" I feel like I am just a puppet on a string, being pulled here and there by others. I am not able to resist in the least bit.

Hope, Fear, and Risks: Hospitalization as Abductive Commitments

Rong might have been the only person openly practicing Buddhism on the ward, but she was certainly not alone in feeling that her life had been thrown off course by waves of hospitalization. She was also not the only patient who felt that she was a puppet being controlled by the hospital, her family, and her medications. Meanwhile, like Rong's sister, many family members felt that the patient's—or even the whole household's—future was fraught with foreseeable or unpredictable risks of illness. These risks, they insisted, needed to be consistently managed by pharmaceuticals, and at times, by hospitalization.

In the previous chapter, I analyzed how the mental health legislative debate hinged upon controversies around involuntary hospitalization and psychiatric abuse. In the debate, the subject of hospitalization was imagined to be either a (biologically) normal individual whose right to autonomy had been violated, or a pathological individual whose right to health needed to be protected. In this chapter, I want to move away from high-profile legal reform to examine how hospital treatment has been practiced in everyday life, especially before the implementation of the Mental Health Law in 2013. Rather than taking the patient as a pre-formed subject, and evaluating the legitimacy of hospitalization accordingly, I ask how the subject of the patient—his/her past illness history, present treatment, and future prognosis—is constituted in an ongoing way through hospital encounters (Goffman, 1968). Because these encounters are mostly initiated by the patient's family members, I examine what draws people to (commit their loved ones to) the psychiatric hospital and a pharmaceutical life, how hospitalization defines and achieves efficacy of treatment, and how it shapes people's responses to and responsibilities for biomedical care. Since contemporary Chinese psychiatry is dominated by what I call an “institution-family circuit,” I am interested in how this circuit is maintained by a choreography of professional and familial labor, and how the hospital, as a key component of this circuit, shapes life within and beyond its walls, including the making and unmaking of familial bonds. Note that because my fieldwork on the inpatient wards spanned seven years, and because patients coming from all walks of life to flagship Chinese hospitals are known to be hard to follow over time (Song, 2016), my analysis in this chapter relies on common themes that emerge from the hour-long interviews I conducted with over a hundred patients and family members, rather than on a few coherent narratives that one captures longitudinally, as some anthropologists have been able to do.[3]

As can be seen in Rong’s case, patients who are committed, family members who decide upon the commitment, and doctors who carry out the treatment usually have different experiences with and evaluations of hospitalization: it can be seen as care, confinement, or abandonment. Anthropologist Sarah Pinto argues that inherent in psychiatry is an ethical paradox, which “involves the way categories of ethical evaluation—the good and the bad—collapse in medicine and human relationships” (Pinto, 2014, p. 3). Yet rather than merely describing paradoxical, ambivalent experiences and evaluations, in this chapter I argue that this ethical paradox is conditioned by a paradox in psychiatric epistemology and practice, that is, the entanglement of hope and fear along a projected and co-produced course of mental disorder.

In what follows, I will show that people come to psychiatry in hopes of restoring order to a chaotic and precarious life. Psychiatry takes up this hope and reconfigures it into a desire for a pharmaceutical cure. It does so by translating people’s diverse experiences of madness into

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[3] Admirable examples of this other method abound, such as (Biehl, 2005; Garcia, 2010; Mattingly, 2014; Pinto, 2014).

symptoms of an ontological mental disorder, making an exclusive claim on reality, and replacing the patient's (and the family's) alternative quests for order with a biomedical ordering of life. This hope, "engendered by the cultural power of medical imagination," sparks patients'—and in this case, families'—enthusiasm or what Mary-Jo Delvecchio Good has called the "biotechnical embrace" (Good, 2001, pp. 397, 399). However, while promoting a hopeful future of cure or recovery, psychiatry also teaches people to anticipate a fearful future of disability and degeneration. I will show that this double function of "causing and evacuating the terror of a potential future" (Jain, 2007, p. 81) is achieved by the statistical prognosis, which projects mental disorder on a trajectory of chronic risk, relapse, and remission. With this newly constructed temporality, the psychiatric pursuit of hope becomes a life-long task of risk reduction and prevention. Because the patient is assumed to be without insight, it is the family that comes to shoulder this task, employing means of pharmaceutical monitoring and involuntary hospitalization.

Inscribing patients into a chronic trajectory full of hope and fear, the psychiatric epistemology performs what anthropologists have called "abduction," that is, "tacking back and forth between futures, pasts and presents, framing the life yet to come and the life that precedes the present as the unavoidable template for producing the future" (Adams, Murphy, & Clarke, 2009, p. 251). Stefan Helmreich has recently suggested that we examine how abduction as a logical register may do violence to kinship, just as abduction as a corporeal action—the forceful or deceptive taking away of somebody—does. Following Helmreich's suggestion but also pushing it further, I argue that the abductive logic of psychiatry not only has the potential to do violence to kin relations, but also set up the conditions for corporeal abductions and other enactments of kin violence. In particular, by invoking families' hopes and fears in relation to the prognosticated future, the psychiatric logic of risk reduction urges family members like Rong's sister to take timely action for/on the patients, most importantly by forceful or deceptive hospitalization, which many patients experience as a violent abduction. Meanwhile, when family members ask patients to conform to a biomedical future, patients can also hold family members hostage for many demands.

In the process of hospitalization, abduction or taking away happens alongside commitment or surrender, most notably the family's act of giving the patient over to the institution. Lawrence Cohen defines commitment as "(1) the giving of a body (2) to or for another (3) in a way that remakes the limit of that body's existence or horizon." He challenges the assumption of a liberal subject and his capacity to consent that undergirds our common evaluation of commitment. Furthermore, Cohen asks us to heed when a certain form of commitment is deemed either ethical or terrifying in a particular cultural and moral world, as well as what kind of relationship this commitment builds/is built upon (Cohen, 2011). Taking a cue from Cohen, I see that the biomedical future of hopes and fears conditions not only the commitment of patients, but also family members' commitment of financial resources, emotional energies, and physical labor, as well as medical professionals' commitment of attention and expertise. I pay attention to how one form of commitment may enable, require, or obstruct other forms of commitment, and how the convergence or divergence of commitments remakes the existence and horizon of kinship. For example, when the grim prognosis of a mental disorder requires an indefinite commitment of the patient but enables family members' withdrawal of their own commitments, it provides grounds for family dissolution, giving rise to feelings like being abandoned or guilt.

The play of hope and fear, abduction and commitment, characterizes the everyday practices of *guan* in hospital psychiatry. As mentioned in previous chapters, *guan* is a pervasive and polysemous word in contemporary Chinese life. It can refer to concerning oneself with and being responsible for another individual, and/or to managing, governing and control. However, its central reference is always to bringing something to order. This term was hotly debated during the mental health legislative debate, and it has since become the central mandate of the new Mental Health Law. In this chapter, reflecting on common psychiatric practices before (and after) the law's passage, I argue that the multiple dimensions of *guan* coexist, and are constantly negotiated vis-à-vis each other in the dynamic and paradoxical process of hospital treatment. At the same time, risk management through medication and hospitalization gains traction in people's everyday life, precisely by drawing on and reconfiguring *guan* as a shared cultural imagination of forming humans and building order.

Madness, *Guan,* and a Quest for Order

The story of Rong bears much resemblance to the story of Tingting that I described in the book's Introduction. To briefly recap, Tingting was a first-time inpatient, who had been disturbed and rendered sleepless by chaotic experiences both at work and in her love life. Her mother, Mrs. Yuan, had deceptively taken her to the hospital, and had decided to change her job in order to make a more secure future for her, protect her from potential harm, and ensure her medical compliance. Both Rong and Tingting were frustrated about their families' interventions. While Tingting and Mrs. Yuan disagreed on whether it was appropriate to subject Tingting to all of her mother's measures of *guan*, the struggle between Rong and her sister was focused on one such measure, that is, risk prevention through repeated hospitalization.

Although they disagreed on the appropriateness of *guan* in the specific case, Tingting, Mrs. Yuan, and many other Chinese people whom I have interviewed share the same cultural imaginary of *guan,* that is, management as an ethical practice of parenting. As cultural psychologists and anthropologists have told us, when Chinese parents practice *guan* with their children, their seemingly stern behavior of control, discipline, and restraint is supposed to be accompanied by care, love, and sacrificial labor. Underlying these practices is an image of children as "weak, vulnerable, and dependent beings" (Saari, 1990) who have to be protected and trained in an optimal environment by their more mature, responsible, and knowledgeable parents. Parents engage in *guan* with the hope that their children can become fully human, acting in harmony with the social order (R. K. Chao, 1994), and eventually no longer need *guan*. Because this *guan* seamlessly links individual development, parental aspiration, and social order together, David Wu, for example, has argued that *guan* is "the characteristic feature of Chinese socialization" (D. Y. Wu, 1996).

Tingting did not think it appropriate for her mother to practice *guan* with her, partly because as an adult, she thought of herself as entitled to freedom and independence. However, as Mrs. Yuan saw it, the orderly world that Tingting (and the family) had inhabited had been shattered by madness. This had rendered Tingting vulnerable and in need of *guan*. Indeed, on the adult psychiatry wards, I often heard doctors, patients, and family members using the word 乱 /*luan* to talk about madness. As an adjective or sometimes an adverb, *luan* means messy, chaotic, disordered. A patient might feel that her thoughts were chaotic and couldn't be stopped; a second patient's father might complain that he spent money in a disorderly way, buying seven pairs of leather shoes for himself at a time; or a doctor might say that a third patient was deranged (*luan*) because he talked to and laughed with imaginary entities…

Madness, then, is a disturbance of and eruption from the orderly world. In the cases I gathered from interviews and observations, some of the eruptions were volcanic and palpable to everyone present, such as a man frantically smashing everything at home or even stabbing his parents with a knife. Yet other disruptions were quieter, such as an adolescent feeling estranged from her parents and withdrawing to the online world. Sometimes, the disorderly experience was probably an attempt to grapple with a disorderly world that was full of mistrust and injury brought on by social transformations, such as in the realm of gender relations. Rong's ghostly visions appeared shortly after her then boyfriend had abused and threatened her, whereas Tingting had been rendered sleepless thinking about whether, as a woman with a homely appearance, her affection for and lavish spending on a male colleague would be requited. In other cases, the orderly world that madness putatively disrupted was assumed to be the norm only by some—but not all—people involved, and especially not by the patient. For example, a sixty-year-old man told me that he liked buying friends dinner, giving them money as gifts, and investing in real estate with his own money, or as he had planned to, by refinancing the apartment he had bought for his son. For him and his siblings, who had grown up in the adventurous Northeast China, he was just being prescient and wisely investing to gain social and financial capital in the long run. Yet for his son, who had grown up as a careful and pragmatic Cantonese, his behavior constituted manic squandering. In general then, experiences with and claims of disorder often reflect changing social expectations, gender and generation gaps, precarious interpersonal ties, and feelings of vulnerability during the post-socialist transformation.

When chaos is perceived in a family member and found intolerable, a quest for order is triggered, sometimes by patients themselves, but more often by their relatives. Dr. Liu, a psychiatrist on the female ward, told me, “Most patients are sent here because their families feel that they are too chaotic (*luan*) to be managed (*guanli*).” This language of *luan* and *guan* is also often found in many patients’ records, especially their medical histories as provided by their family members and noted by their doctors. They function partly to describe and justify the need for hospitalization. Besides *guan,* 治/*zhi,* the Chinese word for treating or curing (disease), also has an old but enduring reference to administering, governing, and managing by bringing order to chaos.

Despite what Dr. Liu implied, however, hospitalization and psychopharmaceuticals are not the only means through which families—and patients—manage chaos, and the biomedical world order is not their only option. Rong, for instance, brought the disturbing ghosts into a Buddhist cosmological order, in which devotion to Buddhist teachings would allow her to make peace with other beings and herself. Meanwhile, Tingting tried to cool down her head by devoting herself to work, and trying to achieve financial and emotional independence. In both cases, the patient’s quest for order opened a temporal horizon that required self-improvement efforts in order to achieve a promised future, be it sacred enlightenment or secular prosperity. However, because like small children subject to parental *guan,* mentally ill patients were often seen as too vulnerable to care for and make decisions for themselves, family members often felt it necessary to take matters in patients’ lives into their own hands. Therefore, patients’ future-oriented pursuits were often blocked by their families and substituted with plans more consistent with the latter’s own visions. An example of this was Mrs. Yuan’s efforts of hospitalizing Tingting, changing her job, and setting up blind dates for her after discharge in order to help her forget her unrequited love.

Sometimes the family and the patient do share a common quest for order. Many families and patients I spoke with attributed chaotic experiences to a disturbance or stagnation of *qi*, the life force that, according to traditional Chinese medical theory, generates and regulates all cosmological and bodily functions (Y. Zhang, 2007). Ignoring the mind-body dualism taken for granted in psychiatry, those families and patients associated the behavioral and emotional disturbance with physiological chaos, such as the excessive heat of Fire (上火/*shanghuo*) in the patient's body. The families would then use certain foods or herbal concoctions to help the patients bring their *qi* and its various manifestations back to a more natural harmony.

In still other cases, people traced the source of chaos to a disordered family, and sought redress for, or collective repair of, intimate injuries. Perhaps influenced by the popular psychological notion that childhood experience shapes, or even determines, one's life-long well-being (Kuan, 2015), many young adult patients attributed the chaos in their thoughts, behaviors, or bodily rhythms to disorders in their natal families, such as conflicts between parents, between siblings, or with extended family. The family members would often come to agree with this attribution, and would attempt to adjust their domestic dynamics accordingly, by fighting less in front of the patients or by expressing loving sentiments toward them.

Moreover, for some female patients, their chaotic experience expressed their suffering from gender injustice, unrecognized sacrifices in love, or sexual exploitation.[4] Mei, a woman in her late twenties, told me that she had become insane only because of love. She had lived with her boyfriend—a powerful government official—for nine years, and had gone through three abortions for him, but he still refuse to marry her, even refusing to admit their relationship to his own son. In her hallucinations, she heard people calling her a whore, and saw babies' heads

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[4] Some male patients also claimed to suffer from unrequited love, neglect by partners, or other disorders in intimate relationships, but the rate was lower in my observation. This could be because female patients more readily related these experiences to me, a female researcher.

hanging on trees. For her and for many women like her, the only way out of chaos was for their partners and in-laws to recognize their suffering and to (re-)build an order of love and intimate justice.[5] Unsurprisingly, such claims were not easily accepted by those who had been blamed, but they often received support from the women's natal families and even sympathy from the hospital staff, especially the female employees.

We can see that although madness commonly entails experience of chaos and disorder, exactly what is disordered and what kind of order needs to be (re-)installed are uncertain, and open to different perspectives and practices. As phenomenologists remind us, different perspectives emplace human existence within different temporal horizons (Desjarlais & Throop, 2011). In struggles to get out of the maddening chaos, the horizons that might unfold cover a wide range, including remediation for past injustice, restoration of a natural rhythm, striving for a promised future, and so on. As anthropologist Annemarie Mol has pointed out, because bodily reality is not fixed, but always configured by practices, there is "permanent possibility of alternative reconfigurations" (Mol, 2002). Furthermore, she argues, good care is "persistent tinkering in a world full of complex ambivalence and shifting tensions" (Mol et al., 2010, p. 14). In the face of madness, most people are natural pragmatists, experimenting with different treatments or management options to see which world order (or an emergent hybrid) is most inhabitable, often disregarding the epistemic differences between these options. A patient might wear a Taoist amulet in order to drive out evil spirits, while also seeking refuge in the hospital. A family might use herbal concoctions to modulate the patient's bodily cycle while also altering the family's interactional style. As for the psychiatrists, though most would readily name the perception of gods and spirits as delusions, and would deride the efficacy of Chinese medicine in

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[5] Wu Fei documented a similar quest for intimate justice in rural women's suicide in Northern China (F. Wu, 2009).

treating mental illness, even they sometimes went beyond prescribing pills to intervene in apparent domestic dysfunctions or injustice. Dr. Lai, Mei's doctor, constantly told Mei's boyfriend that she needed "emotional warmth from a normal family." Such lived experiments may all involve different practices, perspectives, and temporal horizons, but they all point to and aspire for a hopeful future.

It is with this hope that families—and sometimes patients—turn to biomedicine and the psychiatric hospital as a form of *guan*. Tingting's mother explained that she had only taken Tingting to the hospital upon listening to a doctor friend's suggestion. "We thought she would be OK after a simple physical exam and taking a few pills." This hope that hospitalization and medications would provide a "quick fix" to the disorder was widely shared among family members (and patients), especially those in their first encounter with psychiatry.

In fact, the psychiatric industry actively encourages and promotes this hopeful investment in biomedicine. One day when riding a bus, I noticed an advertisement posted near the front of the vehicle (Figure 3.1). It was for Guangzhou Baiyun Mental Hospital, a new private hospital eager to gain a footing in the city. The ad asks: "Is there such a person around you? They talk and laugh to themselves; they are suspicious and impulsive; they are aloof and dull." Triggered by these clues, you may remember a relative behaving like this sometimes. While you may start worrying about what you should do for the relative, the ad urges you to: "Make the right choice. Make the family happy."

Figure 3.1 Bus Poster Advertisement for Guangzhou Baiyun Mental Hospital
SOURCE: author

Here, the contrast that the phrase “the correct choice” implies is not—or not only—between this particular hospital and other psychiatric hospitals in the city like GBH. After all, these hospitals all employ similar treatment modalities, and Baiyun is under the direct supervision of GBH. Rather, the contrast is between psychiatry and other ways of treating and managing the disorder, and between people who promptly seek psychiatric help for their loved ones and those who do not see these behaviors as disorders. As I just mentioned, when people are conducting everyday experiments in managing madness, they are often pluralists rather than purists. They are often well aware that their attempts might fail, that the order they aspire to might not turn out to be inhabitable. Phenomenologists remind us that no perspective can exhaust the world (Desjarlais & Throop, 2011), and Mol reminds us, “In the logic of care uncertainty is chronic” (Mol, 2008, p. 78). Yet here in the ad, psychiatry claims itself to be the only correct choice, the perspective that can exhaust reality, and the practice that has no place for uncertainty. Moreover, while people often tinker with family dynamics in order to build a more orderly world for the patient, the ad makes an opposite claim, suggesting that subjecting one person to the hospital can secure happiness for the whole family. How can psychiatry deliver on this promissory note? What order does it seek to build, and what temporal horizon does it open? As we saw in Tingting’s case, psychiatric commitment is initiated by patients or their family members as one among their many attempts to *guan*, to bring hope to the person rendered vulnerable by the disorder. Then how is this *guan* transformed into a predominantly psychiatric one, one that tends to turn patients and their family members against each other on issues of hospitalization, as we have seen in Rong’s case?

Psychiatric Translation and Biomedical Order(ing)

While the behaviors that the ad describes may, in vernacular discourses of madness, emanate from different configurations of disorder and be addressed by different quests for order, they are seen by contemporary Chinese psychiatrists as signs of mental disorders that disrupt the individual self. According to psychiatrists from a wide variety of hospitals whom I have interviewed, the diagnosis that they most frequently make in inpatient settings is schizophrenia. The characteristic symptoms of schizophrenia include delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms (such as affective flattening or avolition).[6] This list of symptoms provides the most common grid to which

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[6] According to a senior psychiatrist, when he was trained in the 1980s, his supervisor told him that 95% of the patients he would see would have schizophrenia, and the drug for all was clozapine. Nowadays,

psychiatrists translate the signs that family members (or, in rare cases, patients themselves) initially provide. To undertake the translation, these initial signs serve as clues for psychiatrists to observe more symptomatic behavior or to elicit reports of underlying thought processes from patients. For example, after learning about Tingting's sleeplessness and mood swings from her mother, Dr. Liu asked Tingting what had kept her up at night and disturbed her. According to Tingting, it was the thought that her colleagues had all been gossiping about her appearance, laughing at her attempt to pursue love, and conspiring to embarrass her. Dr. Liu considered it impossible that everyone would aim at her, and thus diagnosed her with paranoid schizophrenia. Here and in countless other cases, psychiatrists act as adjudicators of the patients' personal and social reality, against which they compare the patients' thoughts and perceptions. As psychiatrists see it, the only normal relationship between thoughts/perceptions and reality is representational; that is, thoughts/perceptions should exactly reflect reality, or else they are delusions/hallucinations.

In seeking to access patients' thoughts through their words, psychiatrists operate on what Summerson Carr calls a "[linguistic] ideology of inner reference" (Carr, 2010), that is, an assumption that language should normally refer to one's thoughts, emotions, and perceptions. However, because patients putatively lack knowledge of their own mental illness, or worse still, because they might deliberately hide their disorders for fear of treatment, psychiatrists often perceive a need to play linguistic games of suggestion, elicitation, and confrontation with them. For example, Yun, a thirty-year old woman who had previously been hospitalized for schizophrenia, had recently been readmitted by her mother-in-law. The latter complained that whenever Yun was kindly urged by others to visit her natal home, she would burst out crying and

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although the diagnoses of depression and bipolar disorder are on the rise, schizophrenia still dominates the field. In fact, my patient sample is probably a bit skewed toward the new trend, considering the fact that there are some strong advocates for bipolar disorder in GBH.

protest. On the ward, her doctor asked her in a concerning tone why this was the case. Sobbing, Yun responded, “I’m not sick. I just don’t want to see my father. He used to drag me to the [psychiatric] hospital, so I am really scared of him. Also, he has cheated on my mother and treated her badly.” Unable to elicit Yun’s cooperation in producing a “mental,” rather than familial, disorder, the doctor drew in other signs provided by Yun’s in-laws and her medical record, especially the fact that she had previously been troubled by visions of ghosts. The doctor further elicited, “You don’t want to go visit your father’s home because you feel that there are some dirty [i.e. unearthly] things there, right?” Yun turned down this elicitation, claiming that she had always hated her father. The doctor confronted her in an angry tone, “Well, that’s not true. You lived with your parents for quite a while after you got married, and you even worked for your father by collecting rents for his properties. It was only when you got sick that you avoided him!”

Here, the doctor seemed to think of the patient as playing hide-and-seek with her. In fact, many psychiatrists consider their ability to catch patients off guard in this hide-and-seek “game” to be part of their expertise. Yet if we follow Mol’s idea that reality is always being configured, Yun’s case illustrates the patient’s and the psychiatrist’s divergent efforts to configure the reality of dis/order: while the patient struggled to make the disturbing signs point to a family disorder, the psychiatrist put in much semiotic labor to translate the signs into a mental disorder, a personal disorder that was preventing Yun’s necessarily happy reunion with her father. This professional translation is reductionist, limiting the many possible renderings of signs to one. It locates the disorder in the individual mind, which in turn is said to disrupt the patient’s self and thereby the family or even society. Through such a reductionist translation, psychiatrists can thereby create and realize the promise in the ad: by treating the individual, they can bring happiness to the whole household.

After translating signs into symptoms and thus diagnosing mental disorders, psychiatrists further reduce the latter into neurochemical disorders. Contemporary Chinese psychiatry is dominated by receptor theory. This theory attributes mental disorders to the malfunctioning pathways of neurotransmitters, and to altered levels of dopamine, serotonin, or glutamate in the brain. It thus sees treatment as manipulating the corresponding receptors with drugs such as clozapine, perphenazine, and risperdone. Most of the psychiatrists whom I interviewed devoutly follow this theory, and they generally conceptualize the neurochemical malfunctions as determined by genetic factors. Although they sometimes do recognize the role of dysfunctional domestic lives, gender injustice, or other psychosocial factors in triggering disorders, they most often only see these “factors” as stressors that induce expression of the genetic diathesis. Such external stressors, as philosopher Adam Hedgecoe argues about the “diathesis-stressor model,” were seen by Guangzhou psychiatrists as nonspecific, ungeneralizable, less researchable, or even less real than disordered neurotransmitters (Hedgecoe, 2001). This attitude was captured in a psychiatrist’s response when I asked what kind of stress caused mental disorders. “Many people say the onset is due to great pressure or stressors, but how can there be so many stressors? These are not the key problems. The key is biological.”

Besides making a diagnosis, then, a psychiatrist’s job is to use psychopharmaceuticals to reorder the patients’ neurochemical levels and control their symptoms. This is the primary way in which the efficacy of psychiatry is defined. This sort of psychiatric care still requires much tinkering and experimentation on the part of psychiatrists, however. Nevertheless, the objects to be experimented with are limited to the types and dosages of drugs (sometimes together with other neurological treatments such as modified electroconvulsive therapy).[7] Ideally, such experimentation allows doctors to follow or even anticipate the fluctuation of symptoms (e.g. the cycle of depression and mania in bipolar disorder) and to modulate it. Pharmaceutical treatment also helps confirm or overthrow a tentative diagnosis. For example, for a patient who was both suicidal and hallucinating, the fact that antidepressants, rather than antipsychotics, worked to keep both symptoms at bay suggested a diagnosis of severe depression with secondary psychosis rather than schizophrenia. Moreover, psychopharmaceuticals, especially antipsychotics, usually carry with them various side effects, such as obesity, diabetes, extrapyramidal reactions (repetitive, involuntary movements such as tongue protrusion, sialorrhoea, compulsive motions, and related anxiety), and endocrine dyscrasia (e.g. irregular menstruation or amenorrhea). Experimenting with drugs can hopefully help psychiatrists achieve maximum treatment effects (i.e. symptom control) and minimum side effects, so as to ensure treatment safety and to elicit patients' compliance with medications.

As a platform for neurochemical reordering, psychiatric hospitalization also works to reorder the patient's life in several ways. Through brief conversations during ward rounds, psychiatrists at GBH sought to "rehabilitate [the patient's] relationship to language" (Carr, 2010, p. 1), so that patients would learn to honestly report their inner states in order for psychiatrists to monitor the treatment effects. Psychiatrists also attempted to build in the patient a meta-consciousness, or what they commonly called insight, so that patients could distinguish their symptomatic cognitions from those of the biomedically defined reality, and could then commit themselves to controlling the symptoms with the help of psychiatrists. One day during ward rounds, Dr. Lai told Rong, "I'm not against you practicing Buddhism, but you should know that

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[7] Compared to the original electroconvulsive therapy, the modified one uses muscle relaxants and anesthetics in conjunction to avoid possible bone fracture or feelings of suffocation.

the voices of gods and ghosts are caused by mental illness." Then she pointed out a disheveled woman across the activity room, who kept murmuring to a ghost, laughing and crying to herself. "Normal people aren't like that," Dr. Lai said, "if you don't want to end up like that woman, work with me. Let me know what you see and how you feel, but don't stop taking your meds." Rong protested that the meds made her menses stop, which in turn made her irritable. Dr. Lai promised to adjust the dosage and use some ancillary drugs to alleviate the side effects, but she also insisted that amenorrhea was merely a *side* effect, not a pathogenic factor. "The main thing right now is to control your symptoms," Dr. Lai emphasized, "The menses will come back once you're cured and stop the medications. Anyway, isn't it better not to have menses?" Like Dr. Lai, most psychiatrists welcome or even actively solicit patients' reports of treatment side effects as well as symptoms. But as they see it, an insightful patient should trust that her psychiatrists would take care of the side effects; and if they can't, bodily disorder is the necessary price to pay for reestablishing mental order.

The psychiatric construction of mental order is facilitated by the spatial and social ordering of the ward. At GBH, the wards were placed under the panoptical surveillance of the nurses stations, patients' daily schedules were mechanically planned, and their medication received intense monitoring. Four times a day, patients lined up in front of a nurse in the activity room. One by one, they received a small box of pills, swallowed the pills on the spot, and opened their mouths so that the nurse could see if they were hiding the pills under the tongue. In their spare time, they were encouraged by psychiatrists to chat and interact with each other, lest they withdrew into their disorderly minds. In this way, patients were asked to take each other not only as models to emulate or bad examples to avoid, but also as a social reality. Ironically, they were forbidden to contact the social reality of the outside world except for visiting family members, because psychiatrists saw the outside world as a source of distress and disturbance. In this carefully arranged environment, it was considered ideal for patients to develop insight and willingly use psychopharmaceuticals to manage (*guanli*) their symptoms and daily lives. If a patient could not do that, or if he dared to challenge the order of the ward, or if his symptoms became too disruptive to be controlled by simple use of pharmaceuticals, then the staff would readily resort to restraint, such as putting him in the monitoring room and tying him to the bed. Understandably, most patients considered these occasional restraints and everyday regimentations as a cruel form of control, and they protested them publicly and privately. Yet as psychiatrists saw it, these measures reflected a benevolent *guan:* like parents caring for children but in a more professional way, the staff concerns themselves with, commits their expertise to, and takes responsibility for vulnerable patients by bringing their life back to order. In some ways, hospital psychiatric *guan* is thought to be preferable to the *guan* at home, especially if home life has been rendered precarious.[8] For example, when a patient who was a migrant worker living alone in the city begged his doctor to discharge him, the doctor tried to comfort him by saying: “Here [in the hospital] there are people looking after (*guan*) you, and there are routines in your life, whereas at home everything is messed up. [So just stay here,] OK?”

Indeed, hospitalization marks a transfer of responsibility for *guan* away from the patient’s family. Although family members are usually the ones who decide upon and pay for hospitalization, and although the signs they report during intake interviews are the starting points of the diagnostic process, they do not, or are not supposed to, have much influence in the inpatient treatment process. At GBH, family members could visit patients every weekday afternoon and all day during weekends. The staff would sometimes ask them to come so that

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[8] For the idea of constructing a home better than one’s original home in times when home is rendered precarious, see Chapter 4 of (Allison, 2013).

family could learn about patients' treatment progress, provide consent for certain treatment procedures, bring patients daily supplies, clear the unpaid bills, and so on. Yet the staff did not like seeing families come to the ward very often. They often advised family members to visit patients no more than once a week, lest the families' pluralist and non-biomedical quests for order jeopardize the psychiatric ordering of patients' life. Moreover, the staff was afraid that because of their emotional ties, the visiting family members would give in too easily to patients' supplications for discharge. As the staff saw it, family members who lacked knowledge of mental disorders might perceive the treatment measures as cruel, and fail to see the benefits; alternatively, overjoyed by the temporary improvement of patients' symptoms, family members might readily bring patients back home upon seeing the latter's very first signs of symptom improvement, without realizing that time is required for the medication and hospitalization to distill and to stabilize a new order in patients. For example, Mrs. Yuan saw Tingting's disorder as partly associated with a nutritional imbalance, which had made her obese, self-conscious, and emotionally unstable. On the ward, Mrs. Yuan brought Tingting home-cooked meals every day, asked if the doctor could add some nutritional supplements to her medications, and complained that the antipsychotics the doctor had prescribed made Tingting even more obese. Irritated by these suggestions and complaints, the doctor chastised Tingting's mother for being too anxious and for intervening (*guan*) too much. From the psychiatric perspective, once patients were committed to the hospital, family members should commit their financial resources and trust to sustain the biomedical order. However, they should temporarily suspend their emotional and relational commitments to patients. It is only through this reconfiguration and transferal of *guan*, they would argue, that a psychiatric cure can be delivered.

Anticipating Hope, Anticipating Risks

Although the ad in Figure 3.1 seems to promise a cure, and although many family members like Mrs. Yuan bring their loved ones to the hospital in search of a "quick fix," matters turn out to be more complicated. If the recovery for which family members hope for the patient is a permanently well-ordered life after temporary symptoms *and* medications, then recovery as psychiatrists see it has a different meaning and entails a protracted process. At GBH, psychiatrists routinely told family members and patients that treatment for schizophrenia and other severe mental disorders is divided into three phases: acute, stabilization, and stable (or maintenance). The acute phase is the first 6-8 weeks after symptom onset, during which immediate inpatient treatment is desired, and the goal is to use a high dose of drugs to control the symptoms. The next 4-6 months are the stabilization phase, during which a relatively high dose of drugs should be continued in order to consolidate the treatment effects, and the patient can be gradually transitioned back home. Next comes the stable/maintenance phase, during which symptoms are less severe or even absent, but a lower dose of drugs is to be continuously administered in order to prevent relapse. According to psychiatrists, patients in their first episode only need to keep taking the drugs for 1-2 years. The more relapses they have, the longer the drug maintenance phase needs to last. This advice reflects the German psychiatrist Emil Kraepelin's idea more than a century ago that schizophrenia (or dementia praecox) is a degenerative disease that gets increasingly obstinate and disabling over time. It is also reinforced by the recent neurobiological turn in global psychiatry which conceptualizes mental disorders as toxic brain states (Andreasen et al., 2011). In a family education workshop, Dr. Teng, chair of GBH's adult psychiatry department, used MRI scans from the latest neuroimaging literature to warn the audience that the more relapses a patient with schizophrenia has, the more her brain shrinks.[9] However, Dr. Teng did not mention the controversy over whether the use of antipsychotics might also cause brain shrinkage (Zipursky, Reilly, & Murray, 2013).[10] The juxtaposed brain scans, taken at different time points along a patient's illness trajectory, gave the audience a direct visual impression of the frightening future of degeneration. Adding to that, almost every family member visiting GBH had heard a statistical prognosis, from psychiatrists or other families, which projected fear alongside hope. Among all patients with schizophrenia, the prognosis goes, only a third of them will recover completely, without any relapse or any need for further medication. Another third will reach the state of a clinical cure and a partial recovery; that is, their major symptoms will go away, and with only minor symptoms or small-scale relapses, they can manage their everyday lives with drugs. However, the future that awaits the final third of all patients is frequent relapse and complete degeneration.

We can see that while Chinese people commonly perceive madness as a palpable and temporary disorder in and of the present, the psychiatric discourse replaces this phenomenology of the present with an epistemology of anticipation, or as Vincanne Adams and colleagues put it, "a knowledge that the truth about the future can be known by way of the speculative forecast, itself relying on proliferating modes of prediction" (Adams et al., 2009, p. 247). Specifically, the prognosis highlights the uncertain future of mental disorder and renders it as a calculable probability estimate, a basic operation of the modern mechanism of risk management (Lupton, 2013). Under this prognosis, the future for a patient becomes a chronic trajectory of risk, relapse, and remission, and the difference between hopeful recovery and fearful degeneration becomes a mere matter of variations in the number, duration, and severity of relapses along a single

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[9] More accurately, the team of Nancy Andreasen, who pioneers such neuroimaging studies of schizophrenia, argues that not the number of relapses, but the relapse duration, is correlated with brain shrinkage. See (Andreasen, Liu, Ziebell, Vora, & Ho, 2013).

[10] The 2013 article by Andreasen's team also points to this factor.

continuum. Moreover, even if we cannot feel the presence of mental disorder during its remission, the degeneration narrative and the longitudinal brain scans remind us that the disorder is always still there, that the brain damage even after a first episode is irreversible, and that the patient's condition will probably get worse invisibly and insidiously. Therefore, rather than turning attention to the presence (or absence) of symptoms, the anticipations built by the psychiatric prognosis orient us to a life that will be lived at heightened risk, a "future as that which matters" (Adams et al., 2009, p. 249).

This psychiatric anticipation not only makes the future of chronicity and degeneration count for more than the symptomatic present, but also subsumes the present under the future by using the future to set up the conditions of possible actions in the present. As anthropologist Sarah Lochlann Jain points out, the statistical prognosis poses both a stunningly specific (in our case, one has 33 percent chance of complete degeneration) and a bloodlessly vague (this particular patient may or may not completely recover) (non-)prediction. In other words, although the statistical fate of the patient population is set, prognosis also "holds the possibility of the counterfactual" (Jain, 2007, p. 78 & 89) by encouraging present actions aimed at moving a patient, whose future is unknown, from one category of fate to another. At GBH, for example, Dr. Liu told Mrs. Yuan that because Tingting had never had psychotic episodes before, she was likely to completely recover. Meanwhile, because Rong had been hospitalized twice, Dr. Lai gave her sister a more uncertain and pessimistic prognosis. In both cases, the psychiatrists said that in order for their prognoses to improve, the patients had to adhere to the pharmaceutical regimen for at least a few years. During this period (and for the rest of their lives), their risk factors—medication noncompliance, sleep problems, mood swings, and so on—had to be continuously monitored. If present, these risks needed to be controlled or even eliminated immediately, preferably through rehospitalization. Otherwise, the psychiatrists warned, the patients would sooner or later relapse and degenerate.

Therefore, when mental disorder is projected onto a chronic trajectory, the calculus of risk entangles hope with fear. Prognosis juxtaposes the possibility of a relapse-free life with risks of disability and degeneration, both presented as pre-calculated futures of the mentally ill population. Then, in order to pursue a more hopeful future for a particular patient, the present becomes a platform on which signs of risk continue to emerge, get spotted, and be eliminated (an endless process, like the game of Whack-a-Mole). This vigilance, as Adams and colleagues put it, is a strategy to avoid "surprise, uncertainty and unpreparedness, but it is also a strategy that must continually keep uncertainty"—and of course fear and anxiety—"on the table" (Adams et al., 2009, p. 250).

Moreover, in order to produce a life free of disorder (especially that of the debilitating schizophrenia), "a life to which nothing happens" (Castel, 1991), psychiatrists around the globe have been promoting the idea of early detection, or to use a GBH doctor's word, "nipping the disorder in the bud." Early detection involves identifying high risk factors (such as heredity or having a family history of schizophrenia), reducing precipitating factors (especially the psychological stress induced by negative emotional expressions from parents), and recognizing the prodromal phase of schizophrenia. The last refers to a period before the acute outbreak, during which symptoms are vague, easy to miss, and likely to be confused with other minor disorders. The prodromal symptoms include erratic behavior and aloof personality, which can sometimes be traced back to early childhood. In Chinese psychiatry, such practices of early detection have slowly found their ways into cutting-edge research and resulted in the recent establishment of child and adolescent departments of several hospitals including GBH. They are also seen in psychiatric advertisements (such as Figure 3.1) which highlight personality traits and behavioral characteristics (being aloof, dull, or impulsive) that are perhaps unwelcome but not uncommon in everyday life, and which few people would readily associate with madness. These practices may create new promises and problems for future would-be patients in their teens or even in toddlerhood, but for cases on the adult psychiatric wards, they only conjure a history of missed warning signs. In GBH, during patient intake, psychiatrists routinely asked family members to recall the strange behavior or personality that the patient may have displayed before the onset of symptoms. With family members' accounts, psychiatrists would also draw up the family genealogies in order to trace which members had suffered from mental disorders, and thus had probably generically passed the disorder on to the patient. These procedures often seemed unrelated to the treatment measures, even in the eyes of psychiatrists. Granted, reconfiguring the patient's and the family's history through the lens of heredity and early detection might have allowed people to assign blame and responsibility for a crisis in new ways. For example, many mothers who were the sole caregivers for adult patients would liken the latter's "schizophrenic" traits, such as irritability and paranoia, to the personalities of their husbands. In so doing, they found ways to criticize their uninvolved, uncaring, and even abusive husbands, and to fashion themselves as innocent and making sacrifice for their child's patriline. More often, however, the newly constructed history of bad genes and missed signs only engendered regrets and despair for family members: even if patients received hospitalization *immediately* after symptom outbreak, it was already thought to be years too late.

Drawing on the cultural ideology of parenting, *guan* is initiated as an aspirational journey that seeks to transform, with temporary measures of control and discipline, a vulnerable being into a well-ordered human. Yet psychiatry reconfigures this grassroots, pluralistic *guan* into perpetual medical management of a risky subject. Hope then gets entangled with fear, and they are measured by success and failure in risk management. These two notions of *guan* are not separated from each other in practice; rather, the attachment to one fuels the desire for the other. On the ward, Tingting accused Mrs. Yuan of practicing *guan* in an untimely manner. According to Tingting, during her childhood, her mother spent much time working far away from home, and her father was always playing cards with friends. "Why didn't you guys [practice] *guan* [with me] when I needed it, when I was desperate for care and guidance?" Tingting said to her mother's face, "why do you *guan* now, when all I need is independence?" Mrs. Yuan lowered her head and apologized for all that she had done wrong during Tingting's childhood. Yet if Tingting was invoking time-bound features of parental *guan* to resist her mother's current interventions, this attempt had ironically reinforced her mother's desire to intervene. "Yes, your disease is all my fault, and I regret it all the time." Mrs. Yuan said. "Let me make it up to you and *guan* now, OK?"

Risk Reduction and Abductive Commitments

In his analysis of the American pharmaceutical industry, anthropologist Joseph Dumit argues that the traditional concept of health as an absence of illness has been replaced by a new concept of health as risk reduction. In this new concept of health, the "expert patient" is constantly on the lookout for his risks of future illness, discovers that he has always been at risk, and uses pharmaceuticals to continuously modulate the risks. This practice of risk reduction, Dumit argues, ironically proliferates risks, which then allows for the maximization of pharmaceutical prescription and, at the same time, big Pharma's profits (Dumit, 2012). A similar transition happens in Chinese psychiatry, but at the individual and familial level: while family members (and/or patients) seek out hospital treatment with the hope of quelling a presenting disorder, they are asked to recognize the existence of a mental disorder, and are then given a lifelong task of specific risk reduction, regardless of whether symptoms recur. In both Dumit's and my cases, the patient's past, present, and future are all abducted to a trajectory of risks and a hope for risk reduction. Here I follow anthropologist Stefan Helmreich, who in turn follows philosopher Charles Sanders Peirce, to define abduction as "reasoning from an unknown future state" and "retroactive reasonings," both of which place "hope and desire at the center of rationalist reconstruction" (Helmreich, 2007, p. 231&230).[11]

In Dumit's analysis, the logic of abduction is unfolded in, and the task of risk reduction is shouldered by, the expert patient. In Chinese psychiatry, doctors do not expect the insightless patient to become a self-care expert (although they try to train him to be). Therefore, the tasks of risk reduction outside of the hospital fall onto the family. How, then, does psychiatric abduction to the logic of risk reduction shape family relations? Helmreich suggests that we examine how "such abductions in the logical register, like abductions in the more corporeal sense, also have the potential to do violence to kin stories secured through other means" (Helmreich, 2007, p. 231). Though the violence that Helmreich conceives is mainly about kin "stories," I am also concerned with physical violence in kin relations. This includes abduction in the sense of capture by force or deception, commonly seen in the process of committing patients to the hospital. How does the risk management logic of psychiatry abduct kin relations and condition actual kin

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[11] Peirce initially defined abduction as "a method of forming a general prediction without any positive assurance that it will succeed either in the special case or usually, its justification being that it is the only possible hope of regulating our future conduct rationally" (Peirce & Houser, 1998, p. 299). Similar to Helmreich, Adams and colleagues also define abduction as "the processes of tacking back and forth between futures, pasts and presents, framing the life yet to come and the life that precedes the present as the unavoidable template for producing the future" (Adams et al., 2009, p. 251).

abduction? If the American pharmaceutical industry is sustained by the expert patient's labor of self-care, how is the psychiatric institution in China sustained by the family's labor of abduction?

No matter how many times psychiatrists told patients to stick to their meds, many patients whom I encountered started refusing to take medication soon after they went back home, either because they did not think of themselves as suffering from mental illness, or because they could not bear the heavy side effects of psychopharmaceuticals. After all, many side effects, such as drooling, shaky hands, menstrual irregularity, and drowsiness, either worked as visible signs of mental illness and brought stigma or even social exclusion to patients, or severely decreased their daily productivity. In order to ensure patients' medication compliance and monitor their risks for relapse, family members (rather than patients themselves) routinely visited the hospital for prescription refills. During these return visits, they would report any emotional or behavioral change in the patients to the psychiatrists, so that psychiatrists could adjust the prescription. Moreover, in order to facilitate keeping an eye on noncompliant patients, some families asked them to quit their jobs or school and stay at home, as if all their life projects and ambitions had to give way to their new moral careers as psychiatric patients.[12] In such cases, a family member also had to stay at home with the patient. Usually, it was either a retired parent or a female relative, especially one who had been working in a low-income, flexible occupation, and whose job was seen as dispensable. For example, after the doctor repeatedly emphasized to her the importance of continuous risk management beyond the hospital, Mrs. Yuan decided to quit her job and Tingting's, and proposed to run an herbal tea store together with Tingting.

Understandably, families' decisions to rearrange patients' lives and to keep them at home often made them feel angry and miserable. Mrs. Yuan's mere proposal of her plan infuriated

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[12] The idea of the mental patient's moral career comes from Erving Goffman's seminal work *Asylum.* It refers to how the process of hospitalization shapes an inmate's social position and self-image (Goffman, 1968). As I am showing here, the moral career of the patient does not stop when he leaves the hospital.

Tingting, making her feel controlled and infantilized. Such practices did not delight the "controlling" party either. Because of their economic rearrangements, many families sank into poverty. When a family arranged to have a relative stay at home and look after the patient, oftentimes she would have to take the blame herself if anything bad happened to the patient, and she would have to face the patient's anger and frustration directly. Moreover, because many family members were either unable or unwilling to use force, unlike the hospital staff, "how should I *guan*" was a question that preoccupied them every day. For example, in order to get the patients to take their meds, family caregivers often engaged in trivial and yet painful negotiations with the patients. They either doled out "bribes" such as soft drinks or cigarettes, or mixed the ground pills with patients' meals while fearing discovery, or they took the pills themselves in front of the patients in order to prove that the pills were not poisonous. In one case, a patient even yelled at his unemployed mother, "Do you want me to take the pills? Sure, give me a hundred bucks!"

Here, we can see that the abductive logic of psychiatry binds the family together as both the managed and the manager. The managing family members are thus required to constantly commit their emotional energies, physical labor, and financial resources to ensuring the managed patients' medical compliance. While this renders patients subjects of intimate control, this psychiatric abduction also places restrictions on family members' lives, allowing some patients to hold their family members hostage to their own demands for compliance.

Dumit argues that the American pharmaceutical industry maximizes its profits by encouraging the expert patient to mind and monitor his health risks (Dumit, 2012). Similarly, Mary-Jo Delvecchio Good argues that by producing the "biotechnical embrace" (Good, 2001, pp. 397, 399) of patients, a financial flow to medicine is enabled. In Chinese psychiatry as well, the family's commitment to risk management contributes to, and is in turn shaped by, the production of psychiatric profits. In many hospitals that I visited, doctors and nurses spent much time calculating how many inpatients they had and how much money they made on each patient. This was because there were profit quotas set by the hospital, and the money they made as a unit also directly influenced their bonuses. Note that while many doctors see both inpatients and outpatients, the profit that an inpatient brings is far more than that of an outpatient.[13] This financial incentive might partly explain why doctors often encouraged families to send their patients to the hospital, even when families considered the situation to be potentially manageable at home. In April 2014, six months after Tingting's discharge, I accompanied Mrs. Yuan on a return visit to GBH. It turned out that she hadn't been able to get Tingting involved in running the herbal tea store after all. Without a job, Tingting had been staying in her room all day, playing games and watching pornography online. That day at the outpatient clinic, Mrs. Yuan explained Tingting's condition to the doctor and eagerly asked what kind of adjustment was needed for her daughter's medication regimen. The response she got was simple: "It looks like your daughter's illness has aggravated. Why don't you just send her here [as an inpatient]?"

When I left the field three months later, Mrs. Yuan had not sent her daughter back to the hospital. Yet, thanks to the psychiatrists' tireless education, many families did gradually learn to lower their thresholds for risk perception and hospitalization. For example, both Rong and Yun agreed that their initial admissions had been justified, because at that time they had been seriously disturbed by ghostly visions. What they resented, however, was that over time, even little things they did would be interpreted by their family members as indicating a risk for

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[13] In 2014, the fees for outpatient treatment in GBH were usually under a thousand *yuan* per month, whereas those of inpatient treatment could range from three thousand to thirty thousand *yuan* a month.

relapse, and thus lead to their re-admission, such as Rong's occasional irritation and pharmaceutical non-compliance, as well as Yun's sleeplessness and "personality change" (i.e. unwillingness to visit her father). Rong was frustrated with feeling like a puppet on a string. Sometimes even psychiatrists thought that family members were over-reacting a bit. Dr. Lai once remarked to me regarding the father of a forty-year-old patient, "Oh boy, whatever she does, even if she is just lifting a finger, he would say she's sick. This time just because she soaked a dirty pillow in water, he said she was relapsing and sent her right here!" This comment implied that what family members deem to be pathological may well be otherwise. It also implicitly recognized that psychiatry may not be able to (re-)turn the patient to "a life to which nothing happens" (Castel, 1991), and that family members need to live with the patient's small anomalies. However, what Dr. Lai did not realize was that the father's desire for such a life and his "over-reaction" to risk had been conditioned by the psychiatric logic of risk prevention. In fact, the father proudly told me that for many years he had been a regular participant in the hospital's family education sessions and he was an avid reader of popular guidebooks on psychopathology.

In any case, no matter how unnecessary psychiatrists perceived a family-initiated admission to be, they most often considered it morally and technically justified, because it is better to be safe than sorry. Anthropologist Teresa Kuan argues that contemporary Chinese parenting is an "art of disposition," that is, "a moral practice that simultaneously recognizes the embedment of human activity while locating opportunities for strategic manipulation" (Kuan, 2015). It requires parents to detect, intervene in, and even create conditions for child development in a timely manner. This emphasis on timely action is also found in family members' decisions to hospitalize and psychiatrists' support for such decisions. However, in our case, the “art of disposition” is abducted by the psychiatric temporality, which considers that it is never too early to prevent risks. Moreover, while the middle-class parents in Kuan’s account struggle between using discipline to ensure children’s future survival in the market economy and protecting their psychological happiness, their children’s seems too luxurious for family members of psychiatric patients to worry about, given the dire future predicted by the psychiatric logic if intervention is not undertaken. Therefore, for many family members who perceive the patients to be at risk, the timely action that is ethically required of them is to hospitalize the patients, regardless of what they might want, and to abduct the patients at the first sign of risk.

I should retract a bit by saying that family members often do care about how patients feel, because they want to make sure that their labor of *guan* is perceived as benign, and that family life continues to be bearable for both parties. Direct abduction by family members would likely work against these purposes. On the ward, Rong screamed to her sister who had abducted her that she could not trust her any more. At home, several male patients were known to have threatened to kill their elderly parents if they sent them to the hospital again. In order to avoid such rancor, some family members I encountered resorted to deception rather than brute force, for example by telling patients that they were going to the hospital just for a brief check-up, and then attributing the hospitalization decision to the doctor. (In fact, doctors only made suggestions, and family members were the ones who made the decisions and signed the papers.)

If the family’s deceptive or forceful abduction did not work, the hospital was ready to help. Before the passage of the Mental Health Law, many psychiatric hospitals across the country routinely offered a “pick-up service” for families. For a small fee, a family member could have hospital employees—often equipped with a vehicle, ropes, and sedatives—come to her home (or any other place she preferred) and take the person whom she knew or suspected to be mentally ill directly to the hospital ward. During the process, the family member could either help or stand aside, pretending to be uninvolved. This simple "pick-up service" was crucial to conjoining the institution and the family into a close circuit, making it work with no frills. In the market economy, many family members thus came to desire—or even see themselves as entitled to—having patients hospitalized through hassle-free abduction whenever needed, so long as they were able to commit the financial resources.

No matter how the patient was abducted, and no matter how smoothly the hospital-family circuit ran, many family members with whom I talked readily admitted that this whole process of abductive hospitalization was cruel to the patient. Yet they felt that they had to harden their heart and do it, just like parents have to harden their heart to discipline their young children. They initiated (or carried out) the abduction out of the hope that this time the patient would finally be stabilized, if not cured, and that the patient could be moved from one prognostic category to another, no matter how dim the hope was.

Vulnerable Ties and (Im-)Possible Futures

As the psychiatric logic of risk reduction abducts the family's quest for order to the lifelong tasks of financial provision, pharmaceutical monitoring, and abductive hospitalization, it also changes how people experience family ties, as well as how they anticipate and plan for the future of the household—as a place, practice, and promise to live together. Sarah Pinto argues that in India, psychiatric care often mediates the dissolution of kinship bonds and conjugal love. As such, it "adds vulnerability to the already—and inherently—vulnerable condition of kinship" (Pinto, 2014, p. 30). This is equally true in China, where market reform and post-socialist transformation have made kinship ties more vulnerable and their ethical foundations more unstable. As the patient becomes a source of complex and manifold risks, the future of a shared domestic life and of the patient's social being can also become uncertain, if not impossible.

If, as in market transactions, one enters an intimate relationship to seek mutual advantage and one's own pleasure, then the psychiatric prognosis allows one to adjust his investment in the relationship based on "routinized likelihoods, hedged bets and probable outcomes" (Adams et al., 2009, p. 247). Since the prognosis for severe mental disorders is generally grim, it is probably not surprising to find a "rational" person, a homo economicus, not wanting to risk his own future by living with a patient with a high risk of endless relapses or complete degeneration. This calculation was captured perfectly by the words of patient Mei's boyfriend Mr. Lam. On the ward, Mr. Lam told Dr. Lai that he was planning to send Mei back to her hometown, where her next-of-kin had all perished, after she was discharged. He explained his rationale in my interview with him: "From articles online, I know that only 30% of patients can completely recover from a disease like hers without further relapses. Right now I'm really gambling. If I hedge a bet on the 30% side [i.e. Mei' recovery], we'll live together, but I'll face a lot of risks. After all, human beings follow the pleasure principle." Dr. Lai, as well as almost every other staff member on the ward, was indignant about Mr. Lam's plan. They felt that Mei's mental disorder had a lot to do with the intimate injustice she had suffered. Given what Mei had sacrificed for Mr. Lam, especially the abortions she had gone through, they saw Mr. Lam as ethically responsible for giving her marital recognition and continuing to provide for her medical treatment. However, one day in the doctors' office, when Dr. Lai was trying to give Mr. Lam a moral lesson, the latter brushed it off by saying, "Come on. I'm not a savior!" After he left, Dr. Liu reminded the staff how orthodox biomedical logic plus economic rationality could legitimate his withdrawal of relational commitment, “I don’t know why you guys are so angry about him. If I were him, I would also abandon Mei!”

This moral drama[14] of anticipated abandonment took place in 2009. In 2014, right before leaving the field, I ran into Mei at GBH. I was happy to find that she had finally gotten married to Mr. Lam and had given birth to a son. She told me that her father-in-law had been very kind to her and had forbidden his son from walking out on her. However, Mei was still uncertain about her future because she had just been hospitalized again, this time for postpartum depression. In any case, during my seven years of fieldwork, I did not encounter anyone else besides Mr. Lam who expressed a calculated desire to end his/her relationship with the patient so vocally and righteously.[15] However, as I learned from interviews with patients and other family members, some people had simply walked away from their relationship quietly. This most often happened with young lovers and spouses, both male and female, probably because for them, relationships with patients seemed more contractual than inalienable.

Even when family relationships are still in place, what is required by the biomedical order often conflicts with culturally normative demands of kinship and gendered desires for intimacy. Such dilemmas not only entrap the patients, but also make a shared family future particularly precarious. For patient Yun, her sleeplessness and refusal to visit her father was an attempt to endear herself to her husband’s family and to secure a hopeful future with them. Eight

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[14] I borrow the notion of moral drama from Cheryl Mattingly. In her recent endeavor to develop a first-person virtue ethics, Mattingly argues that practical action is “a vulnerable ethical drama.” Her “dramatistic portrait considers the temporal complexity of moral becoming, its rootedness in past histories as well as its link to possible futures” (Mattingly, 2014).

[15] A similar calculation of intimate future based on psychiatric risks is found in the TV drama *Ode to Joy*, a blockbuster across China in 2016. This time, it is the heroine who breaks up with her partner after finding that she has high hereditary risks of severe mental illness because her maternal grandmother, mother, and brother are all severely mentally ill. According to online commentaries, most viewers feel sorry for the couple, some accusing the boyfriend of being selfish, while others blame the heroine for unwisely disclosing this damning information. Yet almost everyone agrees that this hereditary risk poses a daunting future to the relationship.

years before, after her first psychotic episode, her in-laws had decided to send her back to her natal home so that her parents could look after her and monitor her medication. However, her father had continued to re-hospitalize her, instilling in her a constant fear of abduction. During her stay at her natal home, not only had the lengthy separation from her husband been unbearable, but she had also been worried that her lack of children would make her fall from grace with her husband's family, as its members had all expressly valued a woman's reproductive role. In order to avoid potential abandonment, she moved back to her patrilocal home, stopped taking the antipsychotics that would have jeopardized pregnancy, and worked on chores day and night, all in order to prove that she was a worthy wife. To her dismay, these efforts were all seen by her mother-in-law as signs of an impending relapse, and they only earned her another hospitalization. Indeed, in the psychiatric discourse, a female patient is at risk not only for relapse, but also for emotional instability, blind violence, and the passing down of "bad genes" to her children. Deemed by their families to be unfit for marriage, childbirth, and childrearing, many female patients whom I interviewed found themselves unable to enter into, or gradually marginalized within, conjugal intimacy. In the words of Veena Das and Renu Addlakha, severe mental illness as a perceived "defect" imperils the life projects of female subjects, makes them inferior in front of the "overarching, overseeing, hostile collectivity" of the family, and thereby jeopardizes their "domestic citizenship" (Das & Addlakha, 2001).

However, women are not the only ones to whom a normatively gendered future is denied. Many male patients told me that while they had been expected by their family members—especially their spouses—to be the breadwinners, they were often kept away from work by the physical burden of pharmaceutical side effects, and by family members who feared that work might expose them to undesired stress and risks. As in the case of female patients, family members were also concerned with the hereditary risk carried by male patients. Thus they would keep patients from marrying or even dating. Yet compared to their female counterparts, male patients were more often thought of as being sexually overactive. In order to prevent them from falling into untoward sexual relations, their family members often forbade them from going out in the evening, and if they did, would secretly follow them. These restrictions and monitoring had the effect of emasculating male patients. Frustrated by repeated hospitalizations, his inability to support himself financially, and his romantic relationship being broken up by his mother, a 27-year-old patient gave his mother a knife one day and asked her to cut off his penis. “I don’t want to be a man any more,” he said, “let me just be a woman. I’m controlled (*guan*) everywhere, at home and in the hospital. It’s just like being jailed up all the time.”

As I mentioned, hospital psychiatry is the predominant—and often the only available—form of professional care for mentally ill patients across the country. Family members who cannot mobilize financial resources for hospitalization thus sometimes have to watch their loved ones’ disorder aggravate with despair, and they too have to suffer from a disordered domestic life, brought on by the patients’ aggression, caprice, and unreasonable demands. However, families that do have the resources for hospitalization don’t necessarily have an easier time. As a patient is re-hospitalized again and again, his disorder often seems increasingly incorrigible, his potential risks or actual disability seem increasingly difficult to manage, and the family’s hope for his recovery and a shared domestic future grows increasingly dim. A psychiatrist may claim that this course confirms the prognosis for degeneration, and may blame the family for having missed opportunities for intervention. Yet if we follow philosopher Ian Hacking’s discussion on the looping effects of social classifications (Hacking, 1999a), we might argue that the psychiatric classifications shape how family members perceive and intervene into the patients’ behaviors, interrupt the patients' life projects with cycles of commitment, and bring to them heavy side effects of medication. All these processes may then loop back to madden and debilitate the patients.

When families lose hope for the patients, they sometimes choose to keep the patients hospitalized for the rest of their lives. In my fieldwork experience, this usually happened to patients who had public medical insurance and/or monthly retirement pensions, so that their family members, acting as legal guardians, could transfer their money to the hospital and have it take care of the patients for an indefinite period of time. Besides having economic means, another factor that conditioned the families' decision was their own vulnerability in times of change, which colored their perception of the patients' vulnerability. A patient might be hospitalized for the rest of his/her life because the father—the lone caregiver—was old and frail, because all the other family members had emigrated and no one was there to look after the patient, or because the siblings had established their own families, probably with small children, and could not afford to take in a risky patient.

Understandably, patients subjected to life-long hospitalization—some as early as in their thirties—usually felt that they had been cruelly abandoned by their families and deprived of all meaningful social life. When I asked Fei, a female patient who had been living in GBH for eight years, what her biggest wish was, she told me in tears, "I really wish I could go home, even just for a holiday meal. We all have a need for family life. You do too, right?" Then she wiped away her tears and sighed, "Oh well, I guess I should stay here, because the hospital needs a corpse like mine to make contributions to medicine." "Corpse?" I asked in confusion. Fei stretched out her right arm, on which there were bruises and scars from repeated IV injections. She told me that it often took a nurse five or six tries before finding a vein, even though they were supposed to have learned how to give injections by experimenting on animals and themselves. "But I don't care. Whenever they try things on me, I just lie there as if I were dead," she said.

Many inpatients, whether in a long-term stay or not, shared Fei's feeling that they were reduced to physical bodies—or what Giorgio Agamben calls "bare life" (Agamben, 1998)—for the staff's pharmacological experiments. This was not for their own sake, many believed, but for the accumulation of scientific knowledge and profits, and they often referred to themselves as guinea pigs. Yet what makes Fei's self-reference as a corpse particularly striking is that it reveals an extreme—but not unique—experience of "social death"[16]: while psychiatric abduction and pharmacological experimentation are aimed at returning the patient to a life of order and hope, they can also confine a patient to an institution, depriving her of any meaningful sociopolitical life for a very long time. Fei's self-reference as a corpse also reminds us of what anthropologist João Biehl calls the human pharmakon, a person who is relegated by science and the family to "dying at the crux between abandonment and overmedication" (Biehl, 2010, p. 222). According to Biehl, the human pharmakon is excluded from rapid economic globalization and accelerating claims over citizenship, as both a poison of and a remedy for the desired social order (Biehl, 2004).

However, family members who decided to keep the patients institutionalized usually did not think of themselves as having "abandoned" their patients. For them, this decision was a "forced choice" (Rapp, 1999, p. 225), forced by the patients' aggravating risks and disorder, by the precarious family situations, and by the lack of alternative options besides the institution and the family. It was only by institutionalizing the disordered patients that the families could live

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[16] Kleinman coined the term "social death" in his call for global mental health (Kleinman, 2009b, p. 604). Yet as we have seen, much suffering is produced by the psychiatric apparatus itself. It would be interesting to explore how global mental health as an interdisciplinary effort that seeks to integrate cure with care could change this course of social death.

orderly lives, and could survive and thrive in the demanding market economy. Also, if the families' task was to *guan*, now defined as using biomedical means to care for and monitor the perpetually risky patients, then what they did was merely putting the patients in a place where this *guan* could be—according to its own advertising—better practiced.

At GBH, only a small number of patients were there for life, but their presence made other patients fear for their own futures. Psychiatrists deliberately deployed this fear to spur patients on the ward to commit to the biomedical order, and to struggle for pharmaceuticalized hope. The day when Rong was released from GBH, Dr. Lai gave her a lecture:

> "If you don't take your pills, you'll get sick very soon. You know that your family members still understand you[r desire to live a normal social life]. But there are people on the ward who have been left here by their families forever. What a sorry life! Remember, when you are hospitalized another time, things [with your family] will be different."

Conclusion

As suggested by their similar frustration, Rong and Tingting were walking along—or rather, abducted and carried along—the same path that had been constructed by the psychiatric discourse and hospitalization practices, although Rong was slightly ahead. Both of their lifeworlds had been shattered by disorderly experiences (such as in love relationships), and they, as well as their family members, had initiated different quests for order. In particular, Rong herself and Tingting's mother had sought help from psychiatry, hoping that it would offer a "quick fix." In its attempt to deliver this hope, the psychiatrist translates the patient's diverse experience—often as narrated by a family member—into symptoms of a mental disorder, which is further reductively understood as neurochemical imbalances. The psychiatrist then endeavors to build a biomedical order for the patient, by prescribing her with medications and developing an "insight" within her so that she can willingly and truthfully report symptoms and follow treatment. The hospital ward is crucial to this biomedical reordering, for it provides a space to monitor, discipline, and if necessary, coerce the patient, a sociality that grounds the reality sanctioned by psychiatrists, and a wall that stops the infiltration of the family's non-medical quests for order. Ideally, then, the family only needs to commit financial resources and illness information to have the patient committed, while temporarily suspending its emotional and relational commitments to the patient, and a cure will soon be delivered.

However, by inscribing mental disorder into a chronic trajectory of remission, risks, and relapse, the psychiatric prognosis entangles hope with fear, abducting them both into statistical futures that demand present actions. In order to prevent degeneration, the patient's risks need to be continuously managed, even long after her current inpatient stay, through daily medication and timely re-hospitalization. Because the patient is often suspected to be insightless (i.e. holding onto non-medical quests for order), and because her first-hand experience with medication and hospitalization likely makes her resistant of them, her family members are asked to step in to manage her. Rong's case perfectly illustrates this transition: although it was she herself who had first sought help from psychiatry, she quickly resisted it, turning to Buddhism as a more viable avenue to order; meanwhile, her sister, who had accompanied her to the hospital, became attached to biomedical risk management, taking it as the only legitimate form of care. In Tingting's case, while Mrs. Yuan had hospitalized Tingting as one of her multiple attempts to *guan*, the biomedical future was slowly taking over as the only horizon for Tingting and for the family.

Psychiatry's abductive logic of risk management not only changes the patient's life, but also abducts kin relations and conditions kin abductions. In particular, the task of everyday management usually falls onto those more vulnerable within the family, especially elderly parents or women. They often bind themselves with the patient in the same space, committing emotional and physical energy to engage in painful negotiations with the patient. As such, while the patient feels restrictions, family members are also often held hostage to the patient's demands. Moreover, with their newly acquired awareness of risks in the patient's life, family members often learn to—or are encouraged to—lower the threshold for (re-)hospitalization and to use it as a preemptive measure. They either abduct the patient to the hospital themselves, or in the era before the Mental Health Law, they would hire hospital staff to execute the abduction. Help with the abductive hospitalization thus becomes much desired by many family members. By channeling the flow of patients, the hospital-family circuit that is facilitated by such abductions also enables the financial flow from the family to the institution.

While family members (and in some cases, the patient as well) seek help from psychiatry, hoping for an orderly life for the patient and the whole household, ironically the abductive logic of psychiatry, together with the practice of abductive hospitalization, dims this hope. In light of the uncertain and largely grim prognosis of mental disorder, the cessation of contractual intimacy appears to be a—or the—legitimate choice for the rational man. For romantic or kin relations that are still in place, the everyday task of risk management, as well as the patient's identity as a perpetually risky subject, often makes it difficult for her to fulfill the cultural demands of kinship such as reproduction and childrearing, and to attain her desire for normatively gendered intimacy. The patient's standing in the relationship is thus rendered precarious. Moreover, as the patient's condition gradually deteriorates, partly thanks to the repeated disruption to her life brought on by medication and hospitalization, her vulnerability then adds unbearable weight to the already vulnerable family. Family members who are desperate and who can mobilize the necessary financial resources may thus choose to have the patient hospitalized forever. Meanwhile, family members who do not have the necessary resources may feel stuck with the patient, watching the whole family's domestic future fall into despair. In both cases, the fearful picture of degeneration and abandonment may in turn be used by psychiatrists as object lessons to illustrate the importance of biomedical risk management.

Many of the actions and evaluations that I analyzed in this chapter can be, and are, expressed by and contained in the character *guan*. While the patient detests being controlled (*guan*), she also fears being abandoned, that is, no longer being a person of concern (不管/*buguan*).[17] (In the case of life-long hospitalization, these two sentiments are often combined.) For family members, their use of seemingly cruel discipline shows their most loving care for the patient, with both discipline and care encompassed in *guan*. Meanwhile, psychiatrists ask family members to constantly manage (*guan*) the patient's risks, but they criticize family members' intervention into the biomedical order as micromanaging (管太多/*guan taiduo*).

Here, I suggest that the polysemy of *guan* allows the subtle negotiation of, and reconfiguration between, different modes of understanding and engaging with vulnerability. When people use psychiatric means to manage mentally ill patients, they often draw on a culturally entrenched idea of *guan* as childrearing. In it, parents' use of disciplinary measures on children is accompanied by utmost care and love, and it is done with the hope that the vulnerable children will become fully human, acting in harmony with the social order. Psychiatry invokes and reconfigures this cultural ideal of *guan*. It does so by translating the multiple experiences of vulnerability into quantified risks for illness onset and relapse, and by redefining the goal of discipline and care as producing a biomedical normativity. In many cases, family members'

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[17] 不/*Bu* means no or not in Chinese.

regrets with past failures of *guan* fuel their desire of, and attachment to, psychiatric *guan* as risk management. Meanwhile, not just the disciplinary measures, but also the infantilization inherent to *guan*, makes patients especially resistant to psychiatric practices, perceiving them as a form of control devoid of care. Furthermore, the responsibility for and authority of psychiatric *guan* is normally shared between the family and the hospital. However, as the responsibility of risk management becomes chronic, and as the hope that psychiatric *guan* is supposed to produce becomes dim, some families choose to forever relegate the task of *guan* to the hospital. Indeed, *guan* as biomedical risk management is ultimately indifferent to where and through what relations risks are managed. Yet this indifference runs counter to the insistence on intimate affects and the hope for a socially meaningful life central to the cultural ideal of *guan*. The patient thus perceives life-long hospitalization as abandonment, as the opposite of care and concern (*guan*).

As I discussed in the last chapter, the recent mental health legislation debate has been structured by a divide between the biologically normal citizen, who enjoys the right to autonomy, and the pathological subject, who has to have the right to health secured for (or imposed on) her. By looking in detail at the discourse and practice of psychiatric hospital treatment, this chapter shows that the pathological subject, including her moral career (Goffman, 1968, pp. 127-128) as a severely mentally ill patient, is a psychiatric construction. Of course, this construction is not built from scratch, but from people's lived experience with chaos and their ardent quests for order. These experiences, in turn, have already been shaped by an entrenched cultural desire of *guan*, that is, of engaging with vulnerability, forming humans, and producing hope through hierarchical yet dynamic intimacies. Psychiatry reconfigures *guan* into perpetual risk management, thereby forever subjecting the patient to the management of her family members.

In the mental health legislative debate, people from different sides have all assumed the existence of a timeless Chinese culture of paternalism. Yet here, as we can see, paternalism in the sense of managing, controlling, and making decisions for the other's biological life is a psychiatric invention.

In everyday life, people rarely use the term paternalism (父权主义/*fuquan zhuyi*) or its near-synonym patriarchy (家长制/*jiazhang zhi*). Part of the reason, I suspect, is that the simple picture of the father presiding over his children misses the complicated traffic of responsibility and authority in psychiatric practices. Family members have the authority to abduct the patient to the hospital, but at the same time they have to turn over financial resources and epistemological trust to biomedicine. (When the patient goes back home, they also have to commit emotional and physical labor to her care.) When the patient is hospitalized, the psychiatrist takes on the authority and responsibility for the patient. In fact, because the everyday management of the patient is often done by the more vulnerable family members, especially women, they very much want to rely on the hospital's authority for the task of abduction. While the idea of paternalism implies an all-powerful agent who will never be harmed, the abduction and commitments required of psychiatric hospitalization often make family members all the more vulnerable. Of course, psychiatry only conditions, but does not determine, the life of patients and families, which is necessarily more diverse and dynamic. In the next chapter, we will take a closer look at family life outside the institution, as well as how it is shaped by the new community mental health initiative, in order to analyze in what sense we can talk about paternalism in contemporary China.

CHAPTER 4

BIOPOLITICAL PATERNALISM AND ORDINARY MATERNALISM: FAMILY RELATIONS AMIDST THE RISE OF COMMUNITY MENTAL HEALTH

Psychiatric Power, Community Governance, And the Gendering of Everyday Family Relations

In the previous chapter, I examined how hospital psychiatry as practiced in Guangzhou constructs the pathological subject and shapes family authority/responsibility. I argued that by translating patients' chaotic experience and behavior in the present into a chronic mental illness, hospital psychiatry also configures families' responsibilities and authority to include committing patients to the institution, ensuring their compliance with medication outside the institution, and continuously observing and monitoring their risk of illness and relapse. In some cases, the constructed chronicity of patienthood and family responsibility has led to the dissolution of families, has prevented patients from fulfilling normative gender roles, and has also led to controversial practices such as life-long patient hospitalization.

Readers might complain that the above picture looks too deterministic (and grim). Because of my use of the word "construct," readers might also criticize my analysis as merely repeating the social construction theories of illness. Critics have contended that social construction theories, by seeing illness and disability as constructs devoid of reality, ignore the biological processes that influence behavior (Hacking, 1999b), as well as dismissing experiences of embodiment and vulnerability (Shakespeare, 2006). As I have pointed out, however, Chinese people turn to psychiatry precisely because they commonly experience madness as chaos and disorder (*luan*), and as a consequence they attempt to construct an order (*guan*) to end such chaos. Hospital psychiatry is only one of the many constructs that people try. All of these constructive activities have very real effects, side effects, and (in)efficacies on individuals and their surroundings. Meanwhile, I have highlighted the fact that psychiatry seeks to establish itself as the only possible order of life, the only one that can exhaust reality. With its scientific discourse, enforced application of potent substances, and meticulously planned institutional environments, hospital psychiatry has indeed established itself as a hegemonic order for the many people who come into contact with it. In order to reveal and potentially destabilize its power effects, I thus chose in previous chapters to focus on the hegemonic workings of hospital psychiatry, even if this sometimes meant using a slightly reductionist approach to trace the contours of reductionist medical power.

Despite or alongside its hegemonic effects, psychiatry often fails. Not only can it fail to cure or improve the patients' conditions, but it can also fail to address much of their experience, chaotic or otherwise. On the other hand, psychiatry can be a resource that is used for purposes other than normalizing the patients and managing their riskiness. These divergences are particularly explicit when patients live with their family members outside the institution: in everyday domestic life, psychiatry is only one of the many forces that shape patients' lives. Without the ability or willingness to use coercive measures as does the hospital, family members need to find ways to make common domestic life habitable. How, then, do family members relate to patients with severe mental illness living at home, with or without the help of psychiatry? This question will be addressed in the present chapter.

After describing the various modes of family relatedness with patients that appeared during my fieldwork, I will show that there is a gendered pattern among them. Generally speaking, fathers and other male family members are more attached to a single normal/pathological divide, as it has been constructed by the hegemonic psychiatric discourse, and to the biomedical normalization of patients. Meanwhile, mothers and other female family members are more willing to recognize the vulnerable existence of patients and themselves, to open themselves to patients' particular—and often irrepressibly strange—lifeworlds, and to (re)build domestic mutualities with all manners of contingent measures. Note that by "gender(ed)," I mean not only socially constituted responsibilities that are assigned to and practiced by men and women, respectively, but also symbolic systems of masculine and feminine qualities that are ascribed to different dimensions of life. In her critique of the liberal bureaucratic state, Wendy Brown associated these gendered signs and representations with the workings of power, and argued, "While gender *identities* may be diverse, fluid, and ultimately impossible to generalize, particular modes of gender *power* may be named and traced with some precision at a relatively general level" (W. Brown, 1995, pp. 166-167). In Chinese cosmology, gendered social arrangements and symbolic hierarchies are all produced by 阴阳/*yinyang*, two basic types of force that exist in a dialectical relationship with each other, generating myriad life forms and their transformations (Farquhar, 1994; Furth, 1999). In this chapter, I will thus trace the cosmological/ontological, symbolic, and social gendering of family relations in order to show how paternalism—a notion central to the mental health legal reform and the ethics of Chinese psychiatry—is practiced in everyday life, in relation to other forms of intimate labor. Brown suggests that a gender analysis may reveal "the homology between masculinist and state power" (W. Brown, 1995, p. 178). Similarly, the gender analysis in this chapter is aimed at interrogating how the Chinese state's population management efforts may draw on, legitimize, conceal, or reconfigure modes of intimate politics between individuals.

Family life outside the psychiatric hospital does not exist in a vacuum. Since 2004, a state-sponsored community mental health regime, commonly called “the 686 Program,” has been rolled out across the country. As part of the state’s recent efforts at community governance, public health revitalization, and social stability maintenance, the 686 Program seeks to extend basic mental health services to people with severe mental illness who are living outside the hospital, and to minimize the risks of violence that they pose to the general public. Through this program, mental disorder gains significance for social order, risks to one’s own biological life (i.e. illness development and relapse) become entangled with risks to public security, and individual patients also aggregate to form a population that requires management. In this chapter, I will describe the program’s discursive imagination of patients’ families, as well as community mental health workers’ everyday interactions with them. My goal is to examine the place of the family in an emergent form of biopolitics, and in the newly constructed space of governance called “the community.”

To preview my findings, I will show that the state’s biopolitical management of severely mentally ill patients is gendered in a layered way. On the one hand, the 686 Program asks that family members collaborate with medical experts on the work of using pharmaceuticals and monitoring risk, and assumes that patients are submissive followers of this medicalized familial authority. Therefore, the program publicly denounces families’ reliance on domestic confinement and secret administration of drugs. I call this discursive configuration of familial authority and responsibility “biopolitical paternalism.” On the other hand, my fieldwork shows that these often-denounced practices are in fact also often acquiesced to by community mental health workers. This is because they quietly see these practices as acceptable, or even necessary for risk management, especially given the neoliberal policy of hospital service provision. As for family members who resort to secret drug treatment or home confinement, these practices are not only encouraged by demands from community mental health workers and techniques of administering community mental health, but they also come from families' compassion for patients and discomfort with hospitalization. Compassion allows them to engage and rebuild kin relations with patients in ways that go beyond the humanitarian imagination of psychiatry. I call such compassionate, contingent, and often covert practices of relatedness "ordinary maternalism."

I will thus argue that in community mental health practices, ordinary maternalism works as a Derridian supplement (Derrida, 1997) of biopolitical paternalism; that is, biopolitical paternalism requires ordinary maternalism if it is to take effect, but it also criticizes, conceals, and excludes from itself the existence of ordinary maternalism. As such, families simultaneously constitute the basic units, the primary agents, and the very limits of community governance.

Familial Relatedness in Times of Severe Mental Illness

The Story of Many Joys

In 2013, soon after I started fieldwork at Likang, a mental health social work center in Guangzhou,[1] I came to know Uncle Huan[2] (meaning "joy"), a man in his early sixties. Wearing worn clothes but a broad smile, he often used his ringing voice to gather other clients as well as me, the visiting ethnographer, for entertainment activities outside the center such as karaoke, lunch/dinner parties, and excursions. No matter where he went, a woman in her mid-thirties named Sister Duo (meaning "many") would quietly follow him. I initially took her as Uncle Huan's daughter, for most clients in the center were either parents or their adult children with mental illness. It turned out that Sister Duo had indeed long been diagnosed with schizophrenia,

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[1] For more discussions on Likang, please refer to Chapter 6.

[2] In Likang and other community mental health settings, clients often address each other and are addressed by social workers in kinship terms, as a way to show familiarity, friendliness, and informality.

but to my surprise, she and Uncle Huan were girlfriend and boyfriend. As many people remarked behind Uncle Huan’s back: in a society where people with mental illness are heavily stigmatized, who would want to date a “madwoman”?

I carefully alluded to this question in my first interview with Uncle Huan. Smiling, he told me that compared to his ex-wife, a “normal” woman who was ill-tempered and had hurled verbal abuse at him all the time, he actually preferred a mentally ill woman. “She [Duo] is usually very kind and quiet. When she throws tantrums, I know that it’s only because of her illness, not because of her innate personality. It’s easier for me to accept that.”

In other words, the seemingly clear distinction between normal and pathological states allowed Uncle Huan to grasp the “true” person whom he loved and to bracket everything else. Lest the pathological should erupt into and disturb their life, he would make sure that Sister Duo took her medications three times a day. However, in everyday practice, this distinction was often more fluid and blurred. In addition to intermittent behavioral anomalies that could be clearly demarcated, the pathological could also manifest in personalities and habits that permeated daily life, requiring persistent listening and engagement. During my restaurant trips with the couple and other clients at Likang, I noticed that Sister Duo always insisted on knowing the price of every item on the menu, pointing out the cheapest among similar dishes, and calculating the total price before anyone had made the order, no matter how long it took. At first I thought she was concerned with overspending, so once when it was my turn to treat the group, I told her there was no need to calculate for me. Uncle Huan gently chimed in, “Let her be. She likes calculating. She feels calm doing that.” With this small gesture, Uncle Huan subtly made room for Sister Duo’s odd habit in their—or our—lifeworld.

Sometimes, engaging with the loved one with mental illness also meant recognizing, interacting with, and even taking on elements of radical alterity in everyday life. According to Uncle Huan, Sister Duo lived in a world full of gods, ghosts, and spirits: she would stay at home all day, staring at the lightbulb and talking to the "light god." She would ask Uncle Huan not to go out with friends, because the "sky god" had informed her that one of his friends was a mass murderer. Or she would go out and have fun herself, following the command of the "sun god" or the "brick god"…Usually Uncle Huan would not dismiss the existence of these entities in front of her, even though he knew that they were her hallucinations. In order to prevent them from overwhelming her however, he endeavored to distract her with all sorts of fun activities. (This also explained why he was so keen on organizing group gatherings.) To invite her *out*, he had to walk *into* her enchanted world himself. "Hmm, interesting, the sky god told me the exact opposite," Uncle Huan would say to the fearful girlfriend. Or "you know what? I am your guardian god. I won't be harmed or let other people harm you."

By the time I got to know the couple, their relationship had been going on for more than a decade. Intimate knowledge garnered from this extended companionship often allowed Uncle Huan to decipher from everyday details which world Sister Duo was presently in. For example, for a long while she had liked going to a dim sum restaurant with him for brunch. Therefore, her recent refusal to go there suggested to him that she might have become increasingly troubled by certain voices or visions. In situations like this, he would try to control her symptoms by reminding her to take medications on time, by slightly adjusting her dosage based on his own experience or the doctor's advice, or by seeing that she took good naps. If her symptoms continued to escalate, he would consider checking her into an inpatient stay.

However, intimate knowledge was never certain, and the biomedical treatment, though not ineffective, often left behind excesses and ambivalence. Sister Duo's most recent hospitalization had been in 2010. It only lasted half a year, as Uncle Huan quickly became satisfied with her improving condition, and as he could not bear keeping her in the locked ward. Yet in late 2013, as her symptoms flared up again, he told me that he regretted having brought her home so soon, instead of allowing her to fully recover in the hospital. (By "recover," I suppose he meant the permanent disappearance of symptoms.) On the other hand, he doubted that biomedicine and hospitalization could solve all the problems. In fact, as the public discussion on psychiatric abuse continued, he questioned whether patients being compelled by family members to take medications every day might also count as "being mentally illed" (*bei jingshenbing*), that is, being forced to comply with the patient role. He remarked at a family caregivers' gathering, "Of course, now that our loved ones have already been put on medications, we have to make sure that they follow through with the regimen. But when the problem had just started, we should have tried to unknot their hearts (解开心结/*jiekai xinjie*)." As he understood it, the knot in Sister Duo's heart was what the Maoist language called "thought struggles" (思想斗争/*sixiang douzheng*):[3] "We normal people also have different thoughts fighting each other in our heads. She simply treats them as different spirits [coming from outside telling her what to do]." Although he could not go back in time to eliminate whatever had started her thought struggles and knotted them together, this understanding allowed him to accept the pathological as part of the ordinary, and to find (non-biomedical) ways to soothe her heart. In everyday life, then, Uncle Huan had to constantly redraw the divide between the normal and the

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[3] In her recent ethnography on the psychotherapeutic governance of unemployed workers in urban China, Jie Yang discovered that the psychological discourse is often couched in cultural terms, such as *xin* or heart-mind, or in socialist language (J. Yang, 2015).

pathological, construct a habitable world for the two of them that often traversed the divide, and use biomedical or other means to maintain the contingent equilibrium of the world.

Identity, Alterity, and Mutuality

Uncle Huan's story may be special: while most caregivers have no choice but to stick with their family members with mental illness, he *chose* to build a family-like relationship with a patient, and willingly dedicated himself to her care. However, in many ways the diverse practices of this relationship are also found in other cases that I encountered in the field, though with different dynamics and effects in each case. It is clear, for example, that the distinction between the normal and the pathological matters in most domestic relations. While pathology seems to have taken away the persons with whom family caregivers are familiar, bringing a deep sense of loss, the occasional glimpses of patients' normal identity and familiar humanity provides them with consolation. Mrs. Ai, another family caregiver who I met at Likang, often complained with moist eyes about all the messes that her mentally ill son had made at home and outside. Yet one day after the 2014 Spring Festival, she insisted on showing me pictures that her son had taken during their holiday trip, some featuring her. Her broad smile, both in the pictures and in person, bespoke her joy in getting back her once vivacious and lovable son, and in receiving his reciprocal gestures of care, albeit momentarily. Moreover, for patients who seem to be stuck in the pathological world, their occasional whispers of concern for others are often enough to overjoy their caregivers. Scholars have discovered that while people with cognitive disabilities may have diminished mental capacities, they usually display undimmed capacities to care, to empathize, to hold the intimate other in personhood through daily activities, and to give meaning to other people's lives. It is these ethical capacities that give caregivers reasons and rewards for care (de la Luz Ibarra, 2010; Lindemann, 2009; Shoemaker, 2010; Taylor, 2010). This is also the case for people with mental illness and their families.

Yet the assertion of kinship by family caregivers in times of severe mental illness cannot be entirely about fixing the patient's identity or finding the patient's likeness with oneself as a caring human being. Often, the chaos of madness exposes one to a "strangeness which cannot be suppressed" (Levinas et al., 1988, p. 179). Rupert Stasch suggests that kin relations are achieved through recognizing and responding to alterity (Stasch, 2009). Alternatively, as Emmanuel Levinas argues, it is precisely through alterity and vulnerability that the other demands one to engage with him and suffer for him (Levinas et al., 1988). Of course, in times of severe mental illness, the ways that alterity is engaged vary from case to case, and no approach can exhaust the excessive quality of alterity as it appears in mental illnesses. Sometimes, as in Uncle Huan's likening of Sister Huan's hallucinations to "thought struggles," family caregivers try to bring alterity into their own framework of comprehension. For example, Mrs. Ai understood the fuss her son sometimes made as his attempts to get people's attention. "One day he accused me of having stolen his lyrics and he yelled at me. I was confused. Soon I realized that he had given me some lyrics he had copied by hand because he knew I liked singing, but I had turned them down." This understanding made Mrs. Ai sympathize with her son, or even feel guilty in relation to him, but she was also worried by his potentially unlimited demand for attention.

Sometimes, the alterity that patients display does not allow for even tentative comprehension, but only allows for companionship or co-presence. Co-presence may be built through speaking, or more specifically, addressing the other or even enregistering oneself in the other's terms, as we have seen in Uncle Huan's effort to speak to/in Sister Duo's enchanted world.[4] Co-presence may be built through listening, which has been defined by Lisa Stevenson as that which "makes room for hesitation… which persistently disrupts the security of what is known for sure" (Stevenson, 2014, p. 2). Lina, an architect who I met at an outpatient clinic, saw herself as having sex with an Italian soccer star several times a day. Although she lived alone, she called her mother every evening to share vivid details of her experiences, an act that initially surprised me given that discussions of sex are often taboo between Chinese parents and children. Lina told me that she enjoyed being listened to, because it gave her emotional warmth. Meanwhile, although Lina's experience was unfamiliar to her, her mother listened attentively, because she appreciated having Lina's trust, as well as having the opportunity to learn how Lina was doing every day. In still other cases, co-presence may be built through silence. Several patients I encountered would habitually wander in the street, sometimes scavenging in garbage bins. Unable or unwilling to keep them at home, their family members often quietly followed them, making sure that they would not do anything dangerous, and occasionally helping to hold the items they had collected. When one speaks with, listens to, stands beside, and opens oneself to the other, the kin relation thus formed becomes what Marshall Sahlins calls the "mutuality of being," that is, persons "who participate intrinsically in each other's existence" (Sahlins, 2011, p. 2) in a variety of ways. Such participation can work through unstable practices and even in unlikely circumstances.

As will be shown later in this chapter, sometimes the alterity of madness/mental illness even leads patients to be seen and treated more as animals than as humans, and the mutuality of kinship has to be built across a certain human/animal divide. In any case, the diverse array of kin practices in times of severe mental illness reminds one of what Jacques Derrida has called

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[4] Tranulis and colleagues have documented a case in which a woman and her husband used "the 'stories' of her psychotic experiences to construct a shared and even 'safe' and familiar means of spousal connection" (Tranulis, Park, Delano, & Good, 2009, p. 608).

"limitrophy" in his critique of the human/animal divide: instead of taking the divide as ontologically fixed and sticking to one side of it, he proposes working across "the edges of a limit that grows and multiplies" (Derrida, 2002, p. 397). Similarly, in the kin practices that I have witnessed, the normal/pathological distinction(s), the self/other difference(s), and the human/animal divide(s) are constantly constructed and deconstructed, across a heterogeneous and "differentiated field of experience," in a world of diverse life forms (Derrida, 2003, p. 126). Mutuality is built across such jagged boundaries, and its shape and substance are forever uncertain/unstable.

In this differentiated field of experience, psychiatry works as a hegemonic—and thus by definition, incompletely totalizing—organizing force. It establishes a dominant distinction between the normal and the pathological, among persons and within the patient: the normal is to be identified with and desired, whereas the pathological is to be eliminated or managed, but not engaged with. The hope of cure that the psychiatric discourse produces has such a strong purchase on family members that they feel losing it could be devastating. Because of the changing diagnostic practices of Chinese psychiatrists, Mrs. Ai had recently been told that her son, who had been diagnosed with and treated for schizophrenia and bipolar disorder for years, might instead have borderline personality disorder. "It means that there's no drug to cure my son," she murmured repeatedly when telling me of this diagnostic change. Meanwhile, resorting to psychiatry appears to many family caregivers—at least retrospectively—as a deal made with the devil: the benefits of psychiatric treatment, that is, the reduction or stabilization of symptoms, come with high costs, such as side effects of medications, conflicts between patients and caregivers, and social isolation. As revealed in Uncle Huan's remark, family members may regret having signed the deal, but few can resolve to abandon its terms altogether.

On the other hand, as hegemony is established in concrete practices, it is also open to practitioners' maneuvers and experimentation. With years of experience, psychiatrists typically are aware of the costs and benefits of biomedicine. They also know that patients have lives to live, which an overemphasis on symptom management might destroy, so they often tinker with the treatment they prescribe in order to achieve a viable balance for patients. For instance, Lina's psychiatrist, Dr. Wang, appreciated her artistic talent, and he did not want the drugs to slow her mind or stiffen her body. Therefore, he only prescribed her 2.5 mg of risperdal, close to the minimum suggested dosage. This could not end her imagined sex with the soccer star, but it allowed her to continue making designs at home. Such practical tinkering is slowly becoming recognized by the psychiatric profession in Guangzhou and several other major cities, where social workers[5] and reform-minded psychiatrists have introduced the Euro-American idea of recovery, which emphasizes patients' ability and desire to live meaningful lives (Myers, 2015). Although they still stress the importance of symptom awareness and pharmaceutical management, proponents of recovery now ask patients and family members to learn to *live with* symptoms of mental illness. This idea, then, allows for co-presence or even engagement with alterity in kin practices of the kind I have been describing.

Strict Fathers, Compassionate Mothers

Uncle Huan's relationship with Sister Duo drew much attention from others, not only because of its voluntariness, but also because he showed much patience for and willingness to engage with her. This was rare among male family members. Indeed, my fieldwork suggests a

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[5] The social work profession was established in China only in the late 1990s, and it has just started getting involved in mental health care. As of 2014, mental health social work centers only existed in a few provincial capitals. Correspondingly, the influence of social work ideas and practices on the mental health field in China is limited in the present day.

gender difference in how family members interact with patients, especially between fathers and mothers of adult children with severe mental illness. According to mothers and children themselves whom I interviewed, fathers often have a hard time accepting that their children have mental illness, and might be in need of support. Their denial can become an excuse for them not to be involved in their children's care. For instance, Mrs. Ai complained that ever since their son's first hospitalization, her husband never asked about or went to see him. Whenever the son came back home, he just wanted to kick the son out immediately. He would also break down whenever Mrs. Ai mentioned the son in his presence. He never paid anything for the son's treatment, although until recently, it had been he alone who had had a stable income.[6] Other fathers try to beat sense into their children, to restore order with force. During her chaotic moments, Lina told me that her father had beaten her and forbidden her mother from sending her to the hospital, saying that she was just faking it and not thinking straight. Still, other fathers are involved in their children's care, but most of these men tend to emphasize symptom management through medication and hospitalization, instead of trying to understand their children's lifeworlds. Once, when a social worker asked a group of family caregivers whether they could communicate with their children with mental illness, the three men present all shook their heads. They said that their children were ill-tempered and had no sense. All in all, fathers, or male family members in general, tend to maintain a fixed normal/pathological distinction, stick to the idea of normalcy or the normalizing force of psychiatry, and are reluctant to associate themselves with vulnerability and alterity.

At the aforementioned meeting, most women—though not all—responded that they could and should communicate with patients. They shared their experiences in communication, such as

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[6] Mrs. Ai had at one time consulted a lawyer as to whether the court could force her husband to pay for her son's care, but the answer she got was that the law could not intervene into marital property.

waiting until patients calmed down and apologizing for their own mistakes first. In general, the women I encountered were more likely to recognize and accept their loved ones' disorders and vulnerabilities, and accordingly, were more willing to engage with their loved ones. Although women are also invested in the normalizing force of psychiatry, they often supplement it with other healing practices, tinkering with the appropriate balance from moment to moment. They try to relate to patients' experience, including the alienating experience of alterity, even if that means changing their own understandings and everyday practices, and making themselves vulnerable. Moreover, throughout the long journey of recovery, mothers or other female caregivers often act as mediators between the disordered patients and the stern-faced fathers or other unsympathetic family members (typically male), trying to forge a mutual understanding and means of accommodation. According to Mrs. Chen, a client at Likang, when her son became deranged after working in another city for several years, she had to persuade her proud husband to accept the son back home. Later, when her husband accepted the son's illness but insisted that he stay at home and do nothing, she had to persuade him to let the son work again. "I just wanted him [my son] to try. What if it worked out for him? You know, mothers cannot easily give up on their children." When she told me this during our interview, I asked whether a similar gender dynamic could be found among other parents she knew. "Sure," she said, "mothers are more compassionate (*ci*) [than fathers.]"

Here, Mrs. Chen invokes a familiar gender discourse in parenting: strict fathers, compassionate mothers (*严父慈母/yanfu cimu*) (Kuan, 2015); that is, fathers are expected to discipline children according to established principles, whereas mothers are expected to be loving, nurturing, and understanding. These gender roles of parenting resonate with a basic classificatory rubric in Chinese cosmology, *yinyang*. *Yang*, the father of the universe, acts as an active force that generates things and gives them a vital essence, whereas *yin*, the mother of the universe, acts as a structive force that flows through, nurtures, and holds things together (Farquhar, 1994). This gendering of parental roles also had a cultural-historical legacy. As anthropologist Margery Wolf observed in Taiwan in the 1960s, while the Chinese family was publicly recognized as a patrilineal system that transmitted family names down the generations through male members, women actively constructed their own "uterine families," that is, the bonds of nurturance and belonging with their children (Wolf, 1972). In contemporary mainland China, the extended patrilineal family has tended to yield its dominance to the conjugal family (Yan, 1997). Yet mothers are still—or even more so, relative to the Maoist era—seen as the natural and primary caretakers of their children (Evans, 1997), and their care reproduces the uterine bond. Especially in times of severe mental illness, as the last chapter has pointed out, mothers and other female family members often feel obliged to stay at home and look after the patients. Because of this everyday proximity, mothers are more likely to be exposed to patients' vulnerable experiences. This compels them to suffer for and engage with the patients, and under the circumstances they sometimes find that they can rebuild a familial mutuality with them. As Mrs. Chen put it, mothers "will not easily give up." Levinas argues that this "suffering for" precedes any ontological, technical, or political measures, although it can certainly make use of them (Levinas & Kearney, 1986). In the words of Cary Wolfe, there is "an important connection between the exposure of our concepts to the confrontation with skepticism and the *physical* exposure to vulnerability and mortality" (Wolfe, 2008, p. 8). In light of this connection, the compassion that Mrs. Chen ascribed to herself and other patients' mothers should be understood as involving continuous experimentation,[7] excess, and compromise, generating complicated affects such as ambivalence, anxiety, and (however fragile) hope.

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[7] In her study of parents' involvement in the history of autism, Chloe Silverman also argues that

Therefore, the sociocultural distribution of family responsibilities, together with the everyday proximity between particular family members, leads people to relate to their loved ones with severe mental illness in ways that generally follow the cosmological and discursive pattern of gender differentiation: while fathers/men are attached to the single normal/pathological principle, work to maintain the normalcy of individual and family life, and exalt the normalizing power of biomedicine, mothers/women are primarily concerned with building a co-presence with the vulnerable patients (as well as other family members), even if it means making themselves vulnerable, opening their worlds to alterities, and engaging with contingent experimentation. Of course, as *yang* and *yin* are polarities that generate a continuum of possible material manifestations (Farquhar, 1994, p. 32), actual family relations in times of severe mental illness are more diverse, complicated, and flexible. Yet the paternal and maternal modes of relatedness do provide basic symbolic rubrics that register and shape people's practices. If, as Judith Farquhar points out, *yinyang* is not only a classificatory rubric but also a dynamic relationship, entailing "struggle, interdependence, and mutual transformability" between *yin* and *yang* (Farquhar, 1994, p. 219), one might ask what kind of dynamic relationship exists between the gendered modes of relatedness in our case. In particular, as everyday family practices encounter the state-sponsored community mental health program, how does this new state apparatus utilize and shape the dynamic between paternal and maternal modes of relatedness? What is the *yinyang* of state-family relationships? How does state power and professional expertise become gendered in this process? To put the questions in another way, all the relational modalities that I have documented can be called *guan* in everyday parlance, as they all seek to restore order to chaotic life. In fact, the strict father and the compassionate mother are the two inseparable components

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parental—or mainly maternal—involvement in autism care should be seen as experimentations enabled by love (Silverman, 2011).

of parental *guan* in the popular imagination. How, then, does community mental health reconfigure the meaning of *guan* and its practices in everyday life? How does familial *guan* connect to *guan* as population management?

When Families Meet the "Community"

The Emergence of Community Mental Health

Besides the psychiatric hospitals, many of the families that I have described are in regular contact with a newer apparatus of the psychiatric regime: community mental health. Since 2004, the "National Hospital-Community Integrative Treatment and Management Program for Severe Mental Illness," or what is commonly called "the 686 Program," has been promoted throughout China, primarily by the Ministry of Health and local health departments. As its full name suggests, the program's primary aim is to extend the provision of mental health services—especially pharmaceutical treatment—to patients living outside the hospitals, and to facilitate patients' transfer to the hospitals when necessary. Both of these aims are in order to better manage the severely mentally ill patients, more of the time.

The word "community" may seem to refer to something that already exists "out there." However, through tracing the term's history in advanced liberal societies, Nikolas Rose reminds us that community is "a new spatialization of government," consisting of new assemblies of identities, allegiances, and expertise. Under community governance, Rose argues, experts like psychiatrists and social workers "have been allocated accountability not so much for the cure or reform of clients, patients and other problematic individuals, but for their administration according to a logic of risk minimization" (Rose, 1996, pp. 327, 349). Relatedly, scholars have argued that the focus of social administration in advanced liberal societies has changed from dangerousness to risk. Dangerousness is an all-or-none category. Although danger exists only in a limited number of individuals, where it exists and when it appears is ultimately unpredictable. In contrast, risk is a continuum. It can capture an entire population, and yet a division along the continuum can also create a division "between 'we, the public' who can, in our imagination, conduct ourselves responsibly according to the norms of civility, and those others that threaten us" (Rose, 2010, p. 87). This transformation has been facilitated by a number of discursive techniques: statistics helps bring discrete phenomena in the uncertain future to a continuous distribution calculable in the present. Biomedical systems of knowledge, including psychiatry, can help identify sources of risks, put populations at risk under surveillance, and—with the old binary of normal/abnormal—subject people at different points of the risk continuum to different modes of management (Castel, 1991; Lupton, 2013; Rose, 2010).

In China, with the demise of socialist work units, the withdrawal of the welfare state, and the rise of popular unrest, the community has emerged as a new axis of governance (Bray, 2006; Heberer & Göbel, 2011; W.-h. Ma & Gui, 2008; Read, 2012; Tomba, 2014). Unlike the European settings that Rose has in mind, the Chinese state is actively involved in planning, promoting, and overseeing community governance. Yet it also sees people in communities as populations whose biological processes need to be managed, so as to minimize the risks they pose to the social order and political stability.[8] Particularly in the 686 Program, people with severe mental illness are seen as not only at risk of illness and relapse, but also at risk of committing blind violence under the influence of pathological forces, regardless of whether they are currently acting dangerously or not. The program thus trains primary care physicians as

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[8] Mun Young Cho has identified the emergence of "the population" in the state's poverty management through community. Although she does not specifically theorize it, the fact that people with disabilities are centrally featured in poverty relief suggests the importance of biology in the conceptualization and governance of population (Cho, 2010).

community mental health workers to manage patients in their respective jurisdictions, providing them with services and monitoring their risks of violence. In fact, the very term “severe mental illness” was coined by the program, covering schizophrenia, schizoaffective disorder, bipolar disorder, paranoid disorder, mental retardation with psychosis, and epilepsy with psychosis. These illnesses share a common symptom, psychosis, which purportedly distorts patients’ mental activities away from reality, directing them at times to injure and kill (Ministry of Health, 2012). As the program is sponsored and funded by the central government’s “stability maintenance” (维稳/*weiwen*) apparatus, its function in maintaining public security and social order is further emphasized.[9] In sum, community governance in China in general, and the 686 Program in particular, has an explicitly biopolitical dimension of population management (Foucault, 2003).

Given the centrality of families in patient care and hospitalization, the 686 Program, in extending such patient management and entangling it with monitoring patients’ risks of violence, seeks to incorporate families as allies of state intervention into community life. Under the program, outpatient consultation sessions are regularly held at district hospitals or community health stations. There, visiting psychiatrists prescribe qualified[10] patients with free or low-cost psychopharmaceuticals, along with quarterly blood exams and annual physicals. As my fieldwork shows, except for the exams, which demand patients’ presence, family members often appear at the sessions themselves to report patients’ recent condition to psychiatrists, and receive patients’ medications. In fact, because they see patients as insightless but cunning, constantly devising ways to avoid taking medication, some psychiatrists even refuse to dispense medication

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[9] For a more detailed description of the program, especially its history of development, see Chapter 1 of this book and (Z. Ma, 2016).

[10] In Guangzhou, during my fieldwork, the qualifying standards varied from district to district. In some districts, only patients from low-income households were qualified to receive free medication, but in most other districts, eligibility was loose. As the 686 Program tries to include as many patients as possible under its surveillance, eligibility for service has become increasingly relaxed across the board.

to patients if they come alone. Community mental health workers who organize these outpatient consultation often only notify patients' family members about upcoming sessions. For patients whose illness durations and functional deficits have reached the official disability standard, community mental health workers also work with the families to have the patients' disability status registered,[11] so that the costs of their future inpatient stays can be partially reimbursed. Many of the patients and families I have introduced in the previous chapter and this one, especially those from low-income households, were recipients of these services. One could thus argue that as extensions of and partners with hospital psychiatry, these community services further inscribe patients and families into the dominant psychiatric discourse of chronic illness and management, while also providing materials to help remake kin relations in a time of disorder.

A major task of community mental health workers is regular home visits. According to my observations, during these visits, community mental health workers typically speak with the family members who they know from experience are the most familiar with the patients' situations. They ask those family members about the patients' current symptoms, insights, eating and sleeping, social functions, medication compliance, and the adverse effects of medication. They also inquire about patients' recent acts of aggression and violence, which they then translate into risk levels according to the following scale:

Level 0: No behavior listed in levels 1-5.

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[11] The disability evaluation and recognition standards endorsed by the Chinese government follow a medical model which defines disability in terms of the type, severity, and (ir)reversibility of one's impairment (Kohrman, 2005). This is different from a social model which defines disability in terms of the interaction between one's bodily conditions and social, cultural, and environmental barriers (Nakamura, 2013). As a result, people with disabilities in China, particularly those with psychiatric disabilities, are pathologized and subjected to efforts of biomedical normalization every day. Therefore, other than contexts that require specific clarification, in this dissertation I do not distinguish between patients diagnosed with severe mental illness and people officially recognized as psychiatrically disabled.

> Level 1: Verbal threats and screams, but no physical actions.
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> Level 2: Hitting or smashing non-human things, behavior limited to the home, can be stopped by persuasion.
>
> Level 3: Obviously hitting or smashing non-human things, regardless of location or situation, cannot be stopped by persuasion.
>
> Level 4: Continuous hitting or smashing, regardless of location or situation, targeted at objects or human beings, cannot be stopped by persuasion. Including self-injury and suicide.
>
> Level 5: Any violent behavior targeted at human beings, with instruments, arson, or bombing, whether at home or outside.

According to the rule of 686, a patient's risk level determines the intensity of community surveillance and the interval between home visits in his/her case. For example, a patient whose risk level falls between 3 and 5 is labeled an "unstable patient" and should be either hospitalized or closely followed up every one to two weeks (Ministry of Health, 2012, pp. 9-10). This scale thus becomes a tool for community mental health workers to calculate, predict, and manage the possibility of patient violence. Note that in this scale, damaging family property only counts as a low-level risk. If we look closely at the last three levels, which are considered high risks, we find that the home is rarely mentioned, outside of the most extreme occasions. Instead of treating the home as part of the community that needs to be protected, the 686 Program primarily seeks to turn family members into agents who monitor patients' behavior and report on them to professionals[12] in order to protect people outside homes.

Indeed, in the home visits that I shadowed, community mental health workers often ended the conversation with family members by exhorting the latter to *guan*, meaning to closely watch over and manage patients' risks of illness relapse and violence. *Guan* as risk management

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[12] Similarly, Michel Foucault has argued that in Europe, with the rise of a concern with sexuality in the 18th and 19th centuries, family members (especially parents) became doctor-figures, closely monitored and corrected each other's behavior and psychological status, and built alliances with the experts by offering to the latter the private truths of the individual (Foucault, 2006).

also figures centrally in the program's official name and policy documents. If, as I mentioned, *guan* in everyday parlance can refer to a diverse array of forms of relatedness, then community mental health and the discourse it promotes is slowly changing people's practices of *guan* and attitudes towards it. For example, towards the end of my fieldwork, Sister Duo became increasingly irritable and often scolded people who came near her, accusing them of being evil spirits. As in the past, Uncle Huan explained to others that Sister Duo's symptoms had simply flared up temporarily, and all they needed to do was stay away and let her be. This time, however, some people began to criticize Uncle Huan for *buguan* (not practicing *guan*), that is, not taking responsibility for Sister Duo by bringing her for an outpatient consultation or arranging an inpatient stay as soon as possible. This neglect, they warned, would cause her condition to deteriorate, turning her into a nuisance or even a hazard for others. Soon after I left the field, I learned that Uncle Huan had followed others' suggestions and had had the doctor increase the dosage of Sister Duo's antipsychotics.

Biopolitical Paternalism and Ordinary Maternalism: A Case of Hidden Drug Treatment

By redefining *guan* as the management of medical and biopolitical risks, and by turning family members into its primary agents, the 686 Program works to turn communities into spaces where governance happens "at a distance," along with but beyond bureaucratic and institutional power (Rose & Miller, 1992).[13] However, if the subject of community governance in Rose's analysis is the self-responsible individual who acts prudentially to minimize his/her own risk (Rose, 1996), then, in China's 686 Program, the relationship between the patient as the governed subject and the family caregiver as the governing agent is more complicated and layered. In the

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[13] Aihwa Ong and Li Zhang have applied the concept of "governing at a distance" to post-socialist China (Ong & Zhang, 2008).

program's official discourse—as manifested in media representations, educational events, and typical encounters between families and professionals—family members are seen as key to patient management, only because they can use their attention, authority, and intimate knowledge to guide patients through medical treatments. As one community mental health worker told me, "I really like those family members who can supervise and urge (督促/*ducu*) patients to take the meds. If something happens, they will increase the dosage [based on their own experience or psychiatrists' advice]. Then when the patients get better, they will decrease the dosage." In this discourse, patients are seen as submissive dependents whose attitudes and actions can be easily influenced by their family members working in collaboration with the medical experts. No coercion or manipulation on the part of caregivers is needed or should be used. In fact, in educational events in which I participated, psychiatrists and community mental health professionals often advised family members to build therapeutic alliances with patients and not to conceal their administration of drugs. According to the program's discourse, if patients are unwilling to abide by the (medically informed) familial authority, especially when that leads to illness relapse or heightened risks of violence, then family members can and should turn them over to the authority of the hospital.

In everyday life, however, caregivers often find themselves having to use disapproved tactics to engage with patients and to sustain family relations. Community mental health workers often acquiesce to such practices. During one home visit, the community mental health worker Dr. Xu and I were received by an eighty-year-old mother in the living room, while her mentally ill daughter was taking a nap in a bedroom. When Dr. Xu asked the mother what medications her daughter was taking, the mother went to her own room and fetched a small bottle. She told us in a low voice that the psychiatrist had prescribed her daughter 20 mg (10 tablets) of perphenazine a day. For every day during the last ten years, however, she had mixed 30 mg (15 tablets) of perphenazine with some hepatinica, ground both of them up, and dissolved the powder in her daughter's milk. "I have no other choice," the mother explained to me, "my daughter doesn't think she is mentally ill, and she refuses to take any meds. Sometimes she even gets mad at me [when I ask her to take the meds]." As soon as the mother had finished speaking and put away the bottle, the daughter, a fifty-year-old woman, woke up and came out, looking disoriented and fatigued. We all greeted her warmly. Knowing from previous interactions that the patient had admitted having hypertension, Dr. Xu pulled out a blood-pressure cuff from his bag, and checked her blood pressure. As the reading was dangerously high, he asked whether she felt dizzy, how well she had slept, what her mood was, and so on—questions that could get at not only her hypertension, but also, implicitly, her schizophrenic symptoms and side effects of the medication. She slowly answered all his questions with slightly slurred speech. He then asked her to come to the community health station for a checkup, and she agreed.

As we finished the home visit and walked outside the apartment with the mother, I learned about the patient's story: she had been diagnosed with schizophrenia in early adulthood. Back then, her mother had arranged a marriage for her, thinking that love might calm her down. Unfortunately, her husband did not care about her at all, and the despair only worsened her condition. Soon after she gave birth to a son, her husband divorced her and took custody of the child. For years, she had been going to her ex-husband's home every day, trying to catch a glimpse of her son, even though her son did not want to be associated with his "crazy" mother any more. "My daughter isn't violent at all. She just likes wandering around and occasionally yelling at strangers," the mother told me. "Still, you have to keep an eye on her," Dr. Xu chimed in. “I know,” the mother responded, “but I can’t confront her with her illness. Otherwise it will break her heart.” The doctor nodded, and sighed.

During fieldwork, it was not rare for me to encounter family members who had resorted to hidden drug treatment at some points during the course of patients’ illness. Nor was it unusual for psychiatrists or community mental health workers to tolerate this practice. In fact, some even suggested smarter ways to disguise medication to family members. Cases like this reveal the dynamic between two modes of familial relatedness at work in community mental health. On the one hand, the official discourse of community mental health sees people diagnosed with severe mental illness only as patients whose symptoms and risks of violence need to be managed. It further assumes that patients can be easily subjected to the familial authority, which should be invested in maintaining the normal/pathological divide established by psychiatry. This authority, following and intertwined with the medical-bureaucratic expertise of community mental health, guides patients through the long path of normalization and pharmaceutical management. On the other hand, family members often find that patients will not follow their medical advice or commands. Not only do family members—especially women and the elderly—not hold the authority that is needed to win over “noncompliant” patients, but they also know that the patients might be desperately trying to hold onto lifeworlds that are incompatible with their adoption of a sick role.[14] In the aforementioned case, for example, the patient’s dream of motherhood had been

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[14] According to Talcott Parsons’ concept of the “sick role,” the sick person enters a role of “sanctioned deviance.” In this role, he/she is exempt from normal social responsibilities, but he/she is expected to comply with the medical treatment and do his/her best to get well (Parsons, 2013). This concept has faced much criticism, such as its apparent inapplicability to chronic illness, when patients are not expected to recover. I do not share Parsons’ functionalism. For example, I do not think that madness is merely a form of sanctioned deviance; rather, for many Chinese it is a felt disruption of reality. Yet, I choose to invoke this concept to point out that mental health professionals often do come to see patients mainly through the lens of illness, and expect them to continue their efforts at normalization, even though mental illness is chronic. In my case, the sick role is mediated by patients’ families, and as I will soon show, it is merely one aspect of patients’ lives.

continually shattered by her mental illness, or more exactly, her ex-husband's and her son's rejection of it. Family members often have compassion for patients' desires, and such compassion, as well as the need to sustain affective ties with patients, makes them unwilling to confront patients with their medical diagnoses and regimens. At the same time, the disruptions that disorders bring to domestic life, as well as the pressure to minimize the patients' risks to others, make family members feel a need to medicate patients. Hidden pharmaceutical treatment then appears to them as the only possible way to simultaneously build a compassionate relationship and instill order in a (medicalized) everyday life.

Because of its exaltation of medical normality and social order, emphasis on pharmaceutical discipline, and assumption of intimate authority, we may call the familial relationship expected and promoted by the official community mental health discourse biopolitical paternalism. It represents the *yang* face of community mental health. Because of its compassion for patients' desires, openness to their lifeworlds, recognition of all family members' vulnerabilities, and hybrid attempts to sustain the intimate ties, we may call the familial relation enacted in everyday life, particularly through practices officially deemed questionable, an ordinary[15] maternalism. It represents the *yin* face of community mental health. In colloquial Chinese, *yang* and *yin* can also mean being overt, primary, and positive versus being covert, supplementary, and negative. Indeed, because of its covertness, ordinary maternalism displays negative qualities such as being excessive, deficient, and fragile: as shown in the aforementioned case, because patients might not consume all the food or drink provided, family caregivers sometimes choose to hide a larger number of pills than prescribed, as an attempt to ensure the

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[15] My use of "ordinary" is inspired by Veena Das, who examines the conditions and limits of ordinary intimacy in contemporary India after mass violence. She argues that in ordinary life, "it is from such fragile and intimate moments that a shared language had to be built and with no assurance that there were secure conventions on which such a language, in fact, could be founded" (Das, 2006, p. 8).

amount of medication that patients ingest. Caregivers might not have the opportunity to conduct this covert practice every day, and fluctuations in medication intake might lead to the worsening of patients' symptoms. Patients might also suspect or even find out what their caregivers are doing. They might become agitated as a result and lose trust in their caregivers. These negative qualities allow community mental health workers to publicly criticize families' covert practices, and they are addressed in efforts to educate and monitor caregivers. However, the community mental health program, as a technology that governs at a distance, relies on caregivers' intimate practices, which exceed its strict imagination, in order to engage with patients. This is why community mental health workers like Dr. Xu acquiesce to the caregivers' covert practices, and even cooperate with the caregivers in front of patients.

In the dialectic of *yinyang*, *yang* dominates and overshadows *yin*, but *yang* also needs *yin* to exist, and *yin* supplements *yang.* If we apply Jacques Derrida's analysis of the supplement onto the relationship between biopolitical paternalism and ordinary maternalism, then we can see that as a supplement, ordinary maternalism is needed if biopolitical paternalism, especially its mission of patient management, is going to work to its fullest extent. However, ordinary maternalism also exists as "a subaltern instance which *takes-(the)-place*" of biopolitical paternalism in everyday life. Either way, "the supplement is *exterior*, outside of the positivity to which it is super-added," and it always appears as the "negativity of evil" (Derrida, 1997, p. 145). Because of the supplement's subaltern, negative, and external quality, when we look at the official discourse of community mental health and its exaltation of biopolitical paternalism, we are always "blind to the supplement" (Derrida, 1997, p. 149) of ordinary maternalism. In the next section, we will examine another supplemental practice of community mental health, domestic confinement.

The "Trouble" of Domestic Confinement

"Unchaining" and the Legitimation of Psychiatric Power

As discussed in the previous section, the work of biopolitical paternalism in community mental health assumes that patients are easily subjected to familial authority and that they comply with the medical regimen at home every day. It also assumes that when patients are noncompliant and relapsing, their families should, can, and will send them to the hospital, thereby also temporarily transferring their paternal authority and responsibility of patient management (*guan*) to the institution. This clear-cut picture is destabilized by the phenomenon of domestic confinement, or what the 686 Program calls "locking up and chaining" (关锁 /*guansuo*), that is, "the patient's freedom of mobility being restricted by ropes, chains, or iron cages for non-medical purposes" (Ministry of Health, 2012). This troublesome domestic confinement, then, requires intervention. The 686 program demands that if a community mental health worker discovers domestic confinement during home visits, he/she should report it, have the ropes, chains, or iron cages removed, and, if necessary, send the patient to the psychiatric hospital for free inpatient treatment.

In Chapter 1, I already discussed the fact that "unchaining" has become one of the most publicized components of the 686 Program, and I analyzed the discursive effects of highlighting domestic confinement and unchaining. Let me briefly recapitulate my argument there. Like the depiction of domestic confinement by missionary psychiatrists more than a century ago, media reports today, which are typically orchestrated by central and local health departments, often portray patients confined at home as living like animals in a state of complete misery. By claiming to restore human dignity to confined patients, efforts to discover and eliminate domestic confinement thus help fashion the 686 Program as a humanitarian endeavor. However, while medical missionary accounts depicted patients confined at home as innocent victims suffering from their families' cruel oppression, the contemporary picture portrays domestic confinement as the last resort for helpless families dealing with dangerous, violent, and bestial patients. (Figure 4.1, for example, is typical of this portrayal.) Because "chaining" is so often hidden, just a few reports of domestic confinement can stand in, for the public, for an indefinite number of (presently or potentially) violent patients either confined or at large. These cases tend to be understood as the tip of the iceberg. Exposures of domestic confinement in the media thus help justify the biopolitical risk management undertaken by community mental health. Moreover, in contemporary media reports, what happens after the patient is unchained and enrolled in inpatient treatment is usually depicted as miraculous deliverance: his symptoms are stabilized or even disappear, he becomes clear-headed, and he regains his social functions. This portrayal has helped to validate psychiatric expertise and legitimate the expansion of psychiatric institutions across the country.[16] Psychiatrists' nearly miraculous power can be seen in Figure 4.2, in which a psychiatrist comes to unchain and "rescue" a confined patient. Against the background of a decrepit room and a rusty cage, the doctor appears bright and clean. His tall but slightly bending body, as well as his smiling face and the hand gesture accompanying self-introduction, suggests his authority, power, and kindness. Upon seeing him, the patient, who must have been in a chaotic and disoriented state, appears lucid, attentive, and hopeful. Depicted as the humanitarian rescue and miraculous cure, as the unburdening of the hapless family, and as risk management of/for the population, unchaining thus casts the psychiatric profession and the state that sponsors it as a powerful paternal figure that gives (biologically defined) life to its citizens. Of course, in the efforts of unchaining the role of families in patient management is not entirely dismissed.

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[16] As Akihito Suzuki argues about Japan in the early 20th century, "emphasizing the horror of home custody was, at the same time, a convenient lever towards creating hospitals" (Suzuki, 2003, p. 202).

Rather, psychiatric hospitalization and direct interventions by community mental health workers are seen as necessary only in times of crisis. Their aim is to minimize the patient's symptoms and risk to a level that can again be managed by his family, thereby restoring the family's authority and ensuring the smooth implementation of biopolitical paternalism at home.

Figure 4.1 Chongqing, 2011: a 40-year-old patient restrained with chains by her mother for 23 years. Photo credit: Tencent pictures.
SOURCE: http://www.weixinyidu.com/n_1152061.

Figure 4.2 Baoding, 2009: a patient who has lived in a cage for 10 years is "rescued" by hospital psychiatrists. Photo credit: Beijing News.
SOURCE: http://news.xinhuanet.com/politics/2013-07/11/c_124990750_3.htm.

"How Could the Madman Not Be Locked Up?!"

In everyday practices of community mental health, the rejection and elimination of domestic confinement is not always easy. I realized this the first time I shadowed a community mental health worker. In the summer of 2011, Dr. Gao allowed me to accompany him on his home visits to several villages undergoing urbanization on the edges of Guangzhou. He brought with him government-issued bluebooks to record information on each patient. One column in the bluebook inquired whether or not the patient was *guansuo* (locked up and/or chained). Not knowing what this meant back then, I asked, "Locked up by the psychiatric hospital?" "No, by the family," Dr. Gao answered.

Driving through rows of glamorous European-style townhouses, we came to Uncle Long's rundown neighborhood. Uncle Long, an 81-year-old man, greeted us warmly and led us to the place where A Niu, his mentally ill son, stayed. “Just a glance is OK,” Dr. Gao said. It was a detached single-room bungalow, with no light inside and iron bars on the only window. A Niu was standing behind the bars, shirtless and disheveled. With a smile, he said “hi” to Dr. Gao. The doctor approached him, gave him a cigarette, and then drew back about four feet. With a gentle voice, the doctor asked A Niu how he was doing and whether he was taking any medications. A Niu began screaming, and we left the scene.

We then went to Uncle Long’s own house, which was located nearby. To my surprise, Dr. Gao refused Uncle Long’s invitation to enter, and instead we sat on the doorsteps. Uncle Long took out several pill bottles containing clozapine, chlorpromazine, risperidone, sodium valproate, and estazolam. I asked Uncle Long whether A Niu had been willing to take the medications. “Of course not,” he said. “I have to mix ground pills with sugar and put them in my son’s rice or soup. And look at the sleeping pills [estazolam]. Whenever I want to go inside and clean his room or change his clothes, I have to put some of these in his meal and put him to sleep first.”

Uncle Long told me that besides A Niu he had two other sons and a daughter, but they were all married and had their own families. Dr. Gao carefully asked whether his wife was still there—it turned out that Uncle Long’s wife had been paralyzed by a stroke the previous year, and the doctor did not want to go inside and disturb her. She had passed away earlier in the year, Uncle Long answered, leaving him as the only person who could look after and provide for A Niu.

According to Uncle Long, A Niu was now thirty-eight years old, and he had been ill since 1991. “He used to be the smartest and most filial among all of my kids,” Uncle Long sighed. When A Niu was studying at a vocational school, he was probably bullied, tricked, and beaten up by schoolmates. He started having headaches and acting weird, and was diagnosed with schizophrenia. At first, he managed to finish school and worked for two years, but soon his symptoms worsened. He began smashing objects and hitting people. These behaviors and the repeated hospitalizations—he had been institutionalized sixteen times since 1991—were now preventing him from working. At home, he often screamed in the middle of the night. Neighbors had called the police, asking them to put him away. Yet given that he had not actually hurt anyone, the police could do nothing but tell the old couple to keep an eye on their son. Five years before, Uncle Long and his wife had decided to put A Niu in the locked room. Even confinement could not contain A Niu's aggressiveness. He had often thrown objects from the window, and had once injured Uncle Long that way. Over these five years, A Niu had smashed three CD players that Uncle Long had put in his room. He had also broken the television and the lightbulb in the room, which still awaited repair.

When we were about to leave, Dr. Gao suggested that he might be able to set up a three-month free inpatient stay for A Niu, although he was unsure whether the district's quota had already been reached this year. Uncle Long shook his head, saying that A Niu had been beaten up in the hospital before, and he would not be willing to go again. As we bade Uncle Long goodbye and walked back to the car, Dr. Gao asked me what I had learned from the field so far. "It is the first time I have ever seen a patient locked up," I said, "as indicated in one of the categories of your bluebook." Dr. Gao raised his voice, with a slightly embarrassed smile: "Oh dear, please don't tell my supervisor that there are patients being locked up here! What you saw does not count; it only counts when the person's hands and feet are tied." I was struck by his definition of (non)confinement, but Dr. Gao shifted gears: "Nowadays people like talking about humanitarianism. They demand that whoever is chained needs to be unchained. But think about Uncle Long's son. Is it at all possible for his family not to lock him up?!"

Domestic Confinement: Risk Containment or Kin Compassion?

Over the years, I would encounter four additional cases in which patients were either chained or locked up at home. These few cases were rare relative to the number of patients I encountered. Interestingly, the community mental health workers in charge of all four of those cases had either not raised any concerns, or had proposed free hospitalization, but upon hearing the family members' refusals, did not insist. How, then, is domestic confinement possible or even necessary on some occasions? What makes community mental health workers acquiesce to this "problematic" practice? What do the professionals' discursive devaluation of and practical acquiescence to domestic confinement reveal about the relationship between the *yang* and *yin*, the paternal and maternal, aspects of community mental health?

First of all, although domestic confinement is defined by the 686 Program as being for "non-medical purposes," the cases I encountered suggest that domestic confinement is intertwined with biomedical purposes, techniques, and effects. When Dr. Gao said that it was impossible to unlock Uncle Long's son, one of his implied reasons was that if released, this aggressive patient could endanger not just his father, but also people in the neighborhood and beyond. According to Rose, while community governance largely relies on self-responsible individuals managing their own risks—or, in our case, families' gentle management of their submissive dependents—it also comes with an "intensification of direct, disciplinary, often coercive and carceral…interventions in relation to particular zones and persons" (Rose, 1996, p. 345). This includes persons deemed dangerous or those who occupy the far end of the risk continuum (Rose, 2010). As Dr. Gao implicitly admitted, both the psychiatric hospital and the home can be carceral spaces that detain the dangerous patient. The discourse on community mental health distinguishes hospitalization from domestic confinement partly by claiming that hospitalization can bring about miraculous improvement (if not a cure) in the patient, who it typically depicts as naive to biomedical treatment. However, the patients I saw confined at home had all undergone repeated hospitalizations, which had contributed to disrupt their life trajectories, rendering their recovery and social participation much more difficult. Community mental health workers often quietly agree with the patients' families that another round of hospitalization is not likely to produce any substantial change in patients' conditions. Of course, community mental health workers typically blame the inefficiency of hospitalization on patients' families, noting for example their delay in recognizing patients' conditions and in seeking psychiatric help in the first place. By doing so, they inscribe the failure to find a cure or to improve the condition into the statistical prognosis of severe mental illness. This reporting and analyzing practice just does more to reinforce the discursive supremacy of psychiatric expertise over home care. In any case, although domestic confinement, like hospitalization, might be seen as "incarceration without reform" (Rose, 2010, p. 89), community mental health workers still arrange to have family members receive medications for/on behalf of the patients, so that the patients' symptoms and risks might be pharmaceutically tempered.

Even though unchaining and psychiatric hospitalization might not significantly improve patients' conditions, they may at least give family members some respite. Community mental health workers do not insist on, or, at times, even offer unchaining as an option, mostly because of their economic considerations in implementing this neoliberal health policy. Under the 686 Program, each district in Guangzhou is required to arrange for free hospitalization services for impoverished patients.[17] So far, however, such services have been limited. According to my interview with a district supervisor of the 686 Program, as of 2013, her district had set up only five free psychiatric beds in hospitals, but it had a resident population of over 900,000, among which 4,700 had severe mental illness. Eligibility for free psychiatric hospitalization was thus restricted to patients who came from registered low-income households and had a risk level between 3 and 5, that is, those who had damaged property and/or injured humans, especially outside their homes. Each selected patient could only occupy a bed and receive inpatient treatment free of charge for up to three months. (Other districts in the city had similar resource conditions and eligibility standards.) Even so, there were too many patients who met this standard to accommodate all of them, so community mental health workers operated as gatekeepers of resources, and they always had to exercise discretion in offering free hospitalization. When they were chained or locked up at home, patients typically could only damage household property or injure their family members, so they would not be likely to reach risk levels of 3 or above. Thus, they occupied a liminal space in terms of qualifying for free institutional intervention. Out of sympathy for the family members' suffering, community mental health workers might offer to unchain and hospitalize patients confined at home. Yet out of their sense of duty to the financially burdened state,[18] they might choose to reserve scarce public resource for patients who had wreaked havoc in public. The community mental health workers' ambivalence thus suggests an irony built into the community mental health program: the more families participate in and suffer from patient management (to the extent that they have to resort

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[17] Without this policy, the public health insurance scheme typically reimburses part of the inpatient treatment costs for its participants. Whether they have health insurance or not, people registered as having psychiatric disabilities are entitled to an increasingly wider range of hospitalization subsidies. Still, they or their families have to shoulder some treatment costs as well as all costs related to room and board in the hospital. In contrast, hospitalization services under the 686 Program are entirely cost-free.

[18] Didier Fassin argues that this sentiment is often found among the state's humanitarian agents (Fassin, 2012).

to home confinement), the less recognition and relief they are likely to receive from the state and its agents.

The concrete (non-)implementation of unchaining policies also reveals paradoxical entanglements of the 686 Program's two central missions, that is, humanitarianism and risk management: on the one hand, the task of risk management may override that of humanitarian rescue, rendering the patient's placement a matter of indifference. This indifference also suggests the futility of (at least some) medically-mediated humanitarian endeavors. On the other hand, while the promise of humanitarianism is universal, its realization is partial and selective. In order to be counted as humans worthy of rescue by state agents, who are financially savvy and biopolitically minded, patients have to appear as subjects too risky to be managed at home.

For the family members I have encountered, home confinement is one way to manage difficult and potentially dangerous patients. Besides, family members not only are regularly reminded by community mental health workers and other local government officials of the importance of patient management, but are also often implored by neighbors/fellow villagers to keep patients from running loose. These family members might decide not to take the offer of free hospitalization, partly because after three months of involuntary hospitalization, the patients might come back hating them even more, and might seek vengeance.

However, concern with their own safety is not the only reason why some family members hesitate or refuse to hospitalize the patients. As my fieldwork shows, family members caring for patients at home—whether through the means of "confinement" or not—often used the phrase "cannot bear" (不忍/*buren*) or "do not have the heart to" (不忍心/*burenxin*) to explain their decision of refraining from hospitalization. As seen in the case of Uncle Long and A Niu, those family members know from past experience that their mentally ill relatives did not, and will not, enjoy the experience of inpatient stay. While some aspects of institutionalization are seen by family members as beneficial, such as the close surveillance and the forced treatment when patients do not comply, other aspects have made them feel uncomfortable: the crowded ward, the lack of physical comforts (in terms of personal space, food, clothes, and entertainment), neglect by a busy staff, possible bullying or injuries at the hands of other patients, and so on. "My heart ached (心痛/*xintong*) when I saw him/her [the patient] go through these things," several family caregivers told me, "I can't bear to see him/her suffer [such treatment] again."

Caregivers' invocations and professionals' evaluations of "cannot bear" (不忍/*buren*)[19], a colloquial term rooted in Chinese thought, help reveal the gendered ethics and politics of family relations in the face of severe mental illness and in relation to psychiatric power. According to the teachings of Mencius, an early sage of Confucianism, we instinctively cannot bear seeing the suffering of other human beings or animals, even if they are unrelated to ourselves, such as the sight of an ox being sacrificed for a ritual, or a child falling into a well. Such discomfort and compassion constitute the starting point of benevolence (仁/*ren*), the core virtue of human beings (人/*ren*), and should be expanded to lay the groundwork for kingly governance (Shaoming Chen, 2007). However, as time went on, the sentiment of 不忍/*buren* or compassion gained a gendered dimension. The term "womanly benevolence" (妇人之仁/*furenzhiren*) was coined as a (slightly) dismissive evaluation, and Zhu Xi, the 13th-century Confucian scholar, associated it with the vice

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[19] Here I include all the Chinese characters in order to differentiate this (in)tolerance from the homonyms of *ren,* although the similarity has inspired people to build many conceptual associations among the few words sharing that pronunciation. For example, Confucius said, "Human beings are benevolent." (人者，仁也/*Ren zhe, ren ye.*) (X. Zhu, 2013)

of “inability to bear small things” (小不忍/*xiaoburen*) and “inability to bear [the discomfort resulting from] love/compassion” (不能忍于爱/*buneng ren yu ai*) (X. Zhu, 2013). In other words, women’s compassion for, and inability to bear, the suffering of their loved ones is seen as potentially harmful, in that minor suffering, such as children’s growing pains, is often the necessary cost of realizing greater goals and principles, and thus should be endured. This historical ambiguity of *buren* has found its way into the term’s contemporary invocations in times of severe mental illness. On the one hand, it is an instinctive and virtuous human feeling: family members cannot bear seeing patients suffer in the psychiatric hospital. Their corresponding hesitation or refusal to hospitalize the patients is thus a humane decision. On the other hand, as we have noted, the psychiatric regime, including the community mental health discourse, has redefined the goals and principles of being human as seeking biological normality and minimizing one’s risk to the population, no matter how unattainable that goal is in some cases. If family members show so much concern over patients’ suffering as to refuse hospitalization, especially when patients’ symptoms and risks escalate, then from the perspective of the psychiatric discourse, those family members are letting their womanly/motherly compassion obstruct the paternal principles of normalization and risk management. In fact, gender is not merely a symbolic ascription. In practice, mothers and other female family members are usually the ones who show signs of discomfort, anxiety, and hesitancy about hospitalization. For this, they are often chided by the professionals.

If many family members cannot bear to see patients suffer in the hospital, how can a few of them bear to confine patients at home? After all, those family members who resorted to this measure admitted to me that the confined patients did live like animals. From another perspective, if a patient is too intransigent for the humanizing force of psychiatry, if he is seen more as a violent beast than as a human being, how can one have humane and kindred compassion for him? These questions could be posed, partly because when we speak of confinement, we often have in mind an absolute power hierarchy and a segregation of beings, manifested as a segregation in space: the human standing outside the cage dominates the animal locked inside. Moreover, as Derrida points out, we who subscribe to Western ethics, as well as the humanitarian endeavors that derive from them, typically assume that care and compassion are only possible when the target is a human being: presumably, the human has the ethical capability to respond to an other, while the animal only lives in its own body and reacts mechanically to its environment (Derrida, 1991, 2002, 2003).[20]

Granted, many family members do see patients, especially the violent ones and those with florid symptoms, as "beasts," "monsters," or "devils." However, in domestic confinement, the home space is divided, but not segregated within, and "mutualities of beings" (Sahlins, 2011, p. 7) are established over unstable and jagged boundaries between self and the other, "humans" and "animals." In some cases that I have seen, the locked room was inside the household, where the smell of the patient's unwashed body and excrement permeated the entire house. In other cases, the patient's room is separated from the main domicile, and yet the caregiver is within earshot of the patient's screams and sighs. Derrida argues that concrete ethical responsibilities emerge from the limitrophy of jagged boundaries and multiple life forms (Derrida, 2002). Similarly, in some Confucian thought, the feeling of "cannot bear" (*buren*) that stimulates ethical actions takes as its objects not just humans, but also animals, plants, and even insentient objects

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[20] Derrida argues that even Levinas (who does not seem to ascribe any ontology to the fact that the ethical subject responds to and suffers for) subscribes to a human/animal divide. Indeed, Levinas argues that the animal does not have a face, because the animal is a pure being, a being that is only interested in persisting one's own being. The human has a face because "[t]he human breaks with pure being" and possesses the ethical capability to put the other's life above one's own (Levinas et al., 1988, p. 172).

(Shaoming Chen, 2007). Therefore, even when patients are seen as animals, their needs might be addressed in ways that include constant material flows between the outside and the inside of the locked room. In the few cases that I observed, family caregivers served patients meals three times a day, often trying to include their favorite dishes. Some families also put water hoses inside the locked rooms for patients to take showers. For patients' entertainment, caregivers put TVs or CD players inside the locked rooms, even when families were living in relative poverty. Like animals in cages, confined patients were also often administered medications without their knowledge, so that not only could their illness symptoms be managed and their aggression tamed, but family members could also approach them to carry on everyday tasks of care.

In Chinese cosmology, kinship ties can also be built with/among non-humans, such as gods, ancestors, spirits, animals, and ghosts. Although severely mentally ill patients may have been rendered as bestial or monstrous figures by a range of conditions, some even unable to engage in simple conversation or social interaction, their family members still heed their intimate recognitions and responses (Derrida, 2002). In one household, the wife told me that her mentally ill husband had attacked everyone who came near his cage, except for his young daughter. In another household, the mother told me that from time to time she would give her mentally ill son a lit cigarette (she did not dare to give him a lighter). Once, he tried to poke her hand with the cigarette. She scolded him, threatening not to give him cigarettes anymore. "He stopped, and doesn't do this mischief any more. What a kid," the mother shrugged, and smiled.

Compassion and kinship ties that cut across and disrupt the human/animal divide transgress the discursive imagination of community mental health, especially its humanitarian mission and the presumed supremacy of psychiatric expertise. Meanwhile, the biopolitical mission of community mental health makes domestic confinement an acceptable and useful option for managing high-risk patients. The bureaucratic pressure that the 686 Program exerts on patients' families, as well as the psychopharmaceuticals that it provides for them, helps in practice to sustain rather than abolish domestic confinement. The neoliberal policy of hospitalization arrangements, moreover, even requires domestic confinement as a supplementary means of risk containment. Therefore, as a supplement, domestic confinement "transgresses and at the same time respects the interdict" (Derrida, 1997, p. 155) of community mental health. It is seen as existing external to the psychiatric power, and is thus lamented, critiqued, or not even recognized by the psychiatric discourse. If we understand the symbolically—and to a large extent, socially—maternal practice of kin compassion as *yin*, and the work of psychiatric authority in portraying and shaping domestic practices as *yang*, then cases of domestic confinement again reveal the *yinyang* dialectic in community mental health: *yang* gives *yin* principles and materials, *yang* utilizes *yin*, but *yang* also excludes *yin* from itself, insisting on the subaltern status of the *yin* aspect.

When Dr. Gao chose to stand far away from the room where A Niu was confined, and when he refrained from entering Uncle Long's house, his stance betrayed his ambivalence toward both his own community mental health work and the realities of home confinement, as well as his difficult position amongst these practices. He could not bear seeing the misery of either the patient or the mother on her death bed, but he could not take any action, because his profession and program did not give him the resources to repair the damage that neoliberal health and welfare policies had wrought on both the caregiver and the cared for. In fact, by concentrating the responsibility of patient management onto the family, community mental health was implicated in the production of such damage. He did not want to look too closely at the scene of home confinement, because witnessing would lead to the professional and bureaucratic responsibility of reporting. However, he knew that reporting and "rescuing" would not change the patient's fate of incarceration. He also did not need to look too closely at the patient's condition, because as a member of the local community, he knew that the father was still striving to engage with, look after, and *guan* the son as best he could. As the last part of his comments implied, this practice was, in a way, more realistic and humane than the empty promise of humanitarianism; words like "chaining" and "confinement," with their negative connotations, seemed inappropriate to describe this situation. However, this practice of *guan* was not the *guan* exalted by the 686 Program, and Dr. Gao's knowledge of the "case" could not be registered in the bluebook for the patient.

Conclusion

Facing the chaos that is called severe mental illness, family members may engage in diverse modes of relational practices with patients living at home. Because of the illnesses' intermittent qualities, family members may try to hold onto patients' (temporary) identities as the biologically normal beings they used to know and love, or emphasize patients' caring humanity. Yet confronted with the inescapability of changes in patients' conditions and the strangeness of their experiences, family members may also try to comprehend, engage with, or simply go along with such alterity. As a hegemonic organizing force, psychiatry leads people to desire normality and offers them techniques of normalization, such as psychopharmaceuticals. Yet psychiatrists may also tinker with their everyday practices and professional narratives in order to make space for clients' life experiences other than patienthood. Dancing with these unpredictable dimensions of psychiatry, family members constantly experiment with different relational modes, and the contingent results of such experimentation can generate much joy, frustration, and ambivalence.

Taking gender both as sign systems and social arrangements, I have shown that family relations in times of severe mental illness are gendered: while the paternal mode of relatedness enshrines biological normality and the normalizing powers of psychiatry, the maternal mode of relatedness recognizes alterity, opens itself to vulnerability, and emphasizes nurturance and mutuality. This gendered differentiation resonates with a basic classificatory rubric in Chinese cosmology, *yinyang.* Taking the *yinyang* dialectic as an inspiration—or, one could say, taking social practices as concrete manifestations of *yinyang*, the two basic cosmological forces that generate life—we can also understand how different modes of family relatedness are dialectically shaped by the new regime of community mental health.

If hospital psychiatry primarily translates normalization into chronic tasks of managing individual patients' risks of illness and relapse, then community mental health tends to see the population of severely mentally ill patients as posing risks of violence, especially to the general public. Mental disorder leads to social disorder, and community mental health seeks to manage them both. It does so by recruiting patients' families as its agents/allies, who relay medications from psychiatrists to patients, and who report patients' symptoms and risks to community mental health workers. When displacing responsibility for risk management to patients' families, community mental health assumes that patients will be submissive dependents of familial authority, which, in turn, is attached to the principle and expertise of psychiatric power. I use the term "biopolitical paternalism" to refer to the discursive assumption of familial authority and the structural arrangements of familial responsibility that are explicitly at work in community mental health.

The discourse on community mental health asks family members to rely on and to solicit patients' compliance in taking medication. However, in practice, family members often resort to hidden drug treatment, that is, hiding ground-up pills in patients' meals or drinks. This is not only because caregivers, especially women and the elderly, do not in fact hold much authority over patients, but also because they sympathize with patients' attempts to hold onto lifeworlds that are incompatible with that of biomedicine. Meanwhile, the pressure of risk management exerted by community mental health workers, as well as patients' disturbing behavior, necessitate that family members medicate patients. Given its covertness, hidden drug treatment often appears excessive, deficient, or fragile compared to the adoption of psychiatric principles, and it is thus often criticized by community mental health workers. Yet in practice, it is also often tolerated, because community governance, governance "at a distance," requires the intimate work of families if it is to take effect. I use the term "ordinary maternalism" to refer to the contingent and often covert relational practices that are compassionate towards patients' desires, open to different lifeworlds, cognizant of individuals' vulnerability, and aimed at building intimate mutualities. Drawing on Derrida's analysis of the supplement, I argue that the *yin* of ordinary maternalism supplements the *yang* of biopolitical paternalism, for *yang* requires *yin* to work, but *yin* appears negative and exterior to *yang*; as such, *yang* is blind to—or rather, conceals—*yin*.

The dialectic of biopolitical paternalism and ordinary maternalism is also manifested in the community mental health program's representation of, and response to, domestic confinement. The image of domestic confinement has been central to community mental health, for it presents as a humanitarian crisis that requires intervention. By portraying the confined patient as violent and the caregiver who confines as helpless, this image also helps legitimize the community mental health program's risk management efforts. Community mental health workers are required to replace domestic confinement with inpatient treatment, which is seen as a powerful technique, able to magically cure—and re-humanize—the patients and to restore the proper functioning of the familial authority. In their everyday work, however, community mental health workers often acquiesce to the realities of domestic confinement. As community mental health workers see it, the home, like the hospital, can serve as a space to confine high-risk patients, most of whom have proven to be refractory to psychiatric treatment. Home confinement is even necessary in face of a neoliberal policy that seeks to reserve the limited resources of government-sponsored hospitalization for violent patients running at large. Meanwhile, for family members, home confinement is driven not only by the need of risk containment or self-protection, but also by a maternal compassion that makes caregivers unable to bear seeing patients suffer in the hospital. Although patients confined at home do at times look like animals, this compassion allows family members to maintain kinship ties with patients: family members live in proximity with patients, expose their sensations to patients' existence, attend to patients' bodily needs and comfort, and forever await patients' kindred responses. These maternal practices of domestic confinement are thus necessitated/partly enabled by, mark the limit of, and exceed the paternal imagination in the regime of community mental health.

Sometimes criticized/intervened into, but more often simply not acknowledged, ordinary maternalism, as Margery Wolf argues about the Chinese uterine family, "has no ideology, no formal structure, and no public existence" (Wolf, 1972, p. 168). The *yinyang* dialectic of ordinary maternalism and biopolitical paternalism reveals the family's duality in community governance: on the one hand, the family is a basic unit of community governance, and family members become important allies and agents of population management. On the other hand, the family is also what Nikolas Rose calls a "savage space" (Rose, 1996, p. 347), existing on the margin of the community. In it, alterity is segregated but sustained, attended to as a sound of silence.[21]

While all modes of familial mutuality may be called *guan* in everyday life, hospital psychiatry reconfigures *guan* as the management of patients' risks of illness and relapse, and community mental health reconfigures *guan* as the management of patients' risks of violence. As mentioned in Chapter 2, the new national Mental Health Law has made risk to self or others the only criterion for involuntary hospitalization, but here the concept of risk remains vague. How, then, might the existing conceptualizations of risk shape the interpretation of the law and the regulation of involuntary hospitalization in practice? How might practices with—and under—the law influence the work of biopolitical paternalism? I will explore these questions in the next chapter.

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[21] This intimacy with alterity is similar to what Lisa Stevenson calls "song" when analyzing the form of care beyond death (another alterity): "This is what I want to call song— seeking someone, calling someone, singing to someone, and perhaps, yes, even interpellating someone (if we can dissociate the term from its roots in hating)— as company, as a presence. Seeing a human before you (instead of seeing someone as human) means recognizing their potential as company, recognizing them as lovable kinds of beings, capable of showing up regardless of any subject positions they may have been asked to occupy" (Stevenson, 2014). Of course, the intimacy that I describe here does not require the other to be seen as human or lovable.

SECTION THREE

PREDICAMENTS AND POTENTIALS OF *GUAN*

CHAPTER 5

THE INS AND OUTS OF THE MENTAL HEALTH LAW

The Social Life of the Mental Health Law

In Chapter 2, we saw that as a compromise between the human rights campaign and the psychiatric viewpoint, the 2013 Mental Health Law stipulates a principle of “no risk, no involuntary commitment.” That is, admission to the psychiatric hospital should be voluntary in principle. The only exceptions are: 1) when the patient poses risks to—or in the law’s language, “has the danger to endanger”—him/herself, family member(s) have the right to decide for involuntary commitment; 2) when the patient poses risks to another individual, family member(s) or the police can decide for involuntary commitment. Correspondingly, the law stipulates that patients who are voluntarily admitted may have themselves released at any time. Family members may also request discharge for those "voluntary patients" and for patients who are committed because of their risks to themselves,[1] and such requests should be approved. Because the law grants the family automatic guardianship over any patient[2] and the right to act on the patient’s risks, the family has thus become a pivot in mediating the patient’s transition between sovereign rights and managed health.

The principle of “no risk, no involuntary commitment” appears to be liberal, reminding people of the "no danger, no involuntary commitment" principle found in many state mental health laws in the United States. However, unlike danger, which is tied to the actuality of events,

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[1] The Mental Health Law isn’t very clear on who can decide to discharge patients who are committed because of their risks to others. It only states that doctors should regularly assess those patients’ situations, and should the patients be fit for discharge, the doctors should notify their family members.

[2] The stipulation that the unrisky patient can decide for his/her hospitalization logically contradicts with the law’s assumption that any patient has a guardian, but no resolution of this contradiction is found in the law.

risks signify potentialities. As there are multiple ways to forecast the future, there can be many ways to interpret risks. This logic allows diverse calculi to come into play. Relatedly, the law highlights management (*guanli*) as an overall principle of mental health work, and displaces most of the responsibilities for patient management to patients' families (risk or no risk). Yet exactly how the family—along with other stakeholders—should manage the patient, in relation to specific interpretations of risk, remains to be concretized in practice.

Chapters 3 and 4 revealed that before this abstract legal language of risk and management set in, Chinese psychiatry in the market reform era had already been reconfiguring familial *guan* into practices that sought to manage patients' chronic biomedical risks of illness occurrence and relapse. Moreover, the community mental health program (or the 686 program) that had been rolled out over the past decade had highlighted a different—but related—set of risks, that is, patients' risks of committing violent acts against the general public. Correspondingly, *guan* as promoted by the community mental health program served to manage patients' "security risks" and to maintain the sociopolitical stability that was of central concern to the post-socialist state.

How, then, has the new Mental Health Law been implemented and interpreted against the background of the earlier practices? How do implementations and interpretations of the law draw on, reinforce, or destabilize existing configurations and working definitions of risk and management? How do people renegotiate their visions/experience of rights, responsibilities, and relations under the law? What power effects does the law's implementation have on people's vulnerabilities? These are the questions to be addressed by this chapter. My analysis draws on the part of my fieldwork that was conducted around and after May 2013, as well as on media coverage of the law's implementation.

In analyzing the implementation of the Mental Health Law, this chapter draws on and contributes to understandings of "law in society." On the one hand, law is an important social force. Anthropologists and other social scientists have told us that law has a tendency to fix, obscure, or produce its objects, that is, categories of humans and kinds of actions. Laws can be tools to resist oppression or to solidify hegemony (Lazarus-Black & Hirsch, 1994). Scholars have also asked us to pay attention to how people see themselves as empowered by laws, especially the "uneven distribution of legal consciousness" (Diamant, Lubman, & O'Brien, 2005) among different social actors. On the other hand, law does not act in a social vacuum. Given that violations of culturally embedded moral expectations can lead to disputes, laws are often articulated and utilized precisely in order to address such disputes. Laws are thus not just institutional sanctions, but also cultural values and symbolic constructs. Yet as Laura Nader argues, a law as a normative system is often abstract, full of "elasticity, loopholes, malleability, etc" (Nader, 1969). We need to look at how people interpret, implement, and enforce the law, how they make claims with it, or self-consciously diverge from it (C. Brown & Rieger, 2001). The paths that a law takes in these concrete enactments are often full of surprises. Elizabeth Davis reminds us: “[R]eal law, too, works metaphorically, asserting ends as if it could produce them, while actually producing effects that do not correspond to those ends” (E. A. Davis, 2012, p. 224).

Following these insights, this chapter focuses on the implementation of the Mental Health Law especially with regard to hospital admission and discharge, the two areas of practice that have been the most controversial prior to and under the law. I analyze how people struggle to make sense of the new law’s abstract and apparently liberal provisions, which seem to differ so much from existing psychiatric practices, and how their interpretations and strategic mobilizations of the law in turn open up or foreclose new possibilities of actions and unforeseen relations. While analysts have tended to examine either court cases or everyday practices in which laws are applied,[3] I pay attention to both, tracing the values, resources, and power differentials that shape the law's enactments in different circumstances, as well as the cumulative effects of these enactments. To borrow Michael Lipsky's famous argument about policy implementation, I suggest that rather than what appears on paper, it is people's decisions in concrete circumstances, "the routines they establish, and the devices they invent to cope with uncertainties" that effectively become the law (Lipsky, 2010, p. xiii).

By examining the actions and relations that are practiced with the law's language of risks, this chapter also explores the relationship between risk, responsibility, and vulnerability. Scholars have pointed out that risks are ways in which an uncertain and incalculable future is transformed into (what seems to be) a calculable reality, thereby rendered amenable to action and intervention (Dean, 1998). Therefore, different ways of calculating and preventing risk have given rise to different responsibilities for action, tethered to different regimes of government.[4] However, risk calculation is not just a technical matter that exists before the social or the ethical. Anthony Giddens reminds us: “There is no risk which can even be described without reference to a value” (Giddens, 1999, p. 5). That is, what kinds of risks are highlighted and how they are calculated depend a great deal on the ethical values and responsibilities at stake. Giddens also

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[3] For example, anthropologist Carol Greenhouse has argued that close examination on court cases will risk prioritizing rules over social and cultural contexts in which rules operate. On the other hand, examining everyday practices related to legal processes can illustrate the sociocultural context in which law operates and the “power that the law generates in social systems” (Greenhouse, 1989, p. 32). I find this distinction problematic, for it assumes that law takes a fixed shape and simply applies itself to court cases. As I will show in this chapter, the “application” of law in court cases also brings sociocultural contexts to bear.

[4] For example, in advanced liberal societies, the social insurance risks—misfortune such as unemployment and ill health--that required state protection have given way to a different set of health and life-style risks that require individuals themselves to manage (Lupton, 2013).

asks us to distinguish between different kinds of responsibilities, including ethical responsibility, obligation, and liability, examining how they shape or are shaped respectively by risk calculations.

This dialectic of risk and responsibility is important in our case, as the mental health legal reform provides an occasion for people to renegotiate the values of post-socialist governance and the distribution of responsibilities to achieve those values. These processes can be pried open by examining how people determine the existence of risks—a seemingly straightforward and technical matter—in everyday medical practices and in court cases. I focus on how risk determination is influenced by different sets of responsibilities, such as legal obligations for intervention and management, liabilities for wrongful hospitalization, and ethical responsibilities for care, paying attention to how these responsibilities are distributed across different actors. These medical practices and ethico-legal considerations are important; they can even redraw the public/private divide and reorient family relations. They also illustrate the many shades of *guan* in post-socialist China. Of course, the values that shape risk calculations are not just ethical or legal ones, but also politico-economic ones. As I have shown in the last several chapters, mental health practices in the market reform era have been entangled with the devolution and selective re-emergence of welfare, as well as the reorganization of professional interests. This chapter will further interrogate how practices under the new Mental Health Law solidify or rearrange the production and distribution of economic values, such as how the discharge of long-term inpatients might serve or jeopardize the financial interests of different psychiatric hospitals, and how that in turn shapes doctors' views of patient risk.

Risk management is supposed to eliminate forms of vulnerability such as individual suffering and public insecurity. However, as this chapter will show, when risk management is tied to a prioritizing of certain ethical and economic values over others, when responsibilities for risk management are distributed in an uneven way, it may elide or even create new forms of vulnerability. In what follows, two parallel sections will be dedicated to practices of hospital admission and discharge under the Mental Health Law, respectively. Each section will start by considering a controversial case, where a liberal understanding of risks potentially destabilized the de facto psychiatric practices in place prior to the law. I then analyze how people reacted to such destabilization, drawing on notions of responsibility and experiences of vulnerability in order to struggle for another reading of the law, to imagine another political order of *guan*. Each section will end by considering people's practical adjustments under the apparently liberal law, and the cumulative effects of such adjustments for patients, families, and professional practices. The conclusion will take these two sections together and consider how practices under the Mental Health Law reshape the political culture of *guan* in post-socialist China.

Negotiating Commitment

The Tragedy of Freedom

On September 10, 2013, an eighty-year-old lady rushed into a mental health social work center in Guangzhou. She told the staff there that her fifty-year-old daughter had long suffered from severe depression with psychosis. Two months earlier, her daughter had stopped taking her medications. Displaying an increasingly agitated mental state, the daughter had driven her out of the publicly subsidized apartment that they shared. Upon learning this situation, the social workers immediately went to visit the patient's home, together with a police officer, a community doctor, an official from the residents' committee, and the mother.

Because the patient had locked the door from the inside, the group had to break in. What met their eyes was a naked woman—the patient—pacing the floor restlessly, the whole room sprinkled with some sort of white powder, and belongings tossed around everywhere. When asked what was wrong, the patient wearily responded that she was smelling something strange and unpleasant. The mother quietly told the group that the powder might be body powder used by the patient to cover the "smell," which was her hallucination. When the mother suggested to the patient that she put on clothes, the latter yelled: "Don't bother (*guan*) me! I'll clean the room myself if it's dirty. Now get out, all of you!"

The group had to retreat outside to talk about strategies of intervention. They all agreed that the patient was relapsing and should be committed immediately. But the critical question was: How, and by whom? The Mental Health Law that had recently come into effect preoccupied every professional present. Article 30 of the law requires that hospitalization should be voluntary, except when the patient has endangered, or has the danger to endanger, herself or another person. Article 28 requires that if a person suspected to have mental illness might endanger herself or another person, then her work unit and the police may assist family members to send her to the hospital for diagnosis. The group agreed that the patient had not endangered others, but had she endangered—or did she have the possibility to endanger—herself? What were the criteria to evaluate that? The group couldn't find an answer in the law.

What resulted from this conceptual confusion was a practical standstill. For fear of the potential charge of psychiatric abuse, no one in the group dared to be the first one to lay hands on the patient. Prior to the law, upon requests by patients' families, psychiatric hospitals had often sent vehicles to "pick up" patients from home. Indeed, the vehicles had been a thread weaving together the "hospital-family circuit" of care. Thanks to lawsuits alleging psychiatric abuse, however, the law now banned hospitals from dispatching vehicles or even staff. So the group debated among themselves who should provide the vehicle that could transport the patient to the hospital. The community police officer present refused to dispatch a police van, claiming that minor troubles at home were not appropriate causes, and that the van could not be driven to the closest psychiatric hospital, which lay outside of the community's jurisdiction. The residents' committee officer said the jurisdiction rule also applied to their car. Finally, the group agreed that if the patient's mother could find a taxi, they could act together to force the patient into the vehicle. In that way, collective liability would mean no liability. The mother did call up a few taxi drivers, offering them extra tips. But as soon as they heard that they were taking a mentally ill patient to a psychiatric hospital, they all turned down the job.

When apparently nothing could be done, the group dispersed, all feeling helpless. Three days later was the Mid-Autumn Festival, a traditional Chinese holiday that celebrates family reunion. On that day, the social workers knocked at the patient's door again, hoping to check in on her and give her a holiday gift basket in order to establish rapport. The patient did not answer the door, so they left. When they were descending the stairs, they heard a loud crash and then people screaming. The patient had just jumped out of the window and killed herself.

I learned of this tragic incident two weeks later, in a meeting called "How to assist patients with severe mental illnesses in communities to gain involuntary hospitalization and appropriate treatment." The meeting was organized by the traumatized social workers at their agency. Participants included the whole group of street-level bureaucrats present during the futile visit to the patient. Besides me, the social workers also invited Dr. Lin Yongqiang,[5] a senior

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[5] In this chapter, I use the real names when referring to people who are publicly known figures in policymaking or human rights advocacy. Pseudonyms are used for other people.

psychiatrist in charge of community mental health at the provincial level, and the famed human rights lawyer Huang Xuetao, who hailed from the nearby city of Shenzhen, and who attended on video chat.

The atmosphere at the meeting was somber. Everyone was frowning, and the room was filled with constant sighs. Ken,[6] senior social worker and director of the center, started the meeting. He compared this tragic incident with patients with whom he had worked prior to the law. In those previous cases, upon learning of the patients' sudden behavioral change, Ken had immediately arranged for them to be sent to the hospital. Timely hospitalization, Ken argued, had improved those patients' conditions, and most of them had since returned home. Ken attributed the different outcomes between the most recent case and those earlier ones solely to the Mental Health Law, especially the barrier that its liberal principle and risk language now posed to families' and professionals' interventions. At the same time, he downplayed other divergences between the cases, such as the fact that the patient who had recently killed herself had not received any services from or established any relationship with the social workers, whereas all the previous cases had. This selective comparison implied that the only options available for the vulnerable and insightless patient were either tragic and dangerous freedom or coercive hospitalization, and that the legal language of risk, by prioritizing patient freedom, made professional interventions impossible.

Lily, a more junior social worker who had also been involved in the suicide case, complained that the law not only did violence to patients, but also made impossible demands on family members, by placing all the burden of patient management on their shoulders. Tearful, with shaking voice, Lily recalled:

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[6] This is the social worker's pseudonym. Because social work in Mainland China, especially in Guangdong, has been heavily influenced by social work in Hong Kong, many social workers go by their English names. The pseudonym is given following this common practice.

> "We thought that the patient might be said to be posing risks to herself. In that case, according to the law, her family members could hospitalize her. But her mother is eighty-some years old, and even her elder brother is already sixty. Meanwhile, the patient was large and strong, 1.65 meters tall, and weighing 75 kilograms. It was just impossible for the family members to single-handedly restrain the patient. The law says we could assist the family, but our understanding was we could only do this when family members took the lead. So we kept asking the mother to talk the patient into taking her meds when she calmed down, or to simply put some pills in the drinking water. But the mother knew from experience that she couldn't persuade her daughter to either take the pills or drink water. So what could we do?"

After hearing the social workers' attack on the liberal-looking law, which Huang had earlier praised as a historic progress, Huang Xuetao spoke up from virtual space, suggesting a solution that was in line with her idea of the mentally ill patient as a self-determining subject. According to Huang, a patient who has been hospitalized before but who is capable of decision making at some later moment should make an advance directive with a lawyer. The directive would list two persons who can consent to treatment on the patient's behalf when he is in a crisis situation and can't make decisions for himself, provided that they are of the same opinion. "With the two persons helping the patient," Huang said, "hospitalization won't be abused by interested individuals. As to when the two persons can step in, that should be decided by a professional. I insist that there has to be this procedure, lest…"

Ken interrupted, as if trying to prevent Huang from turning the workshop into another platform for a human rights campaign. He asked others for responses to Huang's proposal. After a minute of radio silence, Dr. Lin said, "This is a very good suggestion, but the Mental Health Law doesn't have this 'advance directive' clause. As the saying goes, water afar quenches no fire." He argued that because normally there wouldn't be any revisions to a law during its first five years, they had to work pragmatically, within the framework of the law, no matter how imperfect it was. He also said:

> "Even if there were such a provision, we would still have problems. How can you tell that a patient has recovered, and that the advance directive is made with a sound mind? Who is to make that judgment? If it's the judge, he doesn't necessarily understand a patient's medical conditions. If it's the psychiatrist, our lawyer friends will not be happy. I'm afraid that Ms. Huang's suggestion is just hard to operationalize."

Here, Dr. Lin pointed to a paradox lying at the heart of Ms. Huang's liberalism: because the idea of a free, self-determining subject is hinged on the subject's mental capacity, the evaluation of such capacity requires and reinforces the technical authority, with which this liberalism seeks to do away with.

After Dr. Lin's comments, other people simply ignored Huang's proposal of yet another liberal reform, and went back to complaining about how the Mental Health Law banned the psychiatric hospital's "pick-up service" and made professional interventions difficult. Dr. Lin intervened. Assuming the authoritative voice of a policymaker, he explained that depriving a person of his freedom is a power that can only granted by law, and that a hospital is not a law enforcement agency. Then he directed his criticism at the police: "The law says that the police can help, so why didn't the police do their job?"

The community police officer had to defend himself:

> "Well, according to the 686 Program, our job is really just to deal with violent patients who have caused accidents or incidents (肇事肇祸/*zhaoshi zhaohuo*). Our hands are really tied in cases with minor troubles. Even if we do decide to pick up such a patient, what if he injures himself during the process of transportation? Who bears the liability? This solution, I'm afraid, is just too simple. People may want to rely on the police for everything, but there are many things for which it's not appropriate for the police to take the lead."

Ken followed up on the police officer's remark:

> "It's better to use a hospital van, it's designed to save people. In the past, the moment a patient was aboard the hospital van, a doctor would give him a tranquilizer shot, and that made the transportation so much easier and safer. I've accompanied a patient in a police van before. The back of the van was like a prison cage. The family member and I clutched the patient from both sides, while a metal bar was placed between the patient's legs, so that he couldn't move. But that was a really shameful experience for

> the patient, and the bystanders might have thought that he had committed a crime. That's just too much."

For most participants in the workshop, then, the use of police power was and should be saved for the dangerous outlaw, as its brute force was likely to bring harm and stigma to its subject. In this case, it seems that by prioritizing patient freedom and restricting the powers of involuntary hospitalization, making it either family business or a police matter, the law has made it extremely difficult to care for the vulnerable patient, producing in some cases tragic neglect.

The Desire of *Guan*

The above incident, though extremely sad, reflects common practice at the time the Mental Health Law was first implemented. Aware of the continued media outcry over psychiatric abuse, psychiatrists and street-level bureaucrats were fearful of being held liable for wrongful hospitalization. Therefore, they often interpreted the law stringently, taking its language of risk as meaning that the patient needed to display actual or immanent dangerous behavior in order to be involuntarily hospitalized, and they often highlighted patient autonomy as a reason not to intervene. Of course, fear was not the only sentiment in play here. Professionals, especially high-ranking psychiatrists, also sought to overcorrect with the law in order to protest themselves against pressure from human rights activists during the legislative debate. As Dr. Tang Hongyu, a Beijing psychiatrist who had participated in drafting the law, put it: "[When the law gave in to the human rights claims,] we psychiatrists had strong reactions. Now that we can't change anything, we'll carry the law['s liberal principle] to its extreme. Then let's see what will come out of this."

Regardless of their possibly resistant intentions, the professionals' and bureaucrats' unwillingness to intervene and facilitate involuntary hospitalization threatened to break down the institution-family circuit that had previously enabled the everyday practices of psychiatry. In the past, people had regarded the “pick-up service” provided by psychiatric hospitals mainly as a commercial service, but now, its disappearance under the Mental Health Law was taken to symbolize a retreat of the state and its agents. This perceived state inaction was legitimized in the law by its risk criterion for involuntary hospitalization. In the eyes of many family members, this simple criterion failed to recognize the multiple and often hidden vulnerabilities that they and the patients faced. For example, the mother in the aforementioned tragedy had lost access to her own home, which was damage to *her* life. Therefore, the family members of many patients vehemently attacked the Mental Health Law, calling for the state to resume its responsibilities of *guan* by providing medical interventions to patients.

Family members’ criticisms of the law are best captured in the following encounter. In July 2014, Dr. Zhang and Dr. Niu, two young psychiatrists from the Community Department of Guangzhou Brain Hospital (GBH) went to Likang Family Resource Center to educate family caregivers there about the Mental Health Law. After they plainly stated the do’s and don’ts in the law, a family member raised his hand. It was Uncle Gu, a retired low Party cadre. A thin man in his seventies, he was wearing a worn shirt, his gray hair and beard standing up, as if in anger. He loudly questioned the psychiatrists:

> “In the past, we could at least have the patients taken to the hospital, but now we can’t anymore. Why? It’s all because of the Mental Health Law. I’ll be frank. President Xi Jinping has asked us to build a public service-oriented society (服务型社会/*fuwuxing shehui*). Are we really oriented to service? No, absolutely not!”

Dr. Zhang asked Uncle Gu who was sick in his family and what had happened to that person. Gu replied that it was his daughter, who had fallen ill in 2007. At first she was just slightly upset and emotionally unstable, but her condition got increasingly worse. She threw things, shaved her head, and refused to eat. Her siblings urged her to visit the outpatient psychiatric clinic, but she refused to go. Following a friend's suggestion, Gu contacted GBH, trying to arrange for "pick-up service." However, by then GBH and other big hospitals were already wary of potential lawsuits charging wrongful hospitalization, and they refused to pick up people who had never been diagnosed or hospitalized before. Gu then turned to community bureaucrats for help, but they were all unwilling. So the desperate father had to prepare some ropes at home, in case he needed to tie up his daughter, a sturdy adult woman who had been practicing martial arts, and drag her to the hospital himself. He also became tensely on guard and couldn't sleep at night. To his relief, a childhood friend of his who was a senior psychiatrist gave him a bottle of clozapine and told him to put some in the daughter's food. When the daughter was sedated, the friend had a hospital van come to pick her up. But the treatment, according to Gu, came too late for his daughter. Psychiatrists at the hospital diagnosed her with both schizophrenia and depression. They used every drug, but to no avail. In the end, with great heartache, Uncle Gu had to consent to electroshock. "The situation was totally the state's fault!" Gu exclaimed to Dr. Zhang at the family education meeting. "Now that the Mental Health Law doesn't even allow the hospital to pick up previously hospitalized patients, it fucking blocks every one of our options!"

Some family caregivers in the audience echoed Gu's complaints. Dr. Zhang tried to appease the crowd by saying that according to the new law, the police could assist the family in sending the at risk patient for diagnosis. But there was a deeper problem. Many family caregivers present found it impossible to frame and publicly demonstrate patients' vulnerabilities and treatment needs in terms of risks. One of them chimed in to say that her psychotic son had often waved a knife in front of her. "What can you do when he has the knife in his hand 23 hours a day, but when the police are there, he puts down the knife? Remember, these patients aren't stupid; they are cunning!"

"It's too late when we can call the police," Gu said, his voice getting even louder, and his face reddening.

> "What is real public service? It should be actively provided [to us]! Now the law says that oh, we can't seize the patients because many [normal] people have been framed up [as mentally ill and wrongfully hospitalized]. Have the lawmakers counted how many percents of the inpatients have been framed up? You can't let individual cases make a law! And what is being framed up anyway? The hospital can do appraisals, and the state can act accordingly. If you're sick, stay in the hospital. If you're not, go home. If not sure, go to a social work center. The state has many means, and together they can easily solve a problem. But now the Mental Health Law has led every public sector to do nothing!"

Here, Gu imagined "the state" as an omniscient and omnipotent agent. When it acts, it presumably does only good for vulnerable people. Speaking as a person well versed and highly invested in Chinese socialist ideology, Gu went on to connect this benevolent state paternalism in psychiatric care to socialism in general and to the logic of *guan*:

> "The principle of the Mental Health Law is highly problematic. It says that we need to respect the patients' personal freedom except for those that pose risk. Goddamn American-style freedom! Can a person be free? Why don't you try crossing the street freely? Human beings are always under control. Only control can protect your freedom. Now the whole world is democratic, but does that actually work? That's just fake freedom! Chinese socialism is the opposite of that, and that is the real freedom.
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> Because the patient is already controlled by the mental illness, what we need to manage (*guan*) is the illness, not the person. It is for the protection of the person's freedom that we manage the illness. That's basic logic! Now the Mental Health Law says that patients should be able to go in and out of the hospital freely. Great, so people [doctors, police, community officers, etc.] just don't need to be concerned with (*guan*) patients anymore. And our society has disintegrated."

Here, Gu sounded like the psychiatrists who had drafted the law, whose viewpoint I discussed in Chapter 2. They all saw socialist paternalism as superior to capitalist freedoms, which, by demanding that people fend for themselves, have only exacerbated people's vulnerability and increased social disorder. Adopting the psychiatric discourse that I detailed in Chapter 3, Gu also saw mental illness as an entity separate from the patient's being but jeopardizing the latter, and thereby in need of psychiatric control and management. Yet unlike the leading psychiatrists, who had remained vague about where the paternalistic responsibilities should lie, and who had in effect relegated most responsibilities to patients' families, Gu unequivocally assigned the responsibility to the state and its various agents. In other words, for Gu and the other family caregivers who echoed his opinion, the state should provide *guan* to the mentally ill in the form of paternalistic, biomedical, and institutional interventions. As Gu implied, whether the state and its agents could shoulder such *guan* is a crucial index of the cohesion of the socialist body politic.

Finding it too difficult to appease the crowd, the two psychiatrists quickly found an excuse to leave the meeting. Later they admitted to me in private that they mostly agreed with the family members' criticisms of the law, but that as lowly professionals, they could do nothing to change the situation. In the first days of the Mental Health Law's implementation, there was thus a consensus among most family members, psychiatrists, and street-level bureaucrats, calling for the state's participation in or at least facilitation of *guan* in the form of allowing and enabling involuntary hospitalization. Yet this call for biomedical and institutional *guan* drowned out some other voices. During that particular family education event at Likang, a woman also raised her hand, trying to tell the psychiatrists her vision of *guan*. She said that mental illness, at least her son's, resulted from social pressure, and that she hoped the law could provide more services to comfort and support the patients. Yet the psychiatrists didn't respond to her comments, and her voice was soon lost amidst others' clamor for easier access to hospitalization.

Adjusting Risks, Adjusting Responsibilities

Let’s go back to the meeting about the suicide case. At that time, four months after the Mental Health Law had come into effect, Dr. Lin had already heard many complaints about it. At the meeting, he first took the stance of an authoritative policymaker, explaining the principle of personal freedom underlying the law’s stipulations on hospitalization. However, given that the goal of the meeting was to find pragmatic solutions to the restrictions the law posed to medical interventions, he quickly assumed the role of an experienced psychiatrist, exploring for the audience how the law—especially its risk criterion—could be circumvented, reinterpreted, or bent. Starting from the case at hand and subtly recasting it as a kind of hypothetical, Dr. Lin said:

> “Is she at risk of harming herself? Well, we know that she hasn’t contacted her family for several days. And she’s completely disheveled when we enter the apartment. I guess she hasn’t even eaten for quite a few days. This suggests that she is completely unable to take care of herself, and is at risk of starving herself to death. Simple as that.”

According to Dr. Lin, the law only provides a broad framework for risk evaluation, and the details need to be waked out in practice. In cases of mental illness, a seemingly minor act such as a verbal threat might have grave consequences. Therefore, Dr. Lin contended that the application of the risk criterion should be loosened to allow for more timely interventions. Some participants raised the concern that they might face legal liabilities if they interpreted the law at will or too freely. In response, Dr. Lin called for a sense of moral responsibility for *guan* that transcends legal dictates and any “selfish” concerns:

> “Now that this serious incident has already happened, it’s time for us to stop passing the buck and to examine whether we could push ourselves a bit further. There are many legal standards which, when read literally, prescribe no obligations for us at all. But we all know the consequence of not intervening (*guan*).”

Reflecting on his three decades of psychiatric practices prior to the Mental Health Law, he continued:

> "I don't even remember how many times I was dispatched to pick up a patient. Nobody said it was our [psychiatrists'] responsibility. We did this at our own risk, all simply out of our professional passion and compassion for the patient. Now you guys said that there are all sorts of problems and potential liabilities in using the police van. But do you know, I was also chased and beaten up by patients when I went to pick them up? Every time we dispatched a car, we also worried about whether there was enough staff going, and about what we should do to restrain the patient without injuring him. It's all the same! You might ask why I couldn't just pay to have the doctors come, but frankly, as you see, even a taxi driver wouldn't do it just for the money."

After speaking as a grassroots psychiatrist and appealing to the moral responsibility of other frontline personnel, Dr. Lin put on the hat of a policymaker again, this time to reassure people that no liability would ensue from their actions, provided that they followed some simple strategies. That is, when everyone from relevant community departments is present, and when they act in concert to wrestle the patient into the vehicle, they in effect endorse each other's judgment that the patient is at risk. Moreover, Dr. Lin suggested transposing the risk evaluation mechanism already existing in the community mental health program to hospitalization practice under the Mental Health Law, so as to give the latter an institutional backing:

> "As a community mental health doctor, you need to evaluate a patient's risk level during regular home visits anyway. So why can't you evaluate his risk on the spot [so that people can act based on your evaluation]? Isn't the purpose of our risk evaluation to prevent dangerous accidents and incidents?"

Dr. Lin's moral call reflects an ethic of *guan.* It requires one to respond to another being's suffering, to go out of one's way to intervene in the more vulnerable life, even at the cost of making oneself vulnerable.[7] However, by loosening the interpretation of the risk criterion in the law, and especially by connecting it to the risk apparatus in community mental health, Dr. Lin at least inadvertently was reshaping the ethics of *guan*. As human rights activists struggled for it, and as people commonly understood it, the risk criterion was inscribed in the law in order

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[7] Readers might be reminded of Emanuel Levinas's idea that ethics stem from engaging with and suffering for the vulnerable being, the person undergoing useless suffering. See (Levinas, 1988). For an anthropological use of Levinas's theory, see (Throop, 2010).

to safeguard the patient's personal freedom by marking its boundary. Yet by linking this concept of risk as the boundary of individual autonomy to the risk surveillance mechanism in community mental health, the implementation of the Mental Health Law is made to reinforce the security logic of community mental health, which seeks to protect public security by monitoring and intervening the life of the abnormal subject. *Guan* again becomes a form of security management. In particular, by calling for a risk-based intervention coordinated across different agents, the procedure Dr. Lin proposed could make *guan* as security risk management more overwhelming and less escapable for the patients being managed.

Dr. Lin's call for more courageous intervention was soon taken up by professionals and bureaucrats involved in mental health care throughout Guangzhou. They improvised ways to loosen the risk criterion, so that they could assume the moral responsibility of providing medical interventions without facing any legal liability. And some of their improvisations were routinized or even institutionalized in everyday psychiatric practice. As of late 2013, the Guangzhou Municipal Center for Disease Control stipulated that if a community mental health worker determined a patient's risk level to be at or above 3 on the 0-5 scale, then the police could legitimately assist the family in hospitalizing the family. Note that risk level 3 refers to destructive behavior aimed at property, and that injuries to self or others only appear at risk levels 4 and 5. So the transposition of the community risk surveillance mechanism into practices of involuntary hospitalization has helped to lower the threshold of hospitalization and increase the public sectors' involvement in it.

While the risk criterion in the Mental Health Law was written in a decidedly non-medical language, professionals now used medical information to interpret it and to broaden its expanse in practice. For example, psychiatrists in and beyond Guangzhou began to commonly interpret risks to self as including inability to take care of oneself, apparent impairment of health, refusal to eat, suffering from cold, and perversion of the will. Moreover, having a certificate of mental disability or a history of mental illness was now taken by many professionals to be a proof of risks. Families could commit patients having these characteristics, and could ask public sector agents for assistance. Meanwhile, in expanding the coverage of the risk criterion, professionals and bureaucrats have translated it and registered it in the logic of biomedical management.

Besides broadening the definition of risk, many psychiatrists now treated risk as a post hoc measure to be established after hospitalization, instead of following the reversed order as required by the Mental Health Law. Under the law, doctors at GBH were required by their administrators to fill out a risk evaluation form for every patient, whether admitted under the new law or not. The form was quite short, including only some obviously harmful states such as suicide, injury of oneself, dangerous behavior, wandering, syncope/falling, and dysphagia.[8] So initially some psychiatrists matter-of-factly responded no to every item on the form for certain patients. Yet in a regular roundtable discussion on how to improve medical record writing, the director of a ward picked up a record on which no risks were indicated, and yelled at his subordinates: "How can a newly admitted patient have no risks? On what grounds did we hospitalize her?" The psychiatrist on that case responded that the patient's family had sent her here simply to improve her condition. "Well, that just doesn't work under the new Mental Health Law," admonished the director,

> "We normal people have risks too, like being run over by a car. So how can a psychiatric patient not have risks? When you receive a new patient, just write down some risks, any risks, restrain her physically, and ask the guardian to sign the informed consent. You know, we do this to protect us doctors, and the society."

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[8] Syncope and dysphagia are some of the most severe side effects brought on by long-term and large dosage use of antipsychotics.

As the director put it, manufacturing risks on paper is necessary in order to protect doctors from potential charges of psychiatric abuse. Interestingly, although risks written on the medical records might be manufactured, not necessarily having immediate referents in the particular patients they are supposed to describe, they are not empty scribbles. As the director implied, everyone is to some extent at risk, (which might already require some cautious management,) and the psychiatric patient population as a whole has greater risks of some sort, that is, risks of doing violence to society. By enabling involuntary hospitalizations, risk manufacturing could protect society from these very *real* risks of violence. Here, we can see that risk manufacturing as a bureaucratic tactic enables an ethical action, and the ethics in turn are shaped by and reinforce a socio-technical imagination of mental illness and risk management. This imagination takes any distant potentiality as a pressing reality, seamlessly translates between a particular patient and patients in general, and seeks to produce an absolutely secure life "to which nothing happens" (Castel, 1991, p. 289).

Besides manufacturing risks on paper, professionals have also taught families to implicate patients in risky behaviors. When I followed community doctors to their home visits, I occasionally saw the doctor suggesting to the desperate caregiver: "Well, if the patient smashed things, the police would definitely intervene, right? So you just need to smash something worthless at home and tell the police that it was the patient who did it." Few families would follow this extreme advice and blatantly lie in front of the patient, for fear that the patient would angrily take revenge after being released from the hospital. Yet many families did, upon receiving psychiatrists' suggestions, search for the slightest hint of risk in patients' life and figure out how to make it look serious enough to qualify for commitment. For example, when committing his bipolar father, a young man told the resident psychiatrist that his father had recently bought a kitchen knife and waved it in front of him. But when I later interviewed the father, he said that he had merely replaced the old, blunt knife, and that even if he were to threaten his son with the knife, it would hardly be possible, because they did not live together. My point here is not about who was telling the truth. Rather, I want to highlight the fact that by requiring family members to register their need for hospitalizing their loved ones in the language of risks, the Mental Health Law in practice has led to a proliferation of risks reported and perceived by family members.

Perhaps thanks to all these tactical adjustments by professionals and families, by the end of 2013 doctors at GBH and other smaller psychiatric hospitals in Guangzhou told me that the number of inpatients remained roughly the same as that before the Mental Health Law came into effect. In fact, they noted that in some districts, the police were now more active in assisting families during patient commitment, and that they had adapted some measures of coercion, making them less stigmatizing or harmful to the patients, such as using handcuffs made with softer materials. However, as the last section shows, as of mid 2014, many family members were still complaining about the Mental Health Law. It suggests that how the law is implemented varied from case to case, from locale to locale, depending on the particular ethical orientations, practical concerns, and flexible adjustments made by professionals and bureaucrats. We could thus say that under the (neo)liberal language of the law, family members have increasingly become supplicants of the state and its agents for caring interventions. Whether their supplications are heard, and whether they can secure the hospitalization service they believe they need for their loved ones, depend on how well they—or the professionals/bureaucrats helping them—can couch their requests in the legal language of risks, which now conjoins the biomedical and security logic of risk management.

Trying Discharge

The Hope for Freedom

Because of its liberal appearance, many people initially took the law to mean that a large number of psychiatric inpatients could just go home whenever they wanted. This interpretation stirred some fear in the general public, as some people were worried that without proper management, patients might run around committing violence. Yet other people, including some leading psychiatrists, saw it as good news for long-term inpatients. In Chapter 3, I mentioned that family members who lost hope in patients would sometimes choose to put them in the hospital for an indefinite period, even expecting that this hospitalization would last for the rest of their life. This phenomenon of long-term hospitalization had largely been ignored in the mental health legislation debates, as human rights activists had devoted most of their critical attention to cases of putatively normal people being falsely hospitalized, or "being mentally illed."

However, immediately after the Mental Health Law came out, a few leading psychiatrists started to reveal to the media the existence of this "hidden" population of long-term inpatients. For example, the director of Anding Hospital in Beijing reported that out of the 800 inpatients of the hospital, over 100 of them were long-term patients; the longest stay had been 25 years (R. Zhang, 2013). In fact, in some county hospitals that I visited, this proportion was often much higher, sometimes going up to 50%. According to the psychiatrists who deliberately disclosed this phenomenon to the media, these patients had largely been stabilized by medications, and it was felt they could function in the community. In a survey done by the staff at a Beijing psychiatric hospital in May 2013, 180 inpatients out of the total 300 in the hospital wanted to go home, and among them 150 were considered to be in stable condition. The main reason they couldn't go home, the psychiatrists argued, was because of the stigma in their communities and lack of acceptance their families. The new Mental Health Law would give these patients a means of redress. As Dr. Tang Hongyu from the Beijing Mental Health Institute argued, they or their hospitals could even use Article 9 of the law, which forbids the family from abandoning the patient, to sue their families for “abandonment” (R. Zhang, 2013).

Just as the psychiatrists were beginning to talk about long-term patients, human rights activists started to take action for them as well. On May 6th, 2013, with the help of a few lawyers including the famed Huang Xuetao, Xu Wei,[9] an inmate in a psychiatric hospital in Shanghai, filed suit against the hospital and his guardian, asking to be released. Wei, a 47-year-old man, had been staying in that hospital for 13 years. According to him, he had traveled to Australia for work and to learn English when he was 23. In order to help pay his tuition, he tried his luck at a casino, where he gradually became addicted to drugs. Later when he was refused a visa to stay, he came back to his father’s home in Shanghai in great frustration. He started to feel that he was being followed, so his father and an elder brother sent him to the district mental health center, where he was diagnosed with schizophrenia and kept for a year. Soon after he got back home, he got into a petty fight with his father over work-related issues. He pushed his father and accidentally scratched the latter’s face. His father then had him committed again, this time at the run-down hospital where he would stay for over a decade.

In the segregated environment of the hospital, the desperate Xu Wei initially tried to kill himself by jumping out of a fifth-floor window, but that only gained him bone fractures. Fortunately, he soon fell in love with a female patient at the hospital. In order to have an intimate life together, when they were let out to buy groceries for the hospital one day in 2011, they tried

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[9] This is a pseudonym of the plaintiff that has been universally used by his attorney, other activists, and journalists. Xu Xing, the name used to refer to his brother/guardian, is also a pseudonym in media records. I refer to them by the given names of their pseudonyms in order to distinguish the two brothers.

to escape. They ran as far as to the city's train station, where they were intercepted by the hospital staff. After their failed escape, the hospital held a meeting with Wei's guardian and representatives from his residents' committee. By that time, Wei's father had passed away, and one of his elder brothers, Xu Xing, had become his guardian. At the meeting, both the hospital staff and the resident committee representatives suggested that Wei's condition was stable and that he could live at home. Yet the brother steadfastly rejected this suggestion, saying that he had no time to take care of Wei, and that he'd better not leave the hospital. The other parties felt that they could do nothing but to respect the guardian's decision.

In another attempt for release, Wei tried to change his guardian. The brother, Xing, had been doing business far away in South China, and he seldom visited Wei. Even Wei's hospitalization was paid for with his own medical insurance and welfare benefits. However, Xing's constant opposition to his release made him suspect an ulterior motive: they had together inherited their father's house, for which Xing was collecting rents, so Xing probably didn't want to share the profits with him. Wei thus asked other relatives, who presumably didn't have a vested interest in his hospitalization, if they were willing to step in and become his guardians. His mother, who had left the family three decades ago after a divorce, said yes, even filing a request to the district court in early 2012. The court turned down her request, citing her advanced age as a concern.

Wei did not give up. Searching the internet with his smart phone, he found Huang Xuetao, and the latter put him in touch with a local Shanghai attorney. Six days after the law came into effect, the attorney helped him file what the media called "the first trial under the Mental Health Law." Yet the court immediately refused to take the case. As the attorney later recalled, a staff member of the court simply told him, "A psychiatric patient filing a lawsuit? We can’t take it.” After this failed encounter, the attorney filed an appeal, and Wei began sending a petition letter to the court each day. Perhaps thanks to this unrelenting pressure, in Sept. 2013, the district court changed its decision and took the case. In the pre-trial mediation process, the court asked a forensic center to evaluate Wei’s mental status and legal capacity. The center refused to take on the job, stating that the evaluation would need to be approved by Wei’s guardian. Obviously, as a defendant in the case, Wei’s guardian—his brother—would not approve. After some further negotiations, the court finally decided to directly move the case to trial. Given that this was probably the first time a psychiatric patient in China ever stood on trial as a plaintiff, Wei and his supporters saw signs of progress, and were full of hope.

The Quagmire of Long-Term Hospitalization

For Huang Xuetao, Xu Wei’s case was a simple human rights violation. She saw Wei as perfectly capable of self-determination, functioning well in everyday life, and having almost no need for professional support. He even had the economic means (savings and disability benefits) that would allow him to live independently from his family or other caregivers. What his discharge—and the discharge of similarly competent patients—required was only the court’s recognition of psychiatric patients’ legal right to autonomy.

Most of the psychiatrists I encountered felt uncomfortable about long-term hospitalization, but the reasons for their discomfort were complicated, having a lot to do with their sense of professional interest, expertise, and ethics. These sentiments, as I have discovered, significantly shaped psychiatrists’ practical responses to long-term hospitalization.

Rather than constructing long-term hospitalization as violating patient rights, psychiatrists merely saw it as medically unnecessary for patients whose conditions were stable or in remission. Life in hospital could would even damage patients' social functioning, depriving them of opportunities to form meaningful social relations. Some leading psychiatrists thus publicly expressed deep sympathy for those patients' suffering (G. Li, 2013). It was troubling, moreover, for many psychiatrists to face the same patients at work year after year, whose conditions they could not change. Some psychiatrists complained to me that compared to doctors in other specialties, whose jobs could often make a difference for patients, their sense of job satisfaction and career achievement was much lower.

These moral sentiments were entangled with economic calculations, which varied across locales and institutions. For leading psychiatric hospitals located in urban centers, the large number of long-term inpatients led to a low rate of hospital bed turnover and reduced profit. As the vice director of Beijing Anding Hospital once told the press, during 2007-2012, the hospital received 40,000 fewer new patients than it should have, because those precious beds were occupied by long-term inmates. The director put it as a matter of health disparities: while there are 16 million people with severe mental illnesses in China, very few of them can receive the inpatient treatment that they need, while those who don't really need the services stay on forever (F. Zheng, 2013).

However, what the director of Anding didn't openly mention, and what many psychiatrists in urban hospitals acknowledged during my interviews, is that the low turnover rate also made the hospitals' income decline. For patients in the acute phase, doctors can legitimately prescribe expensive patent drugs and diagnostic examinations (such as MRI scans), even going much beyond the public medical insurance coverage. At GBH, for example, doctors usually recommend a three-month course of inpatient treatment for acute patients. In 2013-2014, the first month of treatment normally cost about CNY 10,000-20,000 (USD 1,500-3,000), and the subsequent months normally cost about CNY 6,000 (USD 1,000) each. In contrast, after many years of trying different medications to no avail, long-term inpatients often only require cheap generic drugs (especially clozapine) and regular blood tests. Any charges beyond what's covered by public medical insurance may run the risk of either generating complaints from the families, or not receiving payments from them. In GBH, the monthly bill for a long-term patient in 2013-2014 was usually about CNY 3,000 (USD 500), plus moderate food expenses that had to be paid by the family. In a few hospitals that I visited in Guangzhou, doctors mentioned that in the 1990s and 2000s, guardians of some patients had signed a contract with the hospitals. According to these contracts, guardians would pay the hospitals a lump sum (from as low as CNY 10,000 or about USD 1,250 at that time), and agree to transfer part or all of the patients' future pensions and/or medical insurance to the hospitals; in return, the hospitals would look after the patients (some as young as in their twenties) for the rest of their lives. While the lump sum might have seemed a lot in those days, in some cases boosting the hospitals' initial development, it was quickly used up in the inflationary economy. As a result, some hospitals were now going into debt from providing room and board or extra medical treatments for those life-long patients.

Under such economic conditions, staff at urban hospitals that have large customer bases naturally feel uneasy with the need to care for long-term inpatients. Yet in the small rural or peri-urban hospitals, which do not have many local customers or the glamor to attract high-end clients from afar, long-term inpatients and their public insurance payments sometimes become an economic lifeline. Staff from these institutions whom I interviewed tended to be more ambivalent about long-term hospitalization. Certainly, they recognized the misery of patients being stuck within walls forever. Yet rather than advocating for their release and for resources to be invested in the community, they often asked that more government subsidies be made *to* the institutions, so that they could provide more services for the inpatients. My brief visit to the hospital where Xu Wei stayed, as well as my interview with him, suggested that it was also a lowly peri-urban hospital that mostly housed long-term inpatients like him. The hospital mainly survived on their welfare.

For the state, there is yet another slightly different economic calculation, coupled with a slightly different ethics and politics. This was best revealed in a presentation by Dr. Yu Xin, director of the Peking University Mental Health Institute, in a global mental health panel in the 2015 conference of the Society for Psychological Anthropology, held in Boston. Speaking with and to a roomful of U.S.-trained anthropologists who are famous for their critical attitudes and reflexivity, Dr. Yu also adopted a critical voice in talking about China’s mental health policy. He pointed to “longer hospitalization and higher readmission rate” as one of the biggest problems in China’s mental health system. The reason for it, he argued, was that as the state sees it, it is very expensive to provide publicly funded community-based mental health care. In contrast, “putting them in the institution is cheaper and more secure for the patients as well as for the society.”

However, the post-socialist state does not simply seek to limit its spending as much as possible. It does invest in mental health care. Dr. Yu told the audience that the largest psychiatric hospital in Asia had recently been built in China, equipped with over 3,000 beds; and in a small county in Guangdong, a hospital with 800 beds had been built, which was much bigger than what the county needed. This, according to Dr. Yu, was all because when psychiatrists presented the number of psychiatric hospital beds per capita in China and showed that it was much lower than in Euro-American countries, the state leaders were very upset and decided to “catch up.” Dr. Yu thus humorously diagnosed the Chinese government with a “ranking syndrome,” that is, being obsessed with its various rankings—from GDP to student test scores, and now to psychiatric hospitals—in the world.

As revealed by Dr. Yu's remarks, the Chinese state's investment in building more psychiatric institutions reflects its commitment to a developmentalist modernity, that is, taking Euro-American countries as the natural end points of modernization and developing China toward the numerical standards that foreign nations have set. In investing in total institutions, this desire is coupled with the state's security concerns. When the giant new hospitals built by the state face pressure to find and retain patients, these institutions' economic dependency on long-term hospitalization, as well as their ideological endorsement of it, will most likely be reinforced.

Amidst this intricate web of economic interests, developmentalist desire, security concerns, and moral sentiments expressed by these different but related agents, even the leading psychiatrists' attitudes toward long-term hospitalization have become complicated and ambivalent. As we have seen, human rights activists presented long-term inpatients like Xu Wei as people who wanted to live independently and were capable of doing so. In contrast, the long-term inpatients whom leading psychiatrists portrayed in the media long for home, and they need the loving care and loose (but not nonexistent) monitoring provided by family members, rather than prolonged confinement in the hospital. Those psychiatrists thus strongly condemned families who had left patients in the hospitals, seeing them as refusing their natural responsibilities of *guan*, and as having committed the crime of abandonment. On the other hand, the psychiatrists also expressed sympathies for the vulnerabilities family members experienced when caring for patients at home. Long-term hospitalization, the psychiatrists concurred, was often a more viable option for families. After all, it provides a more professional form of patient management (*guan*), one that can protect not just the family but also the society from potential patient violence. In the psychiatric logic, then, the hospital and the family together constitute a circuit of *guan*, in which the patient should be constantly cared for and managed. While the degree of coziness of *guan* may differ, it ultimately does not matter where the patient is placed along this circuit, as long as the efficacy and efficiency of *guan* is ensured.

Back to the Status Quo?

On Apr. 14, 2015, I was waiting online in Chicago, virtually together with Huang Xuetao, her colleagues, and other supporters for Xu Wei from different parts of China, for the court's adjudication of Wei's case. I hadn't been able to attend the trial sessions, because most of them had been held after I concluded my on-site fieldwork and went back to the States in July 2014. However, the signs that I had gathered from Huang were hopeful: although Wei's brother hadn't bothered to show up in court at all, the judge had seemed supportive of Wei, not only by unprecedentedly agreeing to hear the case and allowing him to appear in court, but also by sending court officials to visit other relevant people—Wei's mother, another elder brother, and the residents' committee—to see if any of them would like to be the guardian instead and to endorse Wei's discharge.

While I didn't, and still don't, necessarily agree with every aspect of Huang's campaign, at that moment of waiting, I was probably as anxious as she and other people in the online group were. The desperation of countless long-term inpatients whom I had encountered during fieldwork had been weighing heavily on my mind. Since the passage of the Mental Health Law, a few patients had asked me to help them get out of the hospital through legal means. Having failed to find such means myself, I now hoped that the verdict for Wei's case could open a door for those desperate patients.

At about 5pm Beijing time, the news came out. Xu Wei lost the case. According to the verdict, during the investigation, the hospital and Wei's two brothers had all emphasized Wei's violent behavior in the past, especially his minor fight with his father 13 years before. This despite the fact that over the last few years, Wei's risk level recorded in hospital records had always been 1 on a 1-5 scale, that is, "making verbal threats or screaming, without actual damage to any object or person." This risk level was not zero, but it was much lower than 3, the bar commonly set by many psychiatrists for involuntary hospitalization under the law. (In fact, the continuous assessment of 1 was itself suspicious, reminding me of how some psychiatrists I observed manufactured risks in order to justify the hospitalization.) Also, as was noted in the verdict, the court had investigated other stakeholders' willingness and capability to become Wei's new guardian, implying that he could have been released as long as some kind of guardian would be responsible for managing him outside the hospital. Unfortunately, his mother had by now converted to a monastic order, his other brother had said no with the excuse of an illness, and the residents' committee claimed that they simply couldn't afford to provide one-on-one management of every patient in their jurisdiction.

As the verdict shows, the hospital's attorney defended its decision to keep Xu hospitalized by scaling up the case of Xu to a matter central to the guardianship system and public security:

> "There are more than 200 patients in our hospital, and much more throughout Shanghai. If every involuntarily hospitalized patient could file suit and get discharged regardless of the guardian's opinion, then that would create a huge problem for the security of the whole society."

In other words, as the hospital saw it, Xu Wei might well be qualified to be released, but the precedent[10] that his release might set for countless other patients should be avoided at all costs. Otherwise the raison d'être of psychiatric institutions in China—managing the patient jointly with the family—would be jeopardized.

After reviewing the trial process, the verdict then stated as a judgment that, as a patient with schizophrenia, Xu had limited legal capacity, and should be constantly managed (*guan*) with regard to his medications and his everyday life. His guardian had both the responsibility *and* right to arrange for such management. Given the family's circumstances, hospitalization was an appropriate way of management, and thus the guardian had *fulfilled* his responsibility by placing him there. The verdict further stated that although the Mental Health Law granted voluntary inpatients the right to request discharge at any time, Xu had been *in*voluntarily hospitalized, and thus could not enjoy this right.

Figure 5.1 Attorney reading the verdict to Xu Wei at the hospital gate
SOURCE: Hing-Yi Cheung

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[10] The Chinese legal system follows the continental law tradition, rather than the common law tradition. That is, tried cases are not regarded as binding precedents. In effect, however, high-profile cases do have influences on subsequent cases. This is partly why Xu Wei's case received so much media attention.

The whole online group was shocked by the verdict. The activists of course found the court's assumption that any patient with schizophrenia needs constant management to be highly problematic. And we all agreed that the risk logic in the law had created a loophole, which the court had exploited in this case: if a patient is committed because of his one-time risky behavior, he will always be seen as a risk, and his fate will forever be determined by his guardian (or the police).

Apparently, people involved in policymaking also felt bad for Xu Wei. Soon after the verdict came out, Dr. Liu Xiehe, the founding father of the Mental Health Law, told the press that the plaintiff lost the case merely because he had sued the wrong party; that is, he should have sued his guardian for abandonment, not the hospital for violating his personal freedom (Y. Cheng, 2015). However, those of us in the online group found this comment to be ironic. After all, hadn't the court just decided that Wei's guardian had been fulfilling his responsibility all along? It seemed to us that as long as the judicial system defines the patient as an object that needs to be managed, it is impossible to distinguish whether institutionalization counts as responsible management or as abandonment. Moreover, when long-term hospitalization is only seen as a result of *familial* abandonment, there is no space to question the broader political economy that has allowed total institutions to feed on the long-term hospitalization of patients, or to ask what other kinds of support should be provided for patients and their families. Indeed, in Xu Wei's case, it seemed to us that everyone—not just his family—had abandoned him, in the sense that they all refused to be concerned with his desires, happiness, and wellbeing.

The dramatic change in the court's attitude made Huang Xuetao suspect that external political influences had been at play.[11] No one from outside the court—certainly no one in our

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[11] More concretely, Huang suspected that the adjudication committee of the court had been working behind Xu Wei's case. The adjudication committee, as I came to learn, is an internal mechanism of a

online group—could confirm this suspicion. However, Huang's thoughts reminded me of the subtle change that I had observed in the attitude of some leading psychiatrist-policymakers toward long-term hospitalization. Back in June 2014, at a conference in Beijing, I spoke with a psychiatrist who was also an appointed mental health expert of the Ministry of Health. We had known each other for a while, and he had long presented himself as a strong advocate of developing community mental health in China. During break time, I asked him whether it might be possible for a few long-term inpatients to live outside together in a rental apartment, with regular visits by social workers—a dream of some inpatients whom I had interviewed. "No way," he responded steadfastly. "The government is concerned with protecting the society rather than protecting the patient. If nothing bad happens with such group homes, that's fine. But if anything goes wrong, who carries the liability?" Puzzled by his attitude, I mentioned Xu Wei's case, as well as the patients who had requested my help in order to get out of the hospital, asking him what one should/could do for them. "You can't openly help them," he said, "you might do that under the table. But I tell you, the law [about discharge] won't be loosened up."

I am certainly not suggesting that the psychiatrist was involved in Xu Wei's case, or that he or any other leading psychiatrist had the power to determine the way in which the Mental Health Law was implemented. The psychiatrist might have seen himself as simply describing the workings of the state's security concerns, and kindly advising me to play along with them. He might even see security concerns as constraints affecting his own community work. However, by

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Chinese court. It is usually composed of the president, vice presidents, chief judges, and associated chief judges of the court, but the specific membership is designated by the people's congress at the corresponding level. Its job is to review any case deemed to be complicated and/or of major social or legal consequences, and to give advice to the presiding judge. Legal scholars have argued that it is through this structure that the will of the party or other government sectors infiltrate the supposedly independent legal process. Because of the long drawn out process of Xu's case, Huang suspected that the adjudication committee had been involved, bringing in political considerations beyond the case, and putting pressure on the supportive judge.

giving in to the perceived constraints, and by advising others to follow the status quo, he, as well as other leading psychiatrists who were involved in policymaking, at least inadvertently reinforced not only the security state apparatus, but also the economic interests of many psychiatric institutions. It is under such discursive, political, and economic conditions that Wei's discharge (and all those that might have followed its precedent) was made impossible. And as these conditions become entrenched, the psychiatrists who initially clamored for the release of long-term inpatients have become increasingly reticent. When I revisited hospitals in Guangzhou in Summer 2015, patients told me that things had gone back to what it had been in the old days: nobody educated them about the Mental Health Law any more, and when they mentioned their hopes for discharge, the staff would diagnose them as having a mood swing, a relapse.

Conclusion

When the Mental Health Law was passed, people were either hopeful or afraid that it would make many mentally ill patients free from the constraints/care of hospitalization. Such hope and fear made sense. After all, the law was a product of a fierce debate between psychiatrists and human rights activists who championed patients' rights to autonomy and self-determination, and the latter group seemed to have come out having gained an upper hand. Many media reports hailed the law's "no risk, no involuntary hospitalization" principle as a historic progress. However, after some initial destabilization, practices of hospitalization and discharge under the Mental Health Law seem to have gone back to the status quo: the number of patients being involuntarily hospitalized has not decreased, and most of long-term inpatients still remain behind bars. Does it mean that the Mental Health Law as a liberal(izing) reform has failed?

This question, I suggest, is based on a false premise, that is, an absolute separation between law on paper and law in practice, as well as a valuation of the former over the latter. As I mentioned at the beginning of this chapter, although law is often a normative response to moral controversies, as a textual form it is often quite abstract. This is very much the case with China's new Mental Health Law. Its language of risk or "danger to endanger" can encompass multiple ways to calculate the future and to guide present actions. In fact, as policymakers continue to refuse issuing any bylaws explaining the terms in the Mental Health Law, this vagueness is very likely there by design. Rather than seeing the implementation of a law as either following the law's spirit or deviating from it, we should consider law in practice as concrete and socially embedded realizations of the potentialities of law as text. The dialectic between law in practice and law on paper, then, produces generative effects that reorganize the social.

What are the effects of the Mental Health Law in practice? A major effect is the renegotiated relationship between risk, responsibility, and vulnerability. Chapter 2 showed that the post-socialist imagination of personhood, as revealed in the mental health legislation debate, is shaped by a divide between the normal individual holding to the right to autonomy and the pathological subject with the right to health imposed on him. The Mental Health Law in practice has entrenched and reworked this divide by allowing different ways to interpret risks. On the one hand, when psychiatric professionals and street-level bureaucrats read the risk criterion stringently for fear of liability, patients' autonomy and self-determination is highlighted. Yet this has often become an excuse for professionals and bureaucrats to refuse any responsibility for engagement, which could result in tragic neglect of patients and their families. On the other hand, when people read the risk criterion loosely, even manufacturing patient risk, they—meaning not just patient's families, but also psychiatrists and bureaucrats—can assume more responsibility for patient care without fearing liability. However, tethering responsibilities and risks in this way means that patients' vulnerabilities can only be framed as risks to themselves or to the public, and that such risks can only be managed institutionally and biomedically. Other ways to engage with patients' vulnerabilities, wellbeing, and happiness have thus been denied, or not even imagined.

Relatedly, the implementation of the Mental Health Law has remapped the relationship between the family, the psychiatric profession, and the state. Under the law, families and other stakeholders have to express their desire to hospitalize patients in terms of risk management. Therefore, although the number of patients committed has remained the same, one could argue that the law has made people, especially patients' families, more inclined to perceive and present patients as risky subjects. Given the elasticity and at times unpredictability in the way professionals and bureaucrats—both perceived as state agents—interpret the law, family members like Uncle Gu have come to see inpatient care as a public good arbitrarily granted or withdrawn by the state, although families are the ones who pay for it or arrange welfare resources for it. They have thus come to imagine themselves as supplicants to a powerful state (D. Davis, 1993). Indeed, with its security concerns and developmentalist dream, the state has been investing in building more psychiatric institutions. Many of these institutions, in turn, feed on the long-term hospitalization of patients, which reinforces the risk management logic and families' desire for inpatient care.

While this traffic of responsibilities may seem clear-cut, the implementation of the Mental Health Law has in fact generated many ambivalences, ambiguities, and paradoxes. We have seen how, in restricting involuntary hospitalization and public sector intervention, the emphasis on patient autonomy can border on neglect. We have also seen how the political economy of institutional care, as well as their visions of psychiatric expertise, has made psychiatrists—even the putative reformers in favor of community mental health—extremely ambivalent about the discharge of long-term inpatients.

Moreover, under the Mental Health Law, a paradox of *guan* that was already lurking in the hospital-family circuit has come to the fore. In Xu Wei's case, the court's verdict stated that Wei's guardian had already fulfilled the responsibility of *guan* by hospitalizing him. In the online discussion that I participated in, some of Wei's supporters found this claim to be ironic. For them, the problem was exactly the opposite, that is, "nobody wanted to *guan* Xu Wei." Wei, I was told, shared this view as well.

The diversion here, I argue, came from two different and even contradictory ethical visions of *guan.* On the one hand, as the court saw it, a seriously mentally ill patient is a chronically risky subject in need of constant management, and *guan* in this vision refers to such risk management or control. The healthcare structure in the reform era has made the total institution and the home the two primary sites of management. The Mental Health Law has confirmed the rights and responsibilities of patients' families to determine how patients should be managed. So long as the latter's risks to their own biomedical normality and to public security are kept under control, their families' decisions in terms of where to place them and how to manage them have become a matter of ethical and legal indifference. On the other hand, for Xu Wei and his supporters, the invocation of *guan* signifies another culturally entrenched ethical imagination. It hinges upon intimate affects and relations. Such relations may be hierarchical, but they require the agent of *guan* to attend to the concrete circumstances, needs, and desires of *guan*'s specific target. (In Xu Wei's case, his desires would be to live a life with fewer constraints and more love, to have a family of his own choosing.) In these practices of attentiveness, the agent of *guan* should not remain distanced from the target, but should open him or herself to be troubled by the latter. Moreover, compared to the preoccupation in managerial *guan* with preventing future risks, this ethic of *guan* looks toward a future that produces hope in its target, that makes a difference in a person's life. Of course, this *guan* draws on a kinship imagination, but it is a kind of kinship that is generalized and diffused, that exceeds the boundary of the biological family.

Many people I have interviewed are uncomfortable with the court's verdict in Xu Wei's case, and with the general claim that long-term hospitalization is an unproblematic practice of risk management. We can thus see that *guan* as an indifferent form of risk management betrays the spirit of hope and the play of difference in *guan*. As the medico-legal apparatus of Chinese psychiatry continues to invokes *guan*, but at the same time reconfigure it as a managerial practice, and as such managerial responsibilities continue to be displaced onto families, creating mutual vulnerabilities, this divergence of visions of *guan* may continue to generate ethical unease, but also create political potentials.

CHAPTER 6

WAITING FOR THE PARENT STATE: SUFFERING, SOCIALITY, AND CITIZENSHIP AMONG FAMILY CAREGIVERS

One day in April 2014, I followed a group of people with severe mental illnesses and their family members on an excursion organized by a local branch of Likang Family Resource Center, a mental health social work center in Guangzhou. These families had all been designated by the municipal government as low-income households, and they all lived in a public housing community on the city's edge. Most of them had been impoverished by the expensive treatment of and everyday provision for patients, as well as the massive layoff of employees in state-own enterprises. As an activity sponsored by the local Communist Party, the excursion that day was to visit the graves of revolutionary martyrs. Most participants did not really care about the activity, but they were excited about being able to go out and see the city, and were happy to receive free breakfast (a pastry and a small bottle of milk) provided by the community.

On the way to the martyrs' park, Nan and Qin, two female caregivers both in their forties, talked about the minimum living guarantee (低保/*dibao*) stipend that they both received. As a family-based, means-tested cash transfer program, *dibao* was regularly reviewed and approved by the residents' committees. Qin had been laid off several years ago and had been looking after her mentally ill husband at home ever since. She complained, "Officials in my residents' committee insisted that I was able to work. In the means test of my family, they forced me to write down '600 *yuan*' as my salary, or else they wouldn't even consider me for welfare. Having 'income' in this way has lowered the amount of *dibao* that we receive. But look at my husband: he doesn't know how to cook, won't shower or take medication without my constant nagging, and were I not here to keep an eye on him, he would just play with the water or even the electricity obsessively. How can I leave him to work?!"

Nan, who had also quit working to look after her husband at home, suggested, "Well, next time they ask you to work, you can just tell them, 'As his guardian, I have to look after (*guan*) my husband. What if I didn't watch him and he went crazy? What if he ran out and beat people up or even slashed at strangers? Believe me, the first person he would attack is you!' Or you can simply take your husband to the residents' committee and tell the officials, 'Alright, I'm going to work. Now you look after (*guan*) him.' "

After giving a little thought to Nan's suggestion, Qin shook her head. "It won't work. They would say, 'You are his guardian, not us. How can you not look after him?"

Tracing Sociality among Family Caregivers

Nan and Qin are the typical agents of biopolitical paternalism. In previous chapters, I have illustrated how the medico-legal apparatus of psychiatry in China has sought to construct people diagnosed with severe mental illnesses as chronically pathological subjects, and to manage them as such. Patient management is aimed not only at producing biomedical normality, but also at controlling their violent potentials and safeguarding the social order. The cultural discourse of *guan* legitimates this management as paternalistic intervention. However, while the state invokes this discourse to fashion itself as caring (as opposed to capitalist societies that are prone to abandon the vulnerable), it in fact displaces most of the paternalistic responsibilities onto the patients' families, especially women and the elderly, who are also vulnerable. In this process, the familial labor of *guan* is both naturalized and concealed. As the imaginary community bureaucrat puts it, "How can you [a woman] not look after him?"

Instead of seeing people as complete dupes of ideological mystification, anthropologist Joel Robbins contends that "people are highly conscious of the cultural materials they work with and the contradictions between them" (Robbins, 2004, p. 14). Indeed, the conversation between Nan and Qin shows that family caregivers of people with severe mental illnesses (thereafter "family caregivers") can be quite perceptive about the contradiction between the state's biopolitical mobilization and displacement of *guan*, as well as clear about the suffering and disadvantages that it brings to them. In this chapter, I thus examine how the Chinese state's economic, healthcare, and welfare policies systematically marginalize these family caregivers, and how they experience, express, and act on this marginalization, often with the same cultural materials that the state and its institutions have invoked.

In order for family caregivers to articulate and act on their marginalization in a recognizable manner, they have to be associated to form an epistemic, emotional, and praxis community. Anthropologist Paul Rabinow has pointed out the emergence of "biosociality," that is, "a circulation network of identity terms," social relationships, and collective actions based on biological and especially genetic conditions (Rabinow, 1996, p. 99). Yet recent scholarship has argued against taking disorders as self-evident starting points of patient or caregiver organizations. Instead, it urges us to pay attention to "the political and economic context that makes it necessary to organize around illnesses and biomedical facts" (Silverman, 2011, p. 17), and to people's practical experimentations within such communities. Taking a cue from this insight, I examine the conditions that make family caregivers' association and mutual identification possible, and the concrete forms of sociality that emerge from such association. I do so in this chapter by ethnographically tracking the activities within and growing out of Likang Family Resource Center, a social work agency in Guangzhou that features support for family caregivers, established in 1999. At Likang—including its headquarters and local chapters—social workers organize weekly gatherings (usually in the form of psychoeducational lectures), small multi-session workshops/support groups, and cultural and entertainment activities for family caregivers, as well as conducting individual case work. Usually by words of mouth, family caregivers learn about Likang and participate in its activities, often also bringing their patients (whom social workers call “persons in recovery” or 康复者/*kangfuzhe*) to the affiliated clubhouse or sheltered workshop. Besides offering services, the center also becomes a home base for family caregivers to come to know, and even befriend, each other. Likang’s clients often lend a hand or an ear to a peer in trouble, provide useful information to each other, and organize gatherings outside the center. In 2013-2014, I spent months in Likang’s headquarters and the local branch that I mentioned. I interacted with family caregivers as a researcher, a volunteer, and finally, a friend, following them in and outside the center. Because of my interest in the sociality formed among family caregivers, in what follows I will not extensively describe the institutional workings of Likang. Rather, I will focus on the common experience, claims, and actions that I found among family caregivers, while also paying attention to how social work and other institutional complexes facilitate or impede certain forms of sociality.

As I have discovered through fieldwork, an important politico-economic condition of family caregivers’ sociality is the historically specific ways in which their own, and the patients’, dependency is denied or circumscribed by the post-socialist state. In particular, we need to pay attention to how family caregivers are doubly marginalized as both agents of *guan* in the present and, at least for most of them, socialist workers in the past. Indeed, it is from these intersecting historical positions that family caregivers seek to be legible to the state and to reclaim dependency on state services, both individually and collectively.

For one, Qin's account shows that her everyday work of *guan,* as well as her need for support, was dismissed by state agents. Scholars on care work in (advanced) liberal societies have pointed out that by assuming citizens to be "free, equal, independent individuals," liberalism has denied the vulnerability and dependency that are inherent to the human condition, relegating the support for dependencies—such as caring for the chronically disabled—as a private matter, and hardening a public/private distinction (Kittay, 1999; Nussbaum, 2006). Amidst the neoliberal devolution of the welfare state, home care—provided either by unpaid family members or by low-paid care workers—is further encouraged but also naturalized and made invisible (Boris & Klein, 2010). It has not only made people with disabilities dependent on caregivers, but also made the latter dependent on, and vulnerable to, the agents and institutions that provide the means of an uncertain subsistence. Feminist ethicists of care have thus advocated for "a connection-based equality" as the guiding principle of politics, which recognizes our inherent dependency as human beings, and which provides social support for caring relationships (Kittay, 1999, p. 28). Following but also furthering the existing scholarship, this chapter examines how discourses of dependency work with institutional and socio-cultural conditions (Fraser & Gordon, 1994, p. 311) to marginalize caregivers in a post-socialist context. It also explores how political recognition of and economic redistribution (Fraser, 1995) for intimate labor is possible. In particular, while the notion of care often seems apolitical to people in advanced liberal societies, rendering political mobilization around it difficult, I contend that the explicitly (bio)political nature of *guan* has made it possible for Chinese family caregivers to identify the structural violence (Farmer, 2004) that they experience and to struggle in (bio)political terms for welfare inclusion.

Like Nan and Qin, many family caregivers were born and raised in the socialist era. They were thus imbued with a socialist ideology of state paternalism; that is, the parent state will take care of its people, who are expected to identify with it, sacrifice for it, and abide by its order (Verdery, 1996). Workers like Qin who were employed in state-owned enterprises were taken to be especially proper subjects of this state paternalism. In the post-socialist era, this state paternalism is still upheld as an official ideology. One example is indeed the state's use of the term *guan,* which is replete with kinship connotations, to characterize its relationship with the vulnerable population. However, the concrete institutional conditions of state paternalism, such as the existence of many state-owned enterprises, have been eroded by the market economy and neoliberal policies (Cho, 2013). In this chapter, I examine how family caregivers' identity as the abandoned working class intersects (K. Davis, 2008) with their identity as neglected caregivers to produce a marginality that is particularly intractable. Meanwhile, I also show that socialist legacies allow family caregivers to express their grievances with the neoliberal state and the self-interested public, as well as to traverse the public/private boundary and claim dependency on the state or market agents.

I use a term "paternalistic citizenship"[1] to refer to family caregivers' political claims and actions. That is, they ask the state to recognize their labor in providing paternalistic care and management to patients, while also demanding that the state assume/resume its paternalistic responsibilities for both patients and themselves. This term may sound oxymoronic. After all, citizenship entails a sense of entitlement, whereas paternalism implies not only dependence, but often also supplication and patronization on the two sides of the relationship. This chapter will

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[1] Here I follow Lauren Berlant's definition of citizenship: "By citizenship I refer here both to the legal sense in which persons are juridically subject to the law's privileges and protections by virtue of national identity status but also the experiential, vernacular context in which people customarily understand their relation to state power and social membership" (Berlant, 1999, p. 55).

thus end with a discussion of the paradox of paternalistic citizenship in seeking support from and dependence on the very state that citizens identify as the source of suffering.[2] Potential limits of paternalistic citizenship will be explored. For example, as can be seen in Qin's concerns, family caregivers may use *guan* to ask the state to assume the parent role, and yet the state may also re-territorialize kinship responsibilities into the family, reinforcing the biopolitical reconfiguration of domestic relations. All in all, by examining the marginalization of family caregivers in China, this chapter shows how "margins are a necessary entailment of the state" (Das & Poole, 2004, p. 4), especially a state that is assembled through complex forces such as privatization, population control, selective welfare reemergence, and a one-party government.[3] By examining family caregivers' sociality and citizenship struggles, this study also showcases "the creativity of margins," particularly "how alternative forms of economic and political action are instituted" (Das & Poole, 2004, p. 19) and how they are refolded into the state.

Denial of Welfare Dependency and the Production of Everyday Defeat

Nan, Qin, and many other family caregivers belong to an urban underclass that has developed in the market reform era. At the age of forty and beyond, many of them have lived

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[2] Here I am inspired by Wendy Brown's discussion of liberal feminism's paradox in "seeking protection *from* masculinist institutions *against* men" (W. Brown, 1995, p. 170).

[3] Aihwa Ong and Li Zhang asks us to analyze emergent techniques of governance in post-socialist China through the lens of assemblage. They also argue that the co-existence of sovereign power and self-sovereignty in China is not a deviation from neoliberalism, but a particular articulation of it (Ong & Zhang, 2008). Meanwhile, Donald Nonini defines neoliberalism as including at least one of the following claims: "markets are excellent, state controls over them are horrible, globalization and free trade are best, and rational selfish market actors are best" (Nonini, 2008, p. 155). By showing a hybrid of market logics and an oligarchic, paternalistic, and personalistic governance in contemporary China, Nononi argues that China is neither dominated by neoliberalism or becoming neoliberal. In this chapter and this book in general, I limit my use of neoliberalism to a more specific sense, as that defined by Nonini. My fieldwork, however, shows a more prominent force of neoliberalism than what he identified, and I am open to the possibility that some seemingly non-neoliberal forces might have the power effect of reinforcing neoliberalism. In any case, I do not seek to resolve the issue of "whether China is (becoming) neoliberal" once and for all. Rather, I adopt the inside from both sides and explore the hybrid/assemblage of forces at work in contemporary Chinese governance.

through the large-scale structural adjustment of state-owned enterprises (SOEs) in the 1990s, and they are among the tens of millions of laid-off or furloughed workers. Even with institutional assistance for reemployment, most laid-off workers have only been able to find temporary, low-income jobs or resorted to self-employment (Solinger, 2006; J. Yang, 2015). For people who have to stay at home to look after severely mentally ill patients, even those options are often foreclosed to them. However, as seen in Qin's case, they are often classified by policymakers and street-level bureaucrats as being capable of working, and thus not deserving of welfare.[4] While low or even nonexistent household income may qualify them for *dibao* for the moment, they live under the constant fear of welfare withdrawal subject to the whims of petty bureaucrats. Placed on the edge of welfare suspension, Qin and many of her caregiver friends at the public housing community referred to their families as "marginal households" (边缘户/*bianyuan hu*).

Compared to the *dibao* households, another type of families seems to be both more and less fortunate. They are more fortunate, because they have a steady income (salaries or retirement pensions), and are thus not as vulnerable to the caprices of petty bureaucrats. They are less fortunate, however, because in times of severe illness and vulnerability, the household income is basically the only thing they can count on. This plight is particularly acute for households that rely solely on the aging parents' retirement pensions to provide for their mentally ill and unemployed offspring. The public pension is usually not much (in Guangzhou, the average monthly pension in 2014 was about CNY 3,000 or USD 460), and it appears especially meager in face of the inflationary economy and chronic medical expenses. Yet this money is enough to disqualify a two- or three-person household for *dibao*, the income standard for which is very stringent (as of 2014 in Guangzhou, CNY 600 or USD 90 per person per month

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[4] Mun Young Cho has made a similar observation in Northeast China, and has discussed its paradoxical nature given that the *dibao* program was originally designed to assist the laid-off workers (Cho, 2010).

for full entitlement, and CNY 900 or USD 150 for partial entitlement). Social service scholars, providers, and recipients have referred to this type of household, which has become increasingly common in China, as "the old nurturing the disabled" (老养残/*lao yang can*).[5]

Fengxia, a fifty-year-old woman whom I met at Likang, was from one such family. Both she and her younger brother had been diagnosed with schizophrenia in early adulthood. Her brother was rendered hemiplegic by a stroke a few years ago, and, unable to care for him, the family had chosen to hospitalize him indefinitely. Fengxia and her brother used to be able to rely on the double pensions of their parents. Life then was difficult—her father would wear the same jacket every day until it was completely worn out—but bearable. Several months before I met Fengxia, however, her father had passed away. The whole family now had to survive on the eighty-year-old mother's 3,000 *yuan* monthly pension. Apart from what was covered by public health insurance, the medical treatment and hospitalization of Fengxia's brother still cost the family 1,500 *yuan* a month. Treatment for all the ailments that aging had brought to her mother—from hypertension to disk herniation—took up another 600 *yuan*. Fengxia herself had to rely on the free medications provided by the community mental health program. With limited income and bottomless medical expenses, the family had plunged into abject poverty. The day when I first met her, Fengxia told a social worker that she could no longer afford the subsidized lunch at Likang, which only cost 5 *yuan* a day. She told me:

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[5] Scholars define this as households in which elderly people beyond 60 years old (the mandated retirement age for most people) carry the sole/major responsibility of providing for people with disabilities with their own retirement pension. In Shanghai, researchers found that as of 2012, there were 4,857 persons with disabilities who fell into this category, with the majority being persons with intellectual or mental disabilities (SHDPESC & School of Social Development, 2014). In Likang Family Resource Center at Guangzhou, another team of researchers found that among the hundred or so families that regularly participated in the center's activities, 46 had "the old nurturing the disabled" (Lv, Wang, & Luo, 2015).

> "Mother said, now that we are poor, we have to eat less. On this past lunar New Year's Day, [while everyone had finished shopping and was celebrating with festive meals at home,] my mother and I went to the grocery store to shop for left-over, unfresh vegetables. At one *yuan* per *jin* [0.5 kilo], we bought 3 *jin* of veggies, and used them to survive the first three days of the New Year… Alas, we in the 'sandwich class' (夹心阶层/*jiaxin jieceng*) are really miserable."

By "sandwich class," Fengxia referred to the family's predicament of being neither poor enough to qualify for welfare nor rich enough to thrive independently.

Terms like "marginal households," "sandwich class," and "the old nurturing the disabled" all denote a status of being marginalized, unrecognized by neoliberal economic and welfare policies. From them, we can see that social policies in contemporary China operate on a few assumptions of in/dependency: on the one hand, all adults are expected to be independent, productive workers contributing to the market economy. It is only when severe illnesses or disabilities deprive them of the capacity to work that they can legitimately claim dependency, although at that point they will also be subjected to intense efforts at management. Even then, they will be asked to first and foremost depend on their families, taking state welfare only as a supplement and a last resort. On the other hand, the work that family members do to care for, manage, and provide for their dependents is regarded by the state not as labor to be compensated, but as a naturalized and culturally reified kinship responsibility. As such, individual autonomy and intrafamilial dependency go hand in hand with each other in contemporary China, as in other countries that feature neoliberal social policies.[6]

These values of in/dependency have brought daily defeat to people with severe mental illnesses and their family members. In recent years, the state has started issuing small welfare

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[6] In his study of contemporary social policies, John Clarke notes: "*individualism* with *familism* is the elementary form of neo-liberalism—a world of 'possessive individualism' constituted out of individual interests and their interaction in markets. This is the fundamental claim about freedom of (buying and selling) choice." (J. Clarke, 2004, p. 62)

subsidies to people with severe mental illnesses, but it has largely left out their caregivers, who may be equally, if not more desperately, in need of such support. For example, people who were officially classified as psychiatrically disabled can use their disability certificates to take public transportation for free or at a discounted rate, but their caregivers, who often have to travel a lot to run errands for them, are not entitled to this benefit. Therefore caregivers sometimes use their patients' disability certificates on the sly, but in so doing risk being caught and humiliated. During the excursion, Qin was found trying to use her husband's certificate to board the subway. She was then chastised by the subway staff and given a scolding by the social worker leading the group. For the rest of the trip, she was nearly in tears. I suspect that this encounter aggravated her worry about potentially being "caught" by petty bureaucrats and denied welfare.

Meanwhile, given that the only way in which an individual can legitimately claim dependency on state welfare is by having biomedical abnormalities, family caregivers often endeavor to have patients identified as such. During my fieldwork, some family caregivers applied for disability certificates on behalf of the patients but without the patients' knowledge. They begged the evaluating psychiatrists to put the patients in more severe categories, so that higher welfare benefits could be obtained. More often than not, the psychiatrists would gladly comply. However, when those patients found out their documented disability status, they would usually get furious. After all, this status would not only bring them government surveillance, but also potential discrimination on the job market and in other aspects of daily life. Therefore, caregivers' attempt to ensure family survival paradoxically jeopardized family relations.

Moreover, by failing to nurture people's ability to thrive in difficult times, social policies that assume individuals and families to be self-responsible ironically entrench welfare dependency. When I met Qin, she complained to me that her seventeen-year-old daughter Jiani had just graduated from high school and was having a hard time finding a job. This was because long-term poverty and malnourishment had stunted Jiani's growth, disadvantaging her in the job market that unabashedly discriminated among applicants based on their appearance. Later, through personal connections, I introduced her to work as a barista apprentice. By that time, however, her mother had fallen ill from everyday care of, and fights with, her ill-tempered father. Jiani then decided to only work part-time, not merely because she had to take care of her mother, but also because the family became even less able to afford losing *dibao* and all the other benefits that came along with it, especially public housing—these benefits would disappear the moment she started working full-time and receiving a salary that slightly exceeded the income threshold for *dibao*.[7] Indeed, many families affected by severe mental illnesses have to engage in complicated calculations between work and welfare. Oftentimes, their need for mere survival, as well as the career disadvantage that chronic poverty and everyday domestic tasks have brought to them, forces them to choose the relatively stable, though minimal, welfare over a precarious and equally low-paying job.

If intrafamilial dependency is expected by the neoliberal welfare policies, then in times of severe mental illnesses, people often devise alternative forms of intimacy, trying to avoid a state-imposed mutual bondage. In Chapter 4, we witnessed the love story of Uncle Huan and Sister Duo, a woman with schizophrenia. Even though the couple had been together for quite a few years, they had no plans of marrying each other, which constantly drew them gossips in a heteronormative social environment. As Uncle Huan explained to me, this was a conscious choice suggested by Sister Duo's parents. Ten years before, when Sister Duo was divorced by

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[7] In her study of impoverished workers in Northeast China, Mun Young Cho discovered that this kind of dynamic management of *dibao* tended to trouble its recipients. For one, the *dibao* plan presumes that poverty is temporary, so as welfare assistance, but in fact poverty is relatively entrenched. For another, the *dibao* plan encompasses a whole array of benefits, which makes *dibao* recipients unwilling and unable to lose *dibao* (Cho, 2013, pp. 79-82).

her ex-husband because of her illness, she went home to live with her parents, surviving on their income. In an effort to ease their own economic burden and to ensure Sister Duo's livelihood in the long run, her parents bought her a small two-bedroom apartment. Having her own property then allowed her to be registered as a single-person household. As her household income became zero, and as she was categorized as among the most severely disabled, Sister Duo was entitled to *dibao*. Later when she started dating Uncle Huan, he was about to retire and receive a pension. While her parents were happy to have a "son-in-law" to take care of their daughter, they advised against sealing the bond with marriage. Otherwise she would lose her *dibao*, and the two would have to live in a kind of poverty unrecognized by the government.

Uncle Huan was content with this arrangement. Although neither his pension nor Sister Duo's *dibao* was much, the money did provide a safety net for them and allowed them to enjoy their lives to the extent they could. When I went out for meals or karaoke with people at Likang, Uncle Huan often offered to pick up the check, for he saw other people as living in more difficult circumstances. Perhaps inspired by Uncle Huan and Sister Duo's carefree life, a few other couples at Likang also chose not to get married. Several parents tried to set up separate households for their mentally ill children, but their efforts were usually in vain given skyrocketing real estate prices. Uncle Huan remarked on this during an interview:

> How strange the state's policy is! When children grow up, they should be independent, but their household registrations (户口/*hukou*) are still with their parents'. Only when you have property can you have an independent household registration. This is totally unreasonable! Luckily Sister Duo's parents had some money, and buying an apartment wasn't that expensive back then. But most people can't really do that now.
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> This policy is simply not right. The parents have toiled all their life, so they should not be required to provide for their adult children anymore. Now that the state has admitted that people with psychiatric disabilities are unable to work, it should provide for their livelihood.

Conspiracy, Complicity, and Creativity of the Margins

Uncle Huan's criticism of welfare policies that left the old nurturing the disabled is representative of the opinions of most family caregivers whom I interviewed. Indeed, people see such policies not only as unreasonable, that is, running against cultural assumptions about family responsibilities and their limits, but also as signs of the Chinese state betraying its past promises. Many aging parents told me that during the 1980s, when the state was promoting the new one-child policy, it promised, through media propagandas and the words of local government officials, to provide for parents affected by this policy as they aged,[8] especially if their only children were to pass away or become disabled. The state also promised to care for their sick or disabled offspring. Many people, then in their reproductive years, bought into this promise, forsaking the common wisdom of "raising sons for help in old age" (养儿防老/*yang er fang lao*). Three decades later, as the welfare regime has been radically restructured to encourage individualism and familism, they find the state's promise broken and themselves forgotten. Today, aging parents caring for adult children with psychiatric disabilities do not dare to get sick, for they are the only ones their children can count on. Whenever they are asked what their biggest worry is, their answer is always: "When I become too old or pass away, who will kindly manage (*guan*) my child?"

Also broken is the state's promise to secure workers' employment and retirement. When the aging parents (or other family caregivers) first went to work at state- or collective-owned

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[8] Journalistic reports indicate that in 1985, the state issued a slogan, "It's good to have only one offspring. The state will take care of your aging." (只生一个好，政府来养老/*Zhi sheng yige hao, zhengfu lai yanglao.*) In 1995, the promise was weakened to: "It's good to have only one offspring. The state will help with your aging." (只生一个好，政府帮养老/*Zhi sheng yige hao, zhengfu bang yanglao.*) Recently, the teaching has become: "It's good to postpone retirement and provide for your own aging." (推迟退休好，自己来养老/*Tuichi tuixiu hao, ziji lai yanglao.*) See (Si Chen & Xia, 2013).

work units, they were under the impression that with hard work, they would continue to enjoy secure employment until retirement. After all, the People's Republic was founded on, and continues to legitimize itself with, the ideology of working class leadership. Before the 1990s, although full-time workers received only moderate wages, their work units, supported by government-planned budgets, typically provided them with guaranteed benefits in health, retirement, and other aspects of life, which also covered their dependents, especially children (Frazier, 2005). However, as part of the structural adjustment of SOEs since the early 1990s, the state has "socialized" the work-unit-run benefits system. Both the employer and the employee now have to regularly contribute to a "social pool" for benefits, administered by the municipal government, and the benefits no longer cover the insured's dependents. Yet also in the 1990s, tens of millions of Chinese workers lost their jobs to the large-scale bankruptcy of SOEs.[9] With only limited government subsidies, they are expected to shoulder all the rest of their social security premiums. Worse still, for people who left their work units prior to the pension reform, their service records at the work units, which would have entitled them to a corresponding amount of benefits, are often not even recognized by local policies. As a result, they have to "make up" the premiums for the years "lost" in this way in order to remain entitled to retirement pensions at all.

In breaking its promises to workers and their families, the state has in effect denied their past contribution to and sacrifice for the polity. Suffering double disadvantages as former socialist workers and present caregivers, family members of patients with severe mental illnesses are usually highly aware of what scholars have called sovereignty's "organized hypocrisy"; that

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[9] Dorothy Solinger has pointed out that the numerous and imprecise categories that central and local governments devised to talk about and deal with unemployment in China made it impossible to count exactly how many people were unemployed during the state economy's structural readjustment. In any case, the estimates scholars have made are typically in the tens of millions (Solinger, 2001).

is, “states frequently violate long-standing norms to which they pledge adherence” (Diamant, 2005, p. 152; Krasner, 1999). As retired workers experience it, state policies tend to change quickly and randomly, but somehow they are always the ones who are injured. In their attempts to make sense of this cruel dilemma, they often develop conspiracy theories[10] that portray the state as deceitful, aiming its policies especially at them. For example, as an SOE worker from the 1960s to the 1980s, Uncle Huan was among those whose service records at work units had been wiped clean overnight by the pension reform. Once at a gathering with other family caregivers, he transposed the current pension scheme onto the past and argued that previously, workers had also had a significant amount of their salaries deducted by the state for social security purposes.[11] “Now, with the sudden policy change, the state has pocketed our money for nothing,” Uncle Huan said. “Policy change can really kill people. (政策变真是害死人/*Zhengce bian zhenshi haisi ren.*)”

Scholars have argued that conspiracy theories are often developed by people who are vulnerable to structural violence and social marginalization (Fenster, 1999). Building on evidence such as disjunctures in state governance (Butt, 2005), conspiracy theories offer “occult cosmologies” that debunk the state’s claim of transparency and that explain the mysterious workings of power (Briggs, 2004; Sanders & West, 2003). They thus provide people with “occult technologies” to navigate an unjust world (Schrauwers, 2003). In our case, the conspiracy theories that family caregivers develop or help circulate not only reveal the neoliberal

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[10] In his study of Mayan imaginaries of democracy, Nicholas Copeland argues: “In using the term *conspiracy theory,* I do not mean to imply that the rumor is unfounded… only that it posits corruption and nontransparency” (Copeland, 2014, p. 306). Here I follow this definition of conspiracy theories.

[11] Uncle Huan claimed that in the early 1980s, while most workers received only 30 to 40 *yuan* a month for salary, their original salary should have been 200 *yuan*—more than 150 *yuan* were deducted by the state for social security purposes. However, Mark Frazier points out that in typical SOEs, only 3% of the wage bill was set aside by the union committees within the enterprises for benefits (Frazier, 2005, p. 311).

state's valuation of profits over people, but also allow family caregivers to claim resources from the state in creative ways. During my fieldwork at Likang, many family members went for brief inpatient stays at small private hospitals turned "sanatoriums" (疗养院/*liaoyangyuan*) on the outskirts of Guangzhou. There they could receive some recuperative medical treatments, from intravenous infusions to massage therapy, for their chronic ailments. They could also participate in all sorts of recreational activities with friends, such as mahjong, bowling, and dancing. These sanatoriums typically charged nothing or very little, and hence they were highly popular among family caregivers. One day when Uncle Huan was telling some other clients at Likang about these facilities and invited them to join him next time, a person asked how come there could be such a good deal. Uncle Huan explained that the hospitals simply made up or exaggerated patients' diagnoses—for example, by documenting a small artery plaque as a clot—so that the extra health insurance reimbursement they received would be able to cover the costs for patients' room, board, and entertainment.

> "But isn't that fraud?" asked the interlocutor.
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> "Well," Uncle Huan answered, "we've all bought health insurance from the government. Do you know that every year a person can have 400,000 *yuan* (approximately USD 60,000) of medical expenses reimbursed? You don't know that, because the government has deliberately kept it a secret. We're just getting back what we deserve!"

From the perspective of insurance financing, Uncle Huan's understanding was plainly wrong, for the 400,000 *yuan* was the maximum amount an insured could claim in a year, but not what every insured could use in full; otherwise the insurance system would soon collapse. Yet for Uncle Huan and other family caregivers, the state's secrecy was evidenced in the difficulties they routinely encountered when trying to claim even just a small part of their material and symbolic entitlements, difficulties that were often put in place by the state's petty agents. The idea of state secrecy also allowed caregivers to secretly but conscientiously work among themselves or with others to get public resources.

Conspiracy theories of the state, therefore, allow family caregivers to engage in practices of complicity. In his study of sociality in rural China, anthropologist Hans Steinmuller has argued that people often form "communities of complicity," in which they engage in, as well as selectively exposing or hiding, practices that are denigrated by official discourses but that are shared locally (Steinmüller, 2010). In Guangzhou, facilitated by connections made in spaces like social work centers, family caregivers have also formed "communities of complicity." Neoliberal welfare policies, as I mentioned, expect people to fend for themselves and their families, thereby reifying the distinction between public and private, the state and the family. The underclass's dependency on the public is denigrated and disciplined. (For example, local regulations usually ban *dibao* recipients from wearing "expensive" jewelries or eating "lavish" meals, requiring them to be completely austere.) In their everyday interactions, family caregivers often quietly transgress this public/private boundary, seeking dependency on public resources not just for basic subsistence, but also for pleasure and life nurturance (Farquhar & Zhang, 2005). Note that in Steinmuller's study, villagers are often embarrassed about the vernacular practices in which they secretly engage, for they are still attached to the official discourse of scientific modernity. In contrast, as shown in Uncle Huan's remark, family caregivers feel highly righteous about their "complicit" practices. This moral righteousness, I contend, stem from their perception of the neoliberal state's hypocritical and secretive nature. These family caregivers are still attached to an imaginary of the state, but it is a state that recognizes its citizens' contributions to production and reproduction, that allows or even encourage them to be dependent on itself, and that, instead of setting up boundaries, run like a big family—in short, a paternalistic state. In other words, family caregivers righteously engage in practices of complicity, precisely because they take seriously the hypocritical, conspiratorial state's promises of paternalism.

Communities of complicity, however, do not necessarily provide grounds for effective resistance or disruption of neoliberal governance. Instead, in their complicit navigation of welfare resources, family caregivers might run the risk of being caught by state agents as "frauds" and punished accordingly. From their temporary complicity with businesses such as the "sanatoriums," family caregivers might get a small benefit, but it is the businesses that receive the much larger share of profits. This in turn will reinforce the structural inequality and power imbalance in the market economy. Besides, although social work centers like Likang provided the initial space for family caregivers to meet each other and go off to form communities of their own, social workers at these organizations often take pains to distinguish themselves from these complicit activities. When, at Likang's gatherings, some enthusiastic family members told others about upcoming trips to the "sanatoriums," social workers would immediately clarify to all that these activities were not organized by the center. Smiling, they would gently request family caregivers to report to them afterwards how the trips went. Without understanding family caregivers' rationale behind these complicities, they would worry among themselves whether some of the enthusiasts were "shills" for businesses. Steinmuller has argued that everyday practices of hiding and exposing cultural intimacy reproduce boundaries between state and society (Steinmüller, 2010, p. 548). Here, by distancing themselves from family caregivers' complicit activities, social workers marked themselves as state agents,[12] serving to reinforce and monitor the divide between the legitimate state and the private, intimate, and complicit families.

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[12] Likang, like many other social work centers in Mainland China, was established with the municipal government's endorsement and financial support. Although it had been registered as a private non-

Constructing an Emotional Collective

Besides navigating healthcare and leisure resources together, often through complicit means, family caregivers build a common sociality also by collectively engaging in or refraining from certain emotional displays, as well as by recognizing those emotions in each other. At Likang and other community mental health settings, the staff often organizes activities in order to help family caregivers manage their negative emotions that have supposedly been accumulated from prolonged caregiving. However, these events do not receive the same responses from their participants. Sara Ahmed argues, "emotions work to shape the 'surfaces' of individual and collective bodies…by aligning subjects with collectives." She urges us to heed "what sticks" in the circulation of emotions, and how that affects social transformation (Ahmed, 2013, p. 1). In what follows, I will examine the elicitation, display, and circulation of emotions in and across activities organized for family caregivers.

One day in June 2013, the staff at Likang invited a psychotherapist to teach family caregivers to use art to experience emotions. The therapist divided the fifty-or-so family caregivers present into five groups, and gave each group some tools for watercolor painting. Per her instruction, each participant was to draw three circles on the group's paper, which could be either separate from or connected with each other. "How unhappy you feel, [reflects] how big a circle you draw," the therapist said. "And please, whenever you draw a circle, think about why you are unhappy. Because our emotions can be passed on to and felt by others, we can also draw circles inside others' circles or fill colors in them." By way of painting, the therapist thus sought to turn family caregivers into *individual* feeling subjects, with capacities to experience emotions arising from within, express them to others, and give cognitive explanations for their occurrence.

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enterprise entity (民办非企业/*minban feiqiye*) by the time of my fieldwork, its primary funding stream was still the municipal government's service procurement (购买服务/*goumai fuwu*) budget.

These expressions and explanations were supposed to give the individuals catharsis and better self-awareness, but they were also likely to have the effect of tying the responsibilities for emotion production and management to the feeling individuals themselves. After all, the only way in which emotion could be thought of as collective was through the diffusion from one feeling individual to another.

The therapist's instructions seem to have puzzled most family caregivers present, and they did not follow them during the exercise. If, as Ahmed points out, emotions as signs stick to bodies and gain value through their reiteration in, and detachment from, contexts (Ahmed, 2013, pp. 91-92), then we can understand why the therapist's instruction did not stick by looking at some contexts in which similar emotional constructions were circulated. Anthropologist Jie Yang, for example, has identified a trend of psychologization in the Chinese state's recent efforts to address massive unemployment. These efforts ask the unemployed to conceive of themselves as embodying deep interiority, and to believe that the workings of the interiority can be modified by psychological knowledge. Psychologization, Yang argues, constructs the unemployed as "both objects of psychological care and self-reliant subjects who can contribute to the market economy," hence constituting a critical part of contemporary Chinese governance (J. Yang, 2015, p. 163). A similar trend of psychologization is found in social services for family caregivers of people with severe mental illnesses. At educational events held by social work centers, community mental health teams, and psychiatric hospitals, I often saw mental health professionals trying to elicit expressions of suffering from family caregivers, although usually not in such artistic and roundabout ways. For example, a psychiatrist might ask family caregivers to talk about the negative feelings that they had experienced after learning about patients' illnesses. Sometimes the audience did respond to the speaker's elicitation, mentioning feelings of depression, apprehension, shame, and so on. The speaker would then praise the sacrifice that family caregivers had made for patients, arguing that the family was of utmost importance in patient management. In this register, emotions of individual suffering became the necessary cost of the work of patient care and management, as well as a critical component of this work itself. Because of its seemingly spontaneous and heartfelt quality, the emotional work in turn seemed to flow naturally from family love,[13] independent of external demands, and not in need of compensation. Meanwhile, the speaker would also pathologize such negative emotions, taking them as manifestations of family caregivers' obsession with patients' disorders and inability to establish proper interpersonal boundaries with patients. These problematic attitudes and behaviors were said to be likely to frustrate the patients and aggravate their symptoms, as well as exhausting the family caregivers themselves. Registered in this way, family caregivers' emotional confessions would allow the mental health professional to discipline their everyday relational practices (Foucault, 1977).

Therefore, by constructing family members as individual feeling subjects and eliciting their emotions of suffering, mental health professionals seek to summon, discipline, and depoliticize their intimate labor in patient care and management. Reiterated in event after event, such emotional configuration work and subject construction have often failed to stick, however. Instead, they were resisted by most family caregivers. Once at another psychoeducation event for

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[13] Arlie Hochschild has famously defined emotional labor as "the management of feeling to create a publicly observable facial and bodily display; emotional labor is sold for a wage and therefore has *exchange value*. I use the synonymous terms emotion work or emotion management to refer to these same acts done in a private context where they have *use value"* (Hochschild, 2003, p. 7). Yet here I argue that the very distinction between public and private is a discursive-institutional construction. And as we will see soon, family caregivers seek to have their work of patient care and management, including its emotional component, recognized as the state as a form of labor.

Hochschild also argues that while close, long-term relationships "expect to have more freedom from feeling rules and less need for emotion work," that is, emotions flowing naturally from one's heart, in fact "the deeper the bond, the more emotion work, and the more unconscious we are of it" (68).

family caregivers, for example, the speaker tried to warm up by asking the audience whether they felt any pain with the patients' disorders, and whether they had spent much on treatment. An audience member sneered: "Of course, but what's the point in talking about all this? Let's just get down to business!" By brushing aside the speaker's question, the family caregiver refused to have her suffering exposed and deployed for biopolitical ends. Instead, she demanded practical support for patient care and management, the burden of which had been unfairly placed on the family's shoulders, leading to her suffering.

Family caregivers' discomfort with the individualization and psychologization of emotions probably explained their bewilderment with, and reluctance to follow, the therapist's instructions in the circle drawing exercise. Interestingly, after the initial silence, participants in different groups all picked up the brushes and started drawing. Instead of abstract circles, they drew all kinds of colorful objects, such as faces, flowers, birds, and mice, experimenting in a creative and playful manner. Instead of concentrating on one's own painting and emotions, as the therapist had instructed, the family caregivers chatted and collaborated with each other spontaneously. A woman in my group accidentally dropped some red paint on the sheet of paper. Other group members frowned, one even murmuring that it ruined "our picture." Luckily, the woman immediately used that drop of red paint to draw a red flower, and everyone—including the therapist who happened to walk by—smiled in admiration. Here, family caregivers engaged in a collective improvisation. Besides artistic products, it also created emotional flows that transcended but also imbued every participant, and that helped assemble these marginalized individuals into an emerging community.

Figure 6.1 Family caregivers in the circle drawing exercise
SOURCE: author

The emotions that flow among family caregivers and define their sociality are not limited to joy; very often, they include sadness, anger, and suffering, which family caregivers tend to refuse to express on occasions like the aforementioned. In the spring of 2013, I sat in with a multi-session peer support group at Likang. The group consisted of a senior social worker called Linda, who coordinated the meetings, and ten family caregivers, most of whom were new to the agency. At its very first meeting, immediately after being introduced to each other, the participants began telling each other their deepest worries and troubles in everyday life with patients. Linda tried to interrupt, asking them to first discuss the group rules they would like to establish, but the "side" conversation simply went on. Soon it gravitated toward one person's story. Mrs. Mai, the aunt of a young woman with bipolar disorder, complained that after the death of her brother, that is, the patient's father, her sister-in-law refused to care for the patient, leaving the patient to her. However, Mrs. Mai's son and his wife did not appreciate her dedication to a distant relative, and especially hated having to share their tiny apartment with a person they called a "madwoman." For the past few years, Mrs. Mai's daughter-in-law had been giving her niece the cold shoulder, continued to upset the latter, and finally divorced her son in order to avoid the burden of care. As a result of daily irritation, her niece's condition worsened, she was no longer able to work, and she was preying on Mrs. Mai's grandson as well. "I am stuck in between," Mrs. Mai told us, sobbing. "I feel so depressed at home. Why does life have to be so difficult?"

Linda tried to divert the conversation and give every participant a chance to share their own experience. Interestingly, the participants themselves did not seem to mind the conversation's gravitation to Mrs. Mai at all. Instead, they gestured to echo Mrs. Mai's experience, asked questions to facilitate her storytelling, and suggested tentative solutions to the dilemmas she faced. What appeared to be a personal story, then, was in fact a collective construction. Unlike the individualization and psychologization of emotions as promoted by mental health professionals, this co-constructed story attributed suffering not (merely) to the blind fate of mental illness or problematic attitudes of the family caregivers, but also—and more importantly—to the irresponsibility of other family members, unethical practices of some professionals, social discrimination, and the lack of policy support from local and central governments. For example, when asked why the patient, a college graduate with previous work experience, did not work anymore, Mrs. Mai responded that employers had always asked her intrusive questions upon seeing her symptomatic behaviors, such as hand tremor produced by antipsychotics, and that such questioning had brought undue pressure on her, making her worried about potential discovery and discrimination, so she had had to quit. Unemployment in turn made her even more withdrawn. “Alas, your niece’s condition didn’t start out that serious,” a group member remarked to Mrs. Mai, “but it has only gradually worsened. If society had given patients something to do…” “If society had given patients something to do,” Mrs. Mai followed up, “and if more people had cared about them, things would have never gotten that bad.” Later, when another group member asked Mrs. Mai why she hadn’t sent her niece to the hospital, she lamented that she had no money. A few listeners told her that the residents’ committee could arrange for some basic health insurance. Mrs. Mai said in surprise: “I’ve visited the residents’ committee many times and told them my niece’s condition, but they’ve never told me about this policy.” “Well, they are not there to serve you,” even Linda chimed in with a dose of cynicism, “but to manage (*guan*) you. They will never ask what you need or what they can do for you.” As the singular and plural (pro)nouns seamlessly interchanged in Mrs. Mai’s story, and as it was repeatedly echoed by the other participants, one can see that the individual suffering tale was not only co-constructed, but also taken to represent the predicaments family caregivers typically faced as a group.

This co-constructed and representative story of suffering bore similarities with a common, though declining, genre called “speaking bitterness” (诉苦/*suku*). Developed by the Chinese Communist Party in the 1940s and promoted throughout the socialist era, this genre asks people to speak about their suffering in the language of class, exploitation, and social injustice, thereby forming “collective identities as members of oppressed groups” (X. Huang, 2014, p. 586).[14] Born and raised in this language of “speaking bitterness,” family caregivers also framed their suffering in terms of social, political, and economic marginalization. In so doing, they

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[14] Studies of “speaking bitterness” abound, such as (Anagnost, 1997; Hershatter, 2011; Rofel, 1999).

fashioned themselves as virtuous subjects, shouldering alone a task that should not have been their own responsibility. Mrs. Mai complained that her sister-in-law did not *guan* her niece, and that her own son had also asked her not to *guan*. "Sure, I don't have to *guan*/care," she told us her response to her son, "I can simply drive her [my niece] away, but how can she survive in society then? Look at all those miserable people on the street!" As we have seen in earlier chapters, *guan* here refers to an ethical engagement with a vulnerable being, a responsibility that should weigh more on the closest kin, but that should also be distributed across the whole society. Unfortunately, Mrs. Mai ended up as the only provider of such *guan*, as it was she alone who could not bear to look away from her niece's suffering.[15] Even more unfortunately, as Linda remarked on Mrs. Mai's story, the state was performing another type of *guan*, one that saw patients with severe mental illnesses and their families as objects to be managed or even threats to be guarded against.

Scholars have pointed out that the "speaking bitterness" narrative usually follows the temporal arc of "oppression-revenge-liberation" (Y. Zhu, 1992). Similarly, in this and other co-constructed tales of suffering, family caregivers explore ways to help repair the injuries that the narrators and their families endure, solutions that are potentially generalizable to other families. Moreover, in the process of narrating,[16] family caregivers also invite listeners to work with/for them to alleviate their suffering on a structural level. In the support group meeting, Linda asked the participants whether they would like her or me, the visiting researcher, to keep their stories secret. Mrs. Chen, an active member at Likang, answered:

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[15] Mrs. Tan's ethical response is not unlike Emmanuel Levinas (Levinas, 1988) and Jason Throop (Throop, 2010) called suffering for the other's suffering.

[16] Sociolinguists have long distinguished the narrating event (or interactional text) from the narrated event (or represented text) (Jakobson, 1971; Koven, 2002). In particular, Stanton Wortham has discovered that our interactional/narrating self often runs parallel with our representational/narrated self (Wortham, 2001).

> "I don't think so. We don't want our stories to be known, treating them as our privacy, only because we are afraid of discrimination. But now that I'm already in this condition, fallen to the bottom of society, I want the whole world to pay attention to these forgotten people. So I think Ms. Ma's visit is a great opportunity. I hope she can truthfully (实事求是地/*shishiqiushi de*) represent our situation, and I hope the state and the health department can take it seriously."
>
> All the other participants nodded in agreement.

In refusing to treat their suffering experiences as private matters, the family caregivers in effect traversed the public/private divide that kept mental illness and its care a private issue, making them invisible in public. They also refused to be the individualized and psychologized feeling subject, whose interiority could only be accessed and shaped by mental health professionals. As Hannah Arendt has argued, defining freedom in terms of inner experience presupposes an estrangement from the world, whereas true political freedom requires actions in "the company of other men" "to call something into being which did not exist before" (Arendt, 1993, p. 148 &151). By performing emotions such as joy and suffering together, letting them circulate among and beyond themselves, family caregivers have fashioned a collective identity as marginalized but virtuous citizens. In so doing, they demand to be dignified, their emotional and ethical work to be recognized, and their need for a more just redistribution satisfied. The next section will explore some of the concrete policy demands made by family caregivers.

Promises and Perils of Paternalistic Citizenship

The conversation with which I began this chapter is also a co-constructed story of eating/speaking bitterness. In it, Nan suggested that Qin confront the government with her difficult work of *guan* and its importance for the social order, by highlighting the threat that the patient's potential violence would pose to both the general public and government agents. Indeed, in their gatherings, family caregivers often talked about using or staging tragic events in order to make the government pay attention to their suffering. Once when a social worker informed some caregivers about an upcoming policy change that might disqualify them for public housing, an audience member said: “Nobody cares about (*guan*) us marginalized households, unless more and more people can’t stand it and jump off the building! But no, even that won’t work. If you die, it’s your own business. The government will just wait and collect your bodies.” Another time, with the hope to remind family caregivers of the importance of patient management, the social worker told them that a patient in another city had recently slashed at strangers in public and injured six people, all of them policemen. To his surprise, several audience members burst out laughing: “Good job! That person is not crazy at all!”

In their discursive appeals to public tragedies, family caregivers might be said to have resorted to an empty “psychological triumph”[17] or *ressentiment*[18] to which the weak are relegated. However, I contend that such appeals are in fact conditioned by, and reflect family caregivers’ awareness, or even strategic mobilization, of their structural position in contemporary biopolitical governance. Sociologist Ching Kwan Lee has pointed out that as the Chinese state is increasingly preoccupied with “maintaining stability” and has assembled a large institutional apparatus to “buy stability” from its citizens, citizens have also begun to consciously use instability and disorder as “their bargaining chip” (C. K. Lee & Zhang, 2013, p. 1488). In our case, family caregivers know perfectly well that patient violence in public has been registered as a source of potential instability, and that it can serve as their bargaining chip to gain attention and resources from the state. (In contrast, while suicide is a culturally recognized performance of

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[17] In the famous novella *The True Story of Ah Q* by Lu Xun, the protagonist Ah Q, a man from the rural peasant class, is famous for his “method of spiritual victories/psychological triumph” (精神胜利法/*jingshen shengli fa*)—a self-deceiving imagination of defeating whoever gets in his way, especially after being defeated and humiliated in reality (Lu, 2009).

[18] Wendy Brown uses Nietzsche’s term “*ressentiment*”—“the triumph of the weak as weak”—to describe the displacement of anger by valorizing one’s own suffering and blaming others for causing injury (W. Brown, 1995, p. 67).

extreme suffering, especially suffering from injustice (F. Wu, 2009), family caregivers worry that it might fail to register as a threat to the bio/political order.) Of course, unlike other sources of instability, such as street protests, patient violence mostly lies beyond family caregivers' control, and they usually do not really want it to happen. Yet in order to get an upper hand in the bargain, they sometimes remind state agents of its possibility and, quite understandably, take pleasure in others having done the job for them. When things get desperate, some caregivers might even choose to take the patients to state agents, to thrust the violent potential in the latter's face. Nan, for example, suggested that Qin take her husband to the residents' committee. While I did not witness it, a community mental health official told me that a few parents in her jurisdiction had taken their mentally ill children to the local government, demanding welfare resources or financial compensation for their work of patient management.

When family caregivers take patients to government agents, asking the latter to look after (*guan*) the patients, they might not only be seeking compensation for their paternalistic labor, but also—if we understand their words literally—be trying to have the state assume paternal responsibility itself, whether the patients are potentially violent or not.[19] We have already seen Uncle Huan's criticism of the current policies. In it, he argued that the state should provide for adult patients who are not able to work. This argument is echoed among almost all the family caregivers I have encountered. Mrs. Du, then Vice Chair of the Guangzhou Association of People with Mental Illnesses and their Families (GAPMI), herself a patient's mother,

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[19] Many of the phenomena described in this chapter are not limited to families of people with psychiatric disabilities, but shared with other disability groups, especially families of people with intellectual disabilities or autism. For example, in his non-fiction *Country Driving: A Chinese Road Trip,* Peter Hessler told a story in which a peasant in Beijing once brought his brother, an "Idiot," to the township government office in order to demand the monthly disability stipend that was owed to him (Hessler, 2010, p. 189).

emphasized in my interview the time-bound nature of childrearing and the state's duty of parenting:

> "Before a child reaches eighteen years old, it's the family's responsibility [to raise him]. But after eighteen, the child is a natural person (自然人/*ziran ren*),[20] the society's citizen. Society has the responsibility to nurture them. I always raise this issue when meeting with leaders from the provincial or municipal government."

While Mrs. Du used the word "society" here, her targeted appeal to government leaders reveals that it mostly referred to the state. She expected the state to act either as a provider itself or a broker to assemble non-familial resources of all kinds, in order to nurture the mentally ill patients, its own citizens-children.

Invoking this idea of state paternalism, family caregivers have made many concrete demands. Some of these demands have been acknowledged and even partially satisfied by governments at various levels; after all, in the face of growing social inequality and popular unrests, branches of the Chinese government do want to reclaim a populist, paternalistic care for people's livelihood (民生/*minsheng*) (Cho, 2013; Duckett & Langer, 2013). Soon after Likang was founded, with funding and supervision from the municipal government,[21] family caregivers, then Likang's only clients, asked that it also provide vocational training services to patients, so that they would have a place to go during daytime and learn some skills. In response to this request, the center established a clubhouse and a sheltered workshop. Before long, these units began providing their members/trainees with a moderate amount of subsidy (about CNY 500/month as of 2014) as an incentive. Thanks to family caregivers' continued appeal and to

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[20] "Natural person" is a juridical term, referring to a human being, a subject of human rights. It stands in opposition to the term "legal person," which may refer to a business, an NGO, or a governmental organization. The latter may or may not have certain rights.

[21] More exactly, it was sponsored by the Guangzhou Disabled Persons' Federation (GDPF), a semi-governmental organization. As other DPFs in the country, GDPF receives its budget from the government, but it also functions as a civil society organization to organize and represent people with different types of disabilities.

examples set by pioneering agencies like Likang, sheltered workshops, vocational training centers, and clubhouses for mentally ill patients have sprung up across Guangzhou and in other major Chinese cities.

As family caregivers have proclaimed publicly, and as previous research has shown, everyday subsistence and medical expenses are the two major economic burdens for families with "the old nurturing the disabled" (Lv et al., 2015; SHDPESC & School of Social Development, 2014). In recent years, family caregivers in Guangzhou—through the leadership of GAPMI and connections with local politicians—have been asking the provincial and municipal governments to purchase social and health insurance for all patients, and to grant *dibao* entitlements to patients who cannot work, regardless of their family situations or household income. By 2014, the former request had been put on the municipal government's agenda. In fact, over the past decade, the municipal government had been providing different sorts of financial aid for patients' treatment, especially hospitalization, partly to facilitate patient management. Starting from 2012, the provincial and municipal governments have been providing people with severe psychiatric disabilities and their family caregivers small amounts of livelihood and care subsidies.[22] While these subsidies and benefits can partially alleviate some pressing concerns for survival, they cannot address family caregivers' concern about who should shoulder the responsibility and provide the intimate labor to look after (*guan*) the patients when their parents pass away. For that matter, many family caregivers have been asking the

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[22] The amounts of these subsidies cannot compare with *dibao*. In 2014, the livelihood subsidies for impoverished people with severe psychiatric disabilities were CNY 600/year, and the care subsidies for people with severe psychiatric disabilities were CNY 1,2000/year (see http://www.gddpf.org.cn/gzdt/201407/t20140711_632822.htm). In contrast, the *dibao* amount was CNY 600/month.

governments to build nursing homes (托养中心/*tuoyang zhongxin*) and provide long-term residential care for patients.

As former workers, many family caregivers became accustomed to the historical fact that state paternalism was mediated by work units.[23] Therefore, besides making direct appeals to state agents for policy changes, they have also sought to build paternalistic ties between patients and "work units," i.e. companies that are not necessarily state- or collective-owned. In particular, since the mid-2000s, a "quota scheme employment" (按比例就业/*an bili jiuye*) rule has been installed across China. It requires business corporations and government sectors to employ certain numbers of people with disabilities, and punishes those that do not meet this requirement with a fine. In order to avoid paying the fine, many companies have developed a complicit tactic with people with disabilities and their families: a company lists a person who has been certified as disabled as an employee, thus meeting one "quota," but it usually doesn't require that person to actually come to work; in return, the company purchases social and health insurance for that person for the duration of his/her "employment," and sometimes also pays him/her a token salary. The salary is typically far lower than the minimum wage set by local regulations, so that the money that the company spends on the token disabled employees is far less than the fine would be. This practice is commonly called 挂靠/*guakao,*[24] literally "to attach and rely," which

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[23] Of course, as Andrew Walder pointed out, the ties workers were able to build with their work units, or more specifically, workshop foremen, were highly contingent. During high socialism, the ties were largely dependent on workers' political activism. In the early reform era, they were influenced by workers' skills and productivity. See (Walder, 1988), especially Chapter 7.

[24] This complicit practice, though an open secret in the disability service community across China, has rarely been documented. Unfortunately, it is also beyond the scope of this chapter to provide a detailed account of it. See (R. Yang, 2015) for an activist's account of the history of the "quota scheme employment," especially its fine, that is, the Disabled Person Employment Security Fund. See (Xia &

suggest the tie of paternalistic dependency between the person with disability and the employer. My fieldwork shows that just like their fate on the regular job market, people with psychiatric disabilities are typically considered the least desirable choice among all disabled groups for *guakao*, for companies often fear that they might come to the workplace and make a fuss anytime. However, the meager benefits that *guakao* can provide are what people with psychiatric disabilities and their families most desperately need. Therefore, many family caregivers have gone to great lengths begging friends or street-level bureaucrats to introduce them to interested businesses. They hope that in so doing, their loved ones with psychiatric disabilities could become "workers" and enjoy paternalistic dependency on the work units, as they themselves once had.

Through these explicit appeals and implicit/complicit actions, family caregivers are thus struggling and aspiring for what I call a "paternalistic citizenship" for both patients and themselves. They ask the state to recognize, and compensate for, their paternalistic labor for the patients, and they also demand that the state assume paternalistic responsibilities for both patients and themselves. In her study of post-socialist, post-Chernobyl Ukraine, Adriana Petryna uses the term "biological citizenship" to show that the collapsing state has led to people's deteriorated health, and that people now have to struggle for resources and welfare inclusion by claiming illness through technologies and legal procedures (Petryna, 2004). Building on this concept, Vinh-Kim Nguyen has coined the term "therapeutic citizenship" to analyze the personal/organizational networks and moral economies people mobilize in making claims on health resources, as well as the biopolitical dimension of this citizenship, that is, how "a system of claims and ethical projects that arise out of the conjugation of techniques used to govern

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Zhang, 2015) for an empirical study of the structural conditions for *guakao*, especially the complicity between companies, residents' committees, and people with disabilities.

populations and manage individual bodies" (V. K. Nguyen, 2005, p. 126). Taking cues from these insights, the notion of "paternalistic citizenship" seeks to further highlight how the claim of patienthood might be entangled with other cultural-historically legitimized appeals to entitlements. Moreover, while previous discussions of "biologized" citizenships have focused on efforts by and for individuals, the notion of "paternalistic citizenship" explores how citizenship claims are made by, with, and for certain forms of relations.

In particular, the meanings of "paternalism" are multiple. First, family caregivers demand that the state recognize, symbolically and materially, their contribution to biopolitical paternalism, that is, intimate management (*guan*) of severely mentally ill patients who are deemed to pose potential threats to the social order. Second, following the popular imagination of the state as a family writ large, family caregivers ask the state to be a proper parent and look after (*guan*) all its "offspring," particularly the most vulnerable ones, that is, severely mentally ill patients and—by extension—their family members. Third, holding onto the socialist ideology of state paternalism, family caregivers demand the state to be responsible for (*guan*) them as former socialist workers, and for the patients as well, who can claim a worker identity now. The state's neglect of some paternalistic responsibilities and in compensating for others has made family caregivers feel injured, both for themselves and, vicariously, for patients. Correspondingly, in their everyday life, particularly in collective discussions and actions, family caregivers may strategically mobilize any or all of these paternalistic imaginaries, seeking to create intimate ties with the state, repeatedly breaking the public/private boundary.

If the genre of "speaking bitterness" initially asked the suffering subjects to unite and seek liberation from their oppressors, what happens when family caregivers seek dependency on the very state that they identify as the source of suffering? If the state is hypocritical and conspiratorial, prone to forget its paternal promises, can family caregivers really take its words seriously? My fieldwork shows some limits in the practice of paternalistic citizenship. For one, we have seen that the Confucian idea of family-state isomorphism makes the claims of the paternalistic relationship recursive, that is, able to be projected on different levels (Irvine & Gal, 2009); and family caregivers have utilized this recursivity to claim dependency on the state for both patients and themselves. However, this recursivity also means that the paternalistic relationship can be discursively scaled down and nailed onto the family. In the opening vignette of this chapter, after pondering on Nan's suggestion that she ask the street-level bureaucrats to look after her husband, Qin concluded that it would be of no avail, because the bureaucrats would throw the ball back to her, emphasizing her responsibility as a family member. For many family caregivers whom I interviewed, this response is not a fantastic fear, but a reality that they often have to face when interacting with psychiatrists, community mental health workers, and local government officials. Besides, as the state is made up of concrete individuals, family caregivers feel that favorable policy changes can emerge not from state officials' "abstract" goodwill toward the marginalized population, but from their intimate suffering as family members themselves. "The reason why the Party began to pay attention to people with disabilities, especially those with physical disabilities," Uncle Huan commented in a caregivers' gathering, "was because of Deng Xiaoping's crippled son.[25] But unfortunately, our leaders don't have mentally ill patients at home, or even if they have, they won't admit it in public."

In their efforts to build paternalistic ties with bureaucratic institutions or market agents, family caregivers also come to experience themselves and their patients as vulnerable beings,

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[25] For a documentation of how Deng Xiaoping's son Deng Pufang contributed to or basically started institutional advocacy and service for people with disabilities, see (Kohrman, 2005).

who can only maneuver quietly for benefits or supplicate for the powerful party's mercy, but cannot stand up to demand their rights. In December 2013, Mrs. Du from GAPMI took me to a meeting where municipal government officials discussed welfare issues with representatives from different disability groups. There, a few participants from other disability groups complained about the extremely low wages that they received from their *guakao* companies. An official responded that the companies' practice was illegal, and that people should take actions to defend their right (维权/*weiquan*) to a minimum wage. He also promised to provide legal aid to people with disabilities on that issue. Fearing that the government would put a ban on *guakao,* or that the higher costs for *guakao* would make companies even less likely to choose the psychiatrically disabled, Mrs. Du anxiously chimed in:

> "As people with psychiatric disabilities and their family members, it's not that we don't want to defend our rights. But we're afraid that if we do, the work units will immediately let us [people with psychiatric disabilities] go—they are scared of us already. That way, we can't even hold onto the little benefits for which we've fought so hard. As individuals, we are very vulnerable."

In that meeting, Mrs. Du also raised the issue of purchasing social and health insurance for people with psychiatric disabilities. To my surprise, she did not demand full government sponsorship. "I've surveyed all the family caregivers I know. 80% of us said that with some subsidies from the government, we are willing to pay the rest of the premium. You know, we are not trying to shirk our responsibility." She spoke so cautiously and made such a modest request, as if any slightly bolder move would have irritated the government official, giving him a reason to drop the issue once and for all. Later at Likang, I witnessed similar positions taken when family caregivers were negotiating policy demands with (an imagined or real audience of) state agents. It turned out that the idea of socialist state paternalism not only demands that the state provide for its people, but also requires people to reflect on what they have contributed to the state, and to accept the state's difficulties as their own. This spirit of self-criticism has paradoxically conjoined with the neoliberal discourse of self-responsibility, tempering family caregivers' political demands and collective actions.[26] Institutional conditions have further reinforced family caregivers' tendency toward self-tempering: in Guangzhou, both advocacy associations like GAPMI and service agencies like Likang are sponsored and at least partially funded by the local government. Family caregivers there, especially leaders and activists among them, know full well that they have to walk a fine line between pushing the government in their desired direction and assuming a collaborative or even submissive stance in order to maintain government endorsement. If, as Elizabeth Perry has argued, Chinese people are "rules conscious" instead of "rights conscious," that is, conscious of the state's promise of equality (Perry, 2008), then we also need to pay attention to how the rules are historically and institutionally contingent, binding not only the performance of the state but also the demands of its citizens.

Moreover, in seeing mentally ill patients as vulnerable, family caregivers often come to see patients as incapable of independent living and decision-making, thereby contradicting patients' own aspirations. As my fieldwork at Likang shows, while many family caregivers hope to have patients transfer to nursing homes after their caretakers' death, patients themselves often frown upon this idea. For them, nursing homes sound no different from psychiatric hospitals, places where they have experienced extreme misery and humiliation. With the encouragement of

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[26] Mun Young Cho has made a similar observation: "Currently in the PRC, the discourse of citizenship has emerged not only to describe an ideal type of political status but also as a governing rationale that pushes citizens to regulate their own conduct… In the northeast, however, the enduring voice of 'the people'—more precisely the historically paternalistic relationship between the party-state and its people—makes workers reluctant to insist on their 'rights' to receive protection from the government. There I found citizenship discourses predominating not so much when workers adopted law-based discourses to articulate their political demands as when they were encouraged—often forced—to ask themselves 'what the good citizen should do.'" (Cho, 2013, p. 19)

human rights organizations, some patients have tried to expose hospitals' abuses, and to publicly demand support for community living by themselves or with friends. Although family caregivers, on the other hand, also have concerns with the inferior and even inhumane conditions of many hospitals, few of them dare to challenge the hospitals, for fear that the hospitals will refuse to take in their patients in the future. In fact, there has been no institutional channel for patients to put the aforementioned advocacy plan into action. For example, GAPMI consists of family caregivers and a few mental health professionals, and it refuses to admit any people with mental illnesses as its members, although they are front and center in its name.[27] "We [family caregivers] have to make decisions (做主/*zuozhu*) for patients," one of GAPMI's core members said when explaining its organizational structure to me. "I don't want to sound rude, but you know, mentally ill patients have no brains."

The problem, of course, is that severely mentally ill patients are not only incapable, but also potentially disruptive—or so it goes according to biopolitical paternalism. In their attempt to gain recognition for their labor of *guan* by strategically emphasizing patients' violent potential, some family caregivers have also come to sincerely see patients in this light themselves. In Likang, for example, a few caregivers vocally refused to include any patient in their entertainment activities, for fear of patients' volatility. Regardless of what their own perspective might be, this strategy on the part of family caregivers might in effect further stigmatize patients.

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[27] GAPMI is one of the five advocacy associations initially developed and now overseen by the Guangzhou Disabled Persons' Federation. Each of these associations is for a particular type of disability (blind, deaf, physically disabled, intellectually disabled, and psychiatrically disabled). Like GAPMI, the association for people with intellectual disabilities also consists mainly of the disabled people's family members, whereas the other three associations consist primarily of people with disabilities themselves. However, unlike psychiatric disability, the community of intellectual disability and autism in Guangzhou has had a long history of grassroots advocacy. Although the non-governmental advocacy groups were all started by family caregivers or professionals, some of them have recently started to build branches run by people with intellectual disabilities or autism themselves.

Lately, the central and local governments are planning to respond to family caregivers' requests and compensate them for their intimate labor, but this compensation is to be tied to how well family caregivers manage patients' risks of violence. This development is likely to reinforce biopolitical paternalism and further bind it to patients' families, while foreclosing other potentials of paternalisms that could generate more open and mutually enriching relations of responsibility.

Conclusion

In this chapter, we have tracked the sociality among family caregivers like Nan and Qin, including the socio-economic and institutional conditions of its emergence, as well as caregivers' complicit practices and explicit demands. In so doing, we have come to see how a form of marginality is created at the intersection of different forces in post-socialist China, and how the practices and politics of life in the margins "shape the political, regulatory, and disciplinary practices that constitute, somehow, that thing we call 'the state'" (Das & Poole, 2004, p. 3). In particular, by asking people to fend for themselves and their family members, neoliberal social policies have denied vulnerability and the need for dependency in times of severe mental illness. Such denials have burdened family caregivers, as well as their mentally ill loved ones, with poverty, precarity, and everyday defeats. These experiences, along with their traumatic history as former socialist workers, have revealed to family caregivers the post-socialist state's hypocrisy, that is, its way of rhetorically invoking but practically abandoning promises of paternalistic care it has made to its people. They have thus developed conspiracy theories of the state, which help them make sense of their multiple and systematic disadvantages, and allow them to righteously engage in complicit practices themselves in search of welfare, healthcare, and leisure resources.

Moreover, while social work agencies and mental health institutions provide a space for family caregivers' initial gathering, activities there often seek to turn them into individual feeling subjects, whose intimate labor is to be summoned, disciplined, and depoliticized. Refusing this subjectification, family caregivers craft emotional expressions and narratives together, thereby fashioning a virtuous collective identity and attributing their suffering to sociopolitical injustice.

Through these creative practices from the margin, a sociality has emerged among family caregivers. Instead of basing itself solely on biological knowledge and identification, this sociality intertwines understandings of patienthood and kinship with cultural-historical discourses of belonging and entitlement. It allows family caregivers to traverse the public/private boundary and make claims on state or market agents for themselves and patients. I have called such historically-situated, relationally-oriented politics and practice "paternalistic citizenship," and have teased out its multiple discursive dimensions: seeking the state's recognition of familial labor in biopolitical paternalism, asking for the state as an enlarged family to nurture its vulnerable children, and demanding the socialist state to provide for its past and present workers. Paternalistic citizenship, as I have shown, has allowed family caregivers to successfully register certain requests for recognition and redistribution, but it also has some limits in practice. For example, the recursivity of paternalism allows the state to re-territorialize paternalistic responsibilities to the families; meanwhile, (self-)interpellated as dependents and even supplicants of state paternalism, family caregivers have come to experience themselves as vulnerable to state (and corporate) power, and have learned to temper their political demands with a spirit of self-responsibility.

All the different dimensions of paternalistic citizenship can be, and have been, registered in the polysemous concept of *guan.* As theorists in advanced liberal contexts are concerned with how to politicize the often privatized notion of care, the simultaneously intimate and political connotations of *guan* have allowed Chinese family caregivers to negotiate with the state in mutually intelligible ways. Paternalistic citizenship enabled by invocations of *guan* has reconstituted the state: on the one hand, creative marginal practices—such as communities of complicity—exist in parallel to, and as an antidote of, what is seen as a hypocritical state; on the other hand, when government officials affirmatively respond to family caregivers' requests, a populist state is performed. Note, however, that in the Confucian cosmology of kinship/kingship, the state—or previously, the emperor—gains superiority not only by claiming to be a father who rules (*guan*) its people, but also, and more importantly, as a filial son who serves them (Zito, 1997). I suspect that this idea of the filial state underlies people's criticism of bureaucratic institutions that only manage people instead of serving them. Therefore, when paternalism is registered solely in terms of *guan*, and when it is overdetermined by post-socialist conditions such as the withdrawal of the welfare state and the rise of population control, the potentials of paternalistic citizenship are circumscribed. As they are symbolically circumscribed as and economically reduced to supplicants of the parental state, family caregivers, as well as the patients they represent, can no longer claim the more empowering position of paternalistic citizenship.

The struggles for paternalistic citizenship are not limited to family caregivers of people with severe mental illnesses, but rather are generalizable to the broader post-socialist China. For example, in her study of laid-off workers in Northeast China, Mun Young Cho shows that workers have to navigate between invoking the socialist claim as "the people" deserving state paternalism on the one hand, and being counted as members of the newly constituted poor "population," thereby subjected to biopolitical governance, on the other (Cho, 2010, 2013).

Moreover, as the neoliberal welfare policies ask vulnerable people to depend primarily on their families, more and more people will be placed in rigidly paternalistic relationships and struggle for citizenship accordingly. For example, according to my brief interactions during fieldwork with families caregivers of people with intellectual disabilities or autism, they often experience similar socioeconomic predicaments and make similar political demands as our protagonists here do. However, because of the unique intersection into which family caregivers of people with severe mental illnesses are placed, their struggles can tell us more about all the complicated dimensions and dynamics of paternalistic citizenship. The multiple disadvantages that they suffer also require us to work with them and explore what a better future might be, with or without practices of paternalism.

EPILOGUE

Theorizing the Present

In this book, I have traced the circulation, reconfiguration, and transformation of *guan* through family life, mental health institutions, and legal-administrative authorities. In so doing, I have explored the emergence of what I call "biopolitical paternalism" in post-socialist China. Because of the challenges of irrationality, vulnerability, and potential violence that severe mental illnesses pose to the individual and the public, the discipline of psychiatry constitutes a limit case of care and governance in contemporary China. Like Antonio Gramsci's analysis of conjunctural moments in a society's history, psychiatry and the mental health legal reform it has led constitutes a conspicuous terrain on which more sweeping trends of subject formation, intimate association, expert practice, and population management play out.[1] Here I wish to briefly review the forces that have conjoined to make biopolitical paternalism.

1) Formation of biological subjects and a need for their regulation. By now, many scholars have noted the rise of the individual in post-socialist China (e.g. (Fong, 2004; Ong & Zhang, 2008; Yan, 2010)), but few have looked at the simultaneous emergence of different individual subjects and their relations with each other. In this book, I have pointed out that the dominance of biomedicine has given rise to a fundamental split in post-socialist subjectivity,

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[1] In his note "Analysis of Situation: Relations of Force," Antonio Gramsci distinguishes the conjunctural from the organic: "in studying a structure, it is necessary to distinguish organic movements (relatively permanent) from movements which may be termed 'conjunctural' (and which appear as occasional, immediate, almost accidental)." Although conjunctural phenomena themselves may not have "very far-reaching historical significance," they do form the terrains upon which "forces of opposition organize" (Gramsci, 1971, pp. 177-178). Marshall Sahlins has also developed a concept called "structure of conjuncture" (Sahlins, 2013). Note, however, that while Sahlins pays more attention to the symbolic, Gramsci is more concerned with the political. While Sahlins uses conjuncture to explain cultural reproduction in face of new values, Gramsci uses conjuncture to discern forces of change. My analysis draws on elements of both scholars' theories, but I am inclined to use it as a political diagnosis of contemporary China.

between the biologically normal citizen who enjoys autonomy and the pathological patient who requires—and is assumed to benefit from—medical care. This split in the individual subject is scaled up to the population level, producing a propertied, civil, and self-interested public that needs to be defended, and a hazardous and burdensome population that needs to be managed. Bodily disorder is thus connected to social disorder, both of which are now inscribed in the chronic, expansive, and gradational notion of risk.

In a sense, this normal/pathological divide in subject formation and population management is similar to the discourse on Man in 19th- and 20th-century Euro-America. As Michel Foucault argues, this discourse produces the "juridical individual"—the ideal self—through whom "the bourgeoisie claimed power," and the "disciplinary individual"—the abnormal person alienated from the ideal—on whom the bourgeoisie exercised power, distinguishing them from each other (Foucault, 2006, p. 58). I would add that in China, the post-socialist state sees the individual to be disciplined as jeopardizing not only the bourgeois public, but also the stability of its own rule. Moreover, I have shown that in China, management of the abnormal individual and population is justified by, and yet reconfigures, an ethical notion of *guan*. Despite its polysemy, *guan* commonly means bringing things and life into order. For many Chinese, *guan* primarily signifies a cultural ideal of parenting, that is, using care and discipline to bring the vulnerable child to the state of being a full human who is able to act in harmony with the social order. In times of illness and disability, this notion of *guan* gives families and other family-like agents the authority to intervene. Biomedicine is initially only one among many approaches to *guan*. However, it delegitimizes other approaches by restricting *guan* to the management of risks that the pathological subject poses to oneself and to others or even the general public, and by constructing an institutional environment that shores up this biomedical order.

2) Production of the public/private distinction, or homology and divergence between the family and the state. Maoist China downplayed the role of the family and exalted a state paternalism, in which the Party-state envisioned, planned, and built a good life for its people. The post-socialist state, by using law and policy to arrange for interventionist health care, seeks to reclaim this socialist legacy. By establishing *guan*—a notion that primarily signifies parental engagement—as a core principle of governance, the state also draws on the Confucian family-state homology to portray itself as a caring parent. Of course, the life form that the post-socialist state endeavors to produce is no longer a filial citizen or a revolutionary proletariat, but a biologically normal/low-risk subject.

However, the state does not actually perform the work of *guan*, now defined as medicalized risk management, but instead displaces this responsibility onto the family of the pathological individual. This displacement is possible because in the post-socialist era, the family has become the default symbolic and material source of life, carrying the natural(ized) responsibility for care and nurturance. This displacement is possible, also because the increasingly rights-conscious public, especially human rights activists and liberal intellectuals, has become more and more suspicious of state power, often seeing it as an oppressor of the naturally autonomous individual. This anti-state liberalism ironically works with the state's neoliberal orientations. This one can witness in the withdrawal (and, most recently, the highly selective reemergence) of welfare provisions and the cultivation of the self-responsible individual/family through various social policies. In the post-socialist era, a public/private divide of a particular kind has thus emerged, along which the family occupies a flexible position: on the one hand, the family exists as a pristine private realm, protecting the normal citizen against state incursion and spontaneously caring for the pathological subject; on the other hand, the family also becomes a public agent expected to provide for and manage the needy and risky population—public in the sense of contributing to what is taken to be a universal good[2] and enacting what the state claims to be its own character. For researchers, then, this analysis reminds us that individualization in China goes hand in hand with a renewed and revalued familism, and that an attention to the multiple dimensions of subject formation needs to be accompanied by an exploration of the family's multiple roles.

3) Supplementing biopolitical paternalism with ordinary maternalism. Scholars of medical ethics typically define paternalism as using means like coercion, substituted decision-making, choice foreclosure, or information withholding to interfere with a person's liberty of action, in order to promote that person's welfare (Buchanan, 1978; Bullock, 2012; S. Clarke, 2002; Dworkin, 1972). Chinese doctors and policymakers use this presumably universal category of paternalism to justify medical interventions. However, in specific configurations and enactments of paternalism, we need to ask how individual welfare is defined, how it is connected to the desired social order, who actually assumes the responsibility and authority of being paternal, and whether paternalism requires other gendered labors of care.

In contemporary China, when biomedicine defines individual welfare as biological normality, connecting it to public security and political stability, and when the state displaces the responsibility for *guan* to the family, the family becomes a primary agent of paternalism. In particular, families are assumed to be attached to the principle and expertise of biomedicine.

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[2] Yuzo Mizoguchi has pointed out that besides connoting a distinction of spaces/realms, public/private (公/私, *gong/si*) in Chinese also connotes a moral-cosmological distinction between universality and particularities (Mizoguchi, 2011).
Amy Borovoy has shown that in post-war Japan, the family, especially maternal care, is also seen not as a private matter, but as contributing to the public good (Borovoy, 2005).

They are expected to use their authority, attentiveness, and intimate knowledge to guide patients through everyday tasks of medicalization and risk minimization, reporting patients' conditions to professionals and bureaucrats. In this process, patients are imagined to be submissive to familial authority; if they are not, then the medico-legal apparatus allows families to transfer patients to institutions, which can use coercive means and expert power to restore patients to being manageable subjects. I use the term "biopolitical paternalism" to refer to the discursive assumption, arrangement, and circumscription of familial authority/responsibility in individual discipline and population management. The work of biopolitical paternalism allows the state and its institutions to switch flexibly between withholding and extending resources, between governing at a distance and intervening directly. The image of powerful, caring, and non-coercive families helps depoliticize the post-socialist biopolitics (although not entirely so).

In practice, however, the task of patient care and management is often assigned to the more vulnerable family members, such as women and the elderly. Not only do these caregivers not hold much authority over patients, but their proximity with patients also makes them more likely to sympathize with patients' suffering, including suffering as a result of biomedical treatment. Moreover, Chinese ethics and cosmology typically associate paternity with discipline and maternity with compassion. It thus enables a maternal mode of relatedness, which is often but not always practiced by female caregivers. In the practice of what I call "ordinary maternalism," caregivers are open to patients' desires that are incompatible with biomedical normality, and are willing to engage with patients' vulnerability and experiences of alterity. Such engagement efforts are often covert and contingent, and they are often dismissed by the biomedical discourse. In fact, while they may operate with biomedical techniques and under biopolitical demands, the relations that they build often exceed the imagination of biomedicine.

On the other hand, biopolitical paternalism and the state's endeavor to govern at a distance cannot do without the intimate work of ordinary maternalism if they are to take effect. Therefore, biopolitical paternalism takes ordinary maternalism as its supplement, simultaneously enabling, utilizing, concealing, and excluding from itself maternal practices of relatedness. In light of this gendered dialectic, we can see that the family acts as the basic unit, the primary agent, and the limit of post-socialist biopolitics.

4) Power effects and political potentials of biopolitical paternalism. The work of biopolitical paternalism may generate frictions, vulnerabilities, and ambivalence within families. As adults who desire age-appropriate autonomy and meaningful lives are infantilized and subjected to paternalistic *guan*, they develop into conflicts with their family members. What their family members see as care is often perceived by patients as cruel coercion. Indeed, when *guan* is reconfigured as chronic risk management through medicalization and institutionalization, it sometimes brings more disruption to patients' life than the illness itself, making its proclaimed goal of producing hope and normality even more unattainable. Meanwhile, as the responsibility for patient care and management is relegated to women and elderly family members who do not hold much authority over patients, the task of *guan* becomes a constant struggle. Caregivers' suffering and vulnerability fail to be registered in, and are in fact reinforced by, the notion of biopolitical paternalism upheld by the medico-legal discourse. Moreover, given that the task of risk management is indifferent to how and where it is achieved, the work of biopolitical paternalism produces ethical ambivalence about what counts as *guan*. For example, families that choose to hospitalize patients indefinitely may feel that an inpatient stay provides professional *guan*. Yet patients themselves may perceive long-term hospitalization as abandonment, as the

opposite of *guan*, because as a cultural ideal of parenting, *guan* hinges upon intimate affects and kin relations, aspiring to produce differences in life.

By ignoring people's vulnerability and need for dependency, social policies that uphold biopolitical paternalism serve to marginalize the pathological subjects and their family members. However, they have also inadvertently given the marginalized group a discursive leverage to claim recognition and entitlements. In particular, as it connects care, discipline, management, and governance together, the polysemous notion of *guan* can never be completely depoliticized; instead, it always leaves a trace that allows caregivers to detect the biopolitical dimension of their intimate work. When the state uses *guan* to legitimize its own governance but displaces the responsibility for *guan* onto families, caregivers may flip the demand of *guan* back onto the state, asking the state to recognize their contribution to population management. Intertwined with biopolitical paternalism, paternalistic *guan* in China also has Confucian and socialist genealogies. Therefore, caregivers may ask the state to become a proper parent and nurture its vulnerable children (the sick and the old), and they may demand that the state realize its socialist promise and provide for its workers. Besides overt demands, these discourses of paternalism allow caregivers to discern the hypocrisy of the post-socialist state and to conscientiously engage in covert practices of resource navigation. I use the term "paternalistic citizenship" to refer to these historically situated, relationally oriented appeals to entitlements, appeals that destabilize the public/private divide and seek an enlarged relationship of dependency.

While revealed by the limit case of psychiatry here, I contend that biopolitical paternalism bespeaks the general tenor of post-socialist governance in China. This post-socialist governance is shaped by conditions such as the biomedical reconfiguration of "the people" into a “population” that needs to be managed, the neoliberal devolution of welfare and healthcare, the rise of the security state, and the continuation of a one-party rule that invites a range of ideological attachments. We can find other instances of biopolitical paternalism in China. For example, the family planning policy has made the married couples responsible for producing fewer (and now more) children, but children thought to be of better “quality,” in order to save the nation-state from a “population crisis” (Anagnost, 1995; Greenhalgh, 2008). However, children thus produced, especially those that are not fully in compliance with the quantity or quality demand, are primarily seen as families’ responsibility and liability. When parents have difficulties with childrearing, there are no easy ways for them to gain public assistance or to transfer their children to the care of the state, so some of them have to surreptitiously leave their children on the street or in other public settings. In order to decrease the harm such “abandonment” might bring to children, from 2011 to 2014, government-run orphanages in some cities opened “safety islands” for struggling parents to leave their children (typically infants) there. Yet this channel of transfer had many ritualistic arrangements for shame built in. For example, the “safety islands” were only open during nighttime, implying that child abandonment was a crime and could not see the light of day. Even so, there were more infants flowing in than what the orphanages could manage, and most of them had serious disabilities, so the safety islands were soon closed down. When reflecting on these failed experiments, policymakers and experts seldom mention the possibility or even duty for other state agents to get involved and help families in need, such as providing or subsidizing disability and critical illness insurance for children. Instead, the main suggestion they came up with was to enforce the long-standing pre-marital and prenatal examinations associated with family planning, so that it would be less likely for couples to produce abnormal children (Z. Ma, 2014b). Again, the flexibility of *guan* allows the state to choose how to engage or not engage, and to continually re-inscribe the responsibility of population management and disease prevention onto families.

As the post-socialist state increasingly expands its social management, other non-familial relations, such as neighbors and schoolteachers, are pulled in to performing *guan* as well. In our contemporary world, as biomedicalized techniques of rule continue to redefine individual wellbeing and population security, and as neoliberal economic policies continue to relegate responsibilities to achieve these new ideals to the private sphere, one can certainly find manifestations of biopolitical paternalism outside China as well. My point is not that these instances are equivalent, but that an analytic of biopolitical paternalism can illustrate how vulnerability is conceptualized, addressed, elided, or aggravated in each instance. These explorations, in turn, may help us reflect on the vision of good life and the terms of responsibility we hold for others and ourselves.

Intimating the Future

As this book is being written, a sea change is taking place in China's mental health field. Forces that have conjoined to make biopolitical paternalism are taking on new forms. As I hinted in the last chapter, the central and local governments are planning to respond to family caregivers' requests to recognize and compensate them for their intimate labor. In relatively wealthy coastal areas like Beijing and Guangdong, starting from 2016, family guardians are to receive "subsidies for [patient] care and management" (看护管理补贴/*kanhu guanli butie*), ranging from CNY 2,400 (USD 360) to CNY 5,000 (USD 750) a year. This amount is much higher than existing welfare subsidies. However, while existing subsidies are simply handed out to those deemed in need, the new benefit has strings attached, and it has teeth: guardians are required to work closely with community mental health workers, policemen, and other street-level bureaucrats, reporting to them any change in patients' conditions. Should a patient commit any act of violence, a whole year of care and management subsidies will be denied to his/her guardian (BJCHFP, 2016; Hong, 2016).

In fact, one could say that rather than recognizing families' sacrifice or using financial redistribution to restore justice to the situation of care, this new policy of community mental health allows the state to more completely outsource present responsibility and future liability for/of population management to families, although families hardly have the freedom to decide whether to sign the contract or not. This outsourcing is deemed necessary, because the last two to three years have seen a surge of reports about mentally ill patients beating up or slashing strangers in major cities (e.g. (J. Cheng, 2015; D. He & Li, 2015)). These reports have created an impression on the part of both the state and the populace that a pandemic[3] of mad violence is looming. As Carlo Caduff points out, the image of the pandemic enables mass mobilization, and allows a "geography of blame" to be drawn (Caduff, 2015, p. 2). In China, the perceived "pandemic" of mad violence has intensified the community management of severely mentally ill patients, which in turn takes patients' families as key targets of mobilization and blame. In many parts of the country, it was reported in early 2016 that when the new family subsidy was proposed, family members of patients registered in the 686 Program were asked by local policemen or community bureaucrats to sign a liability statement (责任书/*zeren shu*). The statement stipulates that family members/guardians are civilly liable for any damage that their wards might inflict on other persons or properties (Dami, 2016). Some family caregivers in Guangzhou told me that they had refused to sign the statement, for fear that it might mean

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[3] Elsewhere I argue that the 686 Program has implicitly modeled on the infectious disease model dominant in China's and global public health (Z. Ma, 2016).

unlimited responsibility on their shoulders. The push and pull of biopolitical paternalism is thus likely to continue as the unstable foundation of community management, generating new forms of institutional arrangements and new possibilities of resistance.

After the mental health legal reform, human rights activists like those from Equity and Justice Initiative (EJI) have been looking for other battles to fight, to further patient rights to autonomy. They have been struggling for the discharge of long-term hospitalized patients, for psychiatric patients' independent living in community settings, and for an overhaul of the guardianship system. While the previous battle against involuntary hospitalization could be fought with cases of "normal" individuals who claimed to have been wrongfully diagnosed and institutionalized, these new battles require the voices of people who willingly identify themselves as having mental illnesses and yet are dissatisfied with the existing mental health system. After all, back in the days of the mental health legal reform, the fact that the human rights campaign lacked a constituency of mentally ill patients was also what brought it criticisms from psychiatrists. Ever since then, activists have been seeking to cultivate this constituency.

So far the activists' efforts have not achieved satisfying results. As I observe, this is partly because their confrontational methods of rights advocacy, as well as their assumption that rights bearers are free, equal, independent individuals (Nussbaum, 2006), often conflict with the desire for intimacy and the deeply felt vulnerabilities of people with severe mental illnesses. For example, through my introduction, EJI staff came to know Mulan, the niece of Mrs. Mai, whom I mentioned in the last chapter. After learning about Mulan's predicaments—having lost her father, having been abandoned by her mother, and being cold-shouldered at her aunt's home—EJI staff was moved and wanted to help. However, while the help that Mulan asked for was financial support for her small business plan, EJI staff dismissed this request and proposed to sponsor her travel around the country, so that she could tell her story to the public. As Mulan later told me, EJI staff also suggested that they "play with law" together, fight for resources for her independent living, and promote radical changes in, or even elimination of, the guardianship system. Mulan was upset by this proposal:

> "What's the use of giving speeches? You can invite politicians, celebrities, or whoever you want to join the audience, but for them, [my story] will just go in one ear and out the other. Will that make any change? That won't solve our problem at all!
>
> They [EJI staff] said 'playing with law.' Sure, they [lawyers] can manipulate law, but how can we ever do that? At the very best, we can have a dialogue with the law and make it improve. The word 'play' sounds too frivolous and disrespectful. I really don't like it."

As Mulan saw it, the playful or confrontational stance that the human rights activists wanted her to assume required strength and power on her part, and it ignored the key fact that she, like other people with severe mental illnesses, was vulnerable. Exposing one's vulnerability to unconcerned strangers, either through lawsuit or through public speaking, could be humiliating and injurious. Because of this vulnerability, what Mulan wanted was not an end of intimate relationships, which exposing her relatives' wrongdoings would surely bring about. Rather, she longed for a proper *guan*, or kindred care and responsibility, from her relatives. Relatedly, instead of absolutely "independent" living, Mulan aspired to a prosperous life with her families, and a means of economic subsistence that could prove her worth to them. Public support and community resources should help her realize this vision of good life. Law was also required in this process—not a law that consisted only of empty, manipulatable words, but a law that could understand and protect one's vulnerability.

Although not all of her desires and plans are shared by every person with severe mental illness—for instance, many of them do want to live alone—her case helps explain why a legalistic and adversarial approach to rights advocacy might fail to win the support of the very population activists seek to represent. As I see it, it is not that the activists deliberately disrespect anyone, but their dismissal of human attachments and concrete difficulties in life does impose an unbearable lightness on the vulnerable persons. How to engage with vulnerability as a positive existence rather than a mere illusion (Kulick & Rydstrom, 2015), how to advocate for social change that could promote the concrete wellbeing of individuals rather than abstract rights, how to think of law not only as textual/technical instruments but also as objects bearing ideological investments… these are questions that the human rights activists have been and need to continue grappling with in their work. They—or we—can find ways to cure the ills of biopolitical paternalism, as seen in the existing guardianship and hospitalization practices, only by envisioning and helping to assemble a public that engages with vulnerability, but which is open to discussions of what such engagement entails.

Some of the engagement efforts are being made by social workers, a profession that is only recently emerging in China. In this book, we have seen that mental health social work centers have provided spaces for family caregivers to meet each other and form a sociality among themselves. Social workers provide family caregivers with information on mental illness, methods of care, and welfare policies, organize cultural and entertainment activities for patients and families, and hold workshops that allow caregivers to vent their frustration, anger, and sadness. I have also mentioned in passing that operating in a community-based rehabilitation approach or on a mental health recovery model, social workers have been running shelter workshops, vocational training classes, and clubhouses for people with severe mental illnesses, all with the aim of restoring dignity and productivity. Social workers also visit patients' homes, mediating patients' relationships with family members. In cases like the tragic suicide that I discussed in Chapter 5, they conduct crisis intervention on the scene, coordinate help from other professionals and bureaucrats, and after the event, provide recommendations on policy and service improvement to different stakeholders.

Of course, not all aspects of social work services serve to engage with people's desires and vulnerability. During fieldwork, I sometimes saw social workers telling family caregivers not to be overprotective or restrictive in their interactions with patients, that is, not to *guan* too much. Such advice was seldom effective, and it was often seen by caregivers as callous. By now, we can understand why. For one, the social workers' advice ignored the cultural ethics of *guan*, especially in the sense of kind intentions and loving feelings underlying the seemingly tough practices. For another, even though practices of *guan*, as I have shown, could lead to added vulnerability and even to injuries, we should understand the institutional, political, economic, and discursive conditions that have reconfigured *guan* in this way. Because these social workers are trained to work primarily with and on individuals, and because as government contractors, they often consciously avoid challenging the political status quo, their work sometimes has the effect of blaming victims and disciplining the vulnerable.

Even in Guangzhou, one of the hotbeds of developing social work services in China, social workers specialized in mental health are still few in number. So are patients and families who have come into contact with them. Many of the service approaches are experimental and temporary. Therefore, in this book, I did not give much space to the social work profession itself. However, the situation is rapidly changing. In June 2015, the Ministry of Health announced a new five-year plan for mental health work. The plan requires that by 2020, 70% of all cities are to have community rehabilitation agencies (*National Mental Health Work Plan (2015-2020)*, 2015), a rapid increase from the few that exist at the moment. This process will demand a large workforce of social workers. To influence and take advantage of this trend, many interested groups have already been trying to build alliances with social workers. Psychiatric hospitals have started to hire social workers to provide rehabilitative services within their four walls. Local 686 program teams have begun to ask social workers to conduct home visits for them, and to provide case management for select patients. And human rights activists have been trying to recruit social workers in their disability rights training sessions. It would thus be interesting to follow the development of mental health social work across the country, to explore how the new professionals grapple with these different forces, taking on, redefining, or challenging different agendas in their everyday work.

If Chinese psychiatry in the last three decades has been dominated by a keyword, family, then all these new developments are pointing to another keyword, community (社区/*shequ*). In fact, they have all branded themselves as community mental health initiatives. Note, however, that "community" conjures different images for different interested parties, and these images all have roots in global circulations: the 686 Program's effort to establish a network of general practitioners-turned-community mental health workers is partly a response to the global mental health movement's call for scaling up primary care (Group, 2007); influenced by the Euro-American recovery movement, social workers typically see community as a space for inclusion and empowerment (Jenkins & Carpenter-Song, 2005); for human rights activists, community could be either a collective of citizens wounded by and fighting the totalitarian state, or a radical alternative to the total institution, both of which are images advocated by the global human rights movement (Perlin, 1992). Besides these images/ideas, the community mental health programs are also infused with global funds, knowledges, and agendas, such as money from Western foundations that are aimed at promoting civil society development in totalitarian countries. When circulating to China, these diverse global forces each must come to terms with the post-socialist state and its efforts to make its governance more scientific, decentralized, humane, and yet pervasive and stable. As the new five-year plan is likely to bring the development of community mental health programs to an unprecedented level, the next few years will be a golden opportunity for us to examine how the contours of care and governance are reshaped, and how China’s geopolitical position is remade, all through making communities of/with/for the vulnerable in its population.

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