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When psychiatry encounters local knowledge of madness: Ethnographic observations in a Chinese psychiatric hospital

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ABSTRACT

As the number of psychiatric hospitals are on the rise in China, this article examines how the psychiatric discourse as articulated by hospital staff interacts with local cultural understandings of madness/mental illness, as well as how such interactions impact patients and families' reception of psychiatry. Data comes from 16 months of fieldwork in a psychiatric hospital in South China. We show that psychiatric professionals at the hospital attempted to establish their professional authority by discrediting other cultural epistemologies embraced by patients or families, such as religious and traditional Chinese medical understandings. Despite the quick effect of psychopharmaceuticals to control symptoms, the psychiatric perspective ultimately fell short in addressing the social and moral struggles faced by patients, such as patriarchy and gender-based violence. Moreover, as psychiatric professionals unreflexively used certain problematic local concepts to convey a biomedical and even genetically-determined account of mental illness to patients and families, they risked entrenching the stigma of mental illness and disempowering their clients. To improve the quality of mental healthcare, to make clients feel culturally safe and respected in clinical encounters, psychiatric professionals in China should develop a more holistic approach that takes into account the biological, psychological, and sociocultural aspects of mental illness, that recognizes the diverse sources of help clients may rely on. They should also develop a critical awareness of the language they use and of the power dynamics in which they and their clients are situated.

1. Introduction

In China, recent epidemiological studies have indicated a weighted lifetime prevalence rate of any mental disorder (excluding dementia) of 16.6%, marking a higher prevalence than previous numbers (Huang et al., 2019). In response to the increased prevalence of mental illness, the Chinese government has been allocating more resources to mental health, previously regarded as a lower priority in political agendas. Despite the substantial government investment in mental health services, a significant discrepancy persists between the potentially vast needs for mental health care and the under-utilization of services (Xu et al., 2022). This gap might be caused by the stigma of mental illness that prevents people from seeking help (Hu et al., 2021; Xu et al., 2018), but it also could be attributed to differences and even conflicts between local understandings of madness and the psychiatric perspective.

Indeed, while psychiatry positions itself as scientific and universal, interpretations of mental illness in Chinese culture are diverse and closely related to the country's rich tradition of philosophy, religion, language, and medicine (Baum, 2018). This study uses ethnographic fieldwork in a Chinese psychiatric hospital to examine how the psychiatric discourse articulated by the staff interacts with local understandings of madness/mental illness, and how such interactions impact patients and families' reception of psychiatry. Note that by culture, we refer not to an ahistorical whole embraced uniformly by a nation or people, but to matrices of meanings and relations that are historical sediments while also subject to change. Understood as such, cultures in any given society are diverse and suffused with power dynamics (Kirmayer, 2012; Ortner, 2006). Because culture shapes experience, expression, course, and outcome of mental health problems, desired treatment, and help-seeking behavior (Kleinman, 1991), understanding psychiatry's interactions with local knowledges will help stakeholders design and practice culturally more responsive mental healthcare in China and similar contexts.

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2. Historical and theoretical backgrounds

2.1. Traditional Chinese cultural understandings of madness

Historians and anthropologists have examined traditional Chinese medical understandings and classifications of madness (e.g. Kleinman, 1980; Lin, 1983; Tseng, 1973). They found that classic medical texts typically referred to madness as *dian* and *kuang* (or their combination). In the *Suwen* Chapter of the Yellow Emperor's Internal Classic of Medicine (*Huangdi Neijing*), the first ancient medicine text mentioning madness, *dian* and *kuang* were described respectively as excessive elation (*duo xi wei dian*) and excessive anger or perhaps violence (*duo nu wei kuang*). Apart from *dian* and *kuang*, words like *feng* (lack of restraints) and *xian* (unconsciousness and convulsions) were also used to refer to madness in classic Chinese medical texts (Simonis, 2010). Many of these words are still used in everyday conversations in Mandarin. However, few studies have paid attention to the concepts of madness in Chinese dialects.

As different schools of philosophy concurred in Song and Ming dynasties to view things in the world as manifestations of *qi* (life force or vital energy), Chinese medicine also came to prioritize *qi*'s role in illness formation and health maintenance, including in what is called mental health today. Especially through its encounter with Western medicine since the late imperial era, Chinese medicine has been established as a distinct cosmology emphasizing the flows and transformations of *qi* rather than anatomical structures, followed by a holistic rather than segmented view of human beings (Lei, 2014; Scheid and Karchmer, 2016). Unlike biomedicine, Chinese medicine does not assume an absolute mind/body separation. It sees strong emotions, excessive thinking, and physiological imbalance alike as able to disrupt or diminish *qi*, creating mental and physical distress (Chen, 2014). For instance, *yu*, the word that is used to translate depression today, refers to both sadness and feelings of sluggishness, and the whole set of symptoms is considered by Chinese medicine as a result of *qi* stagnation. To facilitate the harmonious movement of *qi*, traditional Chinese medicine tends to treat "mental" illness with techniques such as herbal medication or acupuncture similar to other, more "physical" diseases, as well as social adjustments and emotional counteractions (Zhang, 2007).

Additionally, in traditional Chinese cosmology, reality is not limited to the tangible human world, but also includes realms inhabited by gods and ghosts. One's spirits (e.g., *hun* and *po* "souls") usually reside in one's material body, but they are sometimes abducted by supernatural beings; or supernatural beings could enter one's body, interact with, or even replace one's own spirits (Veith, 1963). In both situations, the person is vulnerable to many disorders, including madness, and religious rites may be practiced for exorcism or restoration of the person's spirits (Ng, 2020; Yang, 2006).

Whether suffering from a *qi* disorder or a spirit disruption, the mad individual could be seen as acting in violation of the social order and not conforming to the Confucian ideal of self-cultivation, hence a moral failure (Li, 2013; McLeod, 2021). For instance, in Chinese classic patriarchy, women were supposed to follow their fathers and husbands. Their values were defined by their sexual purity, ability to procreate, and care for family members (Hong et al., 1993). This patriarchy was repeatedly challenged throughout the 20th century, but it has recently been reinforced by the reintroduction of Confucianism into public discourses (Yu et al., 2022). As such, women who suffer from mental illness might experience added stigma for their presumed impropriety and inability to meet gender expectations. It thus begs the question of how psychiatry may respond to these diverse culturally-situated understandings of mental illness, some of which might give people hope while others might bring them suffering.

In examining these cultural encounters, we pay special attention to the mediating role of language, for it conveys and organizes meaning. Anthropologists and cross-cultural psychiatrists have long been exploring people's idioms of distress across the world. They locate those idioms historically in changing social conditions, while focusing on the "pragmatics and micropolitics" of how, why, and to what effect people "are invested in interpreting polysemious experiences of distress in a particular manner" (Nichter, 2010, 403). For instance, Arthur Kleinman (1986) showed that neurasthenia or *shenjing shuairuo* as a common idiom in 1980s′ China helped people somaticize distress, i.e. experience and express distress in physical terms. He suggested that somatization was partly a legacy of Chinese medicine and partly the result of political undesirability of emotional expressions in the aftermaths of the Cultural Revolution. Although Chinese psychiatrists at the time accepted that term and provided treatment around it, many other idioms of distress are met with negative reactions from psychiatry because they are often associated with alternative understandings of illness etiology and treatment approaches. For example, Beatriz Reyes-Foster (2019) has shown that Mexican psychiatrists tended to dismiss patients' spiritual explanations for symptoms as "poorly structured magical-religious delusions" (111). Meanwhile, Ma (2012a) demonstrated that when Chinese psychiatrists imposed their singular understanding of mental illness, patients and families adopted alternative idioms and explanations to assert "cultural resistance."

In this study, we likewise examine how psychiatric professionals respond to patients' and families' idioms of distress and what effects such responses may produce. Our contributions are three-fold: one, four decades after Kleinman's study, as Chinese psychiatry has become more globalized and the country's sociopolitical environment has dramatically changed, we explore whether and how somatization is still at work in mental healthcare. Two, we pay attention to how idioms of distress are expressed through local dialects and practices, creating a linguistic and epistemological community to which psychiatrists must speak. Third, related to the previous point, while studies have explored how psychiatry dismisses and denounces local cultural idioms of mental illness, we further examine how it may utilize those idioms to convey its own understandings, making them more entrenched. Neely Myers (2016) has shown that recovery from mental illness has less to do with the effectiveness of specific treatment than with whether one can establish moral agency, that is, the intention and support to aspire to good life. In examining the process and effects of Chinese psychiatry's cultural encounters from a linguistic perspective, we thus shed light on how psychiatry may offer linguistic resources to amplify or diminish people's moral agency.

2.2. Psychiatric hospitals and cultural encounters

As one of the key venues of mental health care, psychiatric hospitals offer an important context in which to examine the profession's cultural encounters. At the turn of the 20th century, medical missionaries from Western countries attempted to replace the local perceptions and treatments of madness in China with a "scientific" and "modern" approach (Chiang, 2014). They built asylums for the insane, introduced diagnoses of psychopathology, trained Chinese psychiatrists, and promoted Western psychiatric theories to the public, such as eugenics, psychoanalysis, and later neuropsychiatry. Nevertheless, local concepts of madness still permeated the new institutions and people's everyday lives (Ma, 2014a). Throughout the Republican era, people's understanding of madness/mental illness oscillated between neuropsychiatry, Chinese medicine, and religious therapies "in ways that reflected their individual needs and beliefs" (Baum, 2018:159). In fact, with no more than 10 psychiatric hospitals across the country before 1949 (Liu et al., 2011), people in most areas continued to treat mental illness in traditional ways.

Psychiatry underwent a bout of development after the People's Republic of China was founded in 1949. To this day, three government sectors—health, civil affairs, and police—are responsible for building and overseeing mental health facilities, with the health sector being the main force. By 1958, there were 49 psychiatric hospitals nationwide with 11,159 beds in total. While there were no comprehensive statistics

in the 1960s, records from the Ministry of Civil Affairs indicated that in 1964, it oversaw 203 hospitals accommodating more than 18,000 patients (Xu, 1995). During the Cultural Revolution in the 1960s and 1970s, few new facilities were built. Because mental illness was regarded as a disease of Western capitalist ideologies, patients received thought education, as well as a combination of Chinese and Western medicines, as treatment in hospitals (Baum and Lin, 2022).

In the market-reform era that started in the 1980s, as China embraces globalization, biomedicine has become dominant in most psychiatric hospitals, and psychiatrists typically understand mental illness as a result of neurochemical imbalance (Phillips, 1998). Since the 1990s, psychotherapy and psychological self-help have become increasingly popular among the Chinese public (Huang, 2015; Zhang, 2014). However, for people diagnosed with any kind of serious mental illnesses, such as schizophrenia or bipolar disorder, inpatient pharmaceutical treatment, especially that provided by psychiatric hospitals, is still the dominant mode of service (Ma, 2020). In this era, the number of psychiatric hospitals in China has been growing rapidly. From 2010 to 2015, the number of psychiatric hospitals increased by 41 percent. By 2015, there were a total of 2936 mental health facilities nationally. Among them, 1235 were psychiatric hospitals, which accounted for 77.80% of all psychiatric beds. Other mental health facilities included psychiatric departments in general hospitals, rehabilitation hospitals, primary health clinics, and psychology clinics, but their roles were much less significant in terms of treating serious mental illnesses (Shi et al., 2019).

This rapid increase of mental health institutions in China reflects the state's effort to provide care for people with mental illnesses. Meanwhile, it can also be seen as part of the growth of psychiatric power (Foucault, 2008). For instance, Zhiying Ma (2020) has argued that, by allowing and enabling family members to commit their loved ones, and by emphasizing patients' chronic pathology, risk, and the need for pharmaceutical management, psychiatric hospitals are exerting social control in the name of care. Except for Ma's study and a few others (Ng, 2009, 2020; Yang, 2017, 2023), little ethnographic fieldwork has been done inside the psychiatric hospital at least in the past decade, despite the growing scholarly attention to mental health in China (e.g. Huang, 2015; Kleinman, 1986; Yang, 2015; Zhang, 2020). This is regrettable because it is in the enclosed space of the hospital ward, where many patients are admitted involuntarily and stay for a period of time, and where families are grappling with seemingly radical changes in their loved ones, that one can see the active sense-making of mental illness by all parties involved, with the tensions between them dramatized. In this article, we thus go inside a psychiatric hospital to examine the interactions between psychiatric and local cultural understandings of mental illness. As new professionals such as social workers slowly find their ways to the hospital, we also pay attention to how their understandings of mental illness and their interactions with clients might complicate and enrich the dynamics.

In what follows, we show that psychiatrists and nurses attempt to establish their professional authority by discrediting other cultural epistemologies, but their perspectives ultimately fall short of addressing the social and moral struggles faced by patients. As the biomedical model of mental illness unreflectively incorporates local concepts of madness, it has the potential to further stigmatize patients. With their attention to the whole person and emphasis on social support, social workers might ameliorate some of the impact, but their roles remain marginal. In many parts of the world, psychiatric hospitals are still important venues of mental healthcare, despite the growing trend of deinstitutionalization. They offer spaces to grapple with visions of postcolonial modernities (Reyes-Foster, 2019), to remake or unmake family relations (Pinto, 2011), and to exert social control (Brodwin and Velpry, 2014). By looking at clinical and cultural encounters in the psychiatric hospital, we shed light on the epistemological and linguistic processes of how those effects may be achieved.

3. Materials and methods

Ethnography, or the combination of participant observation and in-depth interviews, has been used for research in medical settings because it allows researchers to capture the clinical encounters and different parties' perspectives in a nuanced and contextualized way (Dikomitis, 2016). To understand the cultural dynamics in psychiatric hospitals, the first author of this paper conducted fieldwork in F Hospital, a municipal psychiatric hospital located in the peri-urban area of a second-tier city in Guangdong Province. The hospital's psychiatry department includes four wards–two male and two female–with 400 beds in total. Each ward has a director, four psychiatrists, a dozen nurses, and a few care workers. Though the wards have a fixed number of beds, the number of patients often exceeds capacity. In 2016, the hospital established a new social work department; it had two full-time staffers at the time of fieldwork. Compared to prestigious psychiatric hospitals in Beijing, Shanghai, Guangzhou or Shenzhen, F Hospital is a more typical hospital in China because of its crowdedness and lower staff-patient ratio.

Data in this paper comes from 16 months of fieldwork that the first author conducted between 2017 and 2019. The fieldwork was approved by the Ethics Committee of F Hospital. On the wards of the psychiatric department, the first author observed how patients, their family members, psychiatrists, and nurses understood mental illness, especially any differences and conflicts among them. She also interviewed those individuals to gain their more systematic understandings and reflections on specific cases or encounters. Moreover, trained as a social worker, she assumed the role of a social work intern on the wards, organized patient groups, and provided individual case management. This direct participation allowed her to have more meaningful interactions with different parties, to better observe and compare their perspectives.

The first author took detailed notes of her participant observation at the end of every day and transcribed the interviews verbatim in Chinese. After the fieldwork, the documents were coded using an inductive approach, that is, reading transcripts to list themes and concepts for the subsequent analysis, reducing, and coding, with a focus on identifying categorizes of perceptions of madness/mental illness. The second author helped develop the analysis with her decade-long ethnographic engagement with hospital psychiatry and family care in China.

4. Results and discussions

4.1. *"Superstitions" vs. medications*

Nana[1] was an 18-year-old high school student diagnosed with schizophrenia. She was in stupor when she was initially hospitalized. Nana's mother thought Nana was horrified by the hospital environment, so she desperately sought accompaniment for her daughter. She eventually found a social worker,[2] with whom she shared Nana's situation: a year ago, Nana started acting strangely, stealing money, and having difficult peer relations at school. She claimed to be ostracized by classmates and teachers. When found talking to herself, she explained that she was responding to a human voice. She then took a leave of absence and avoided people at home. Her mother consulted psychologists, but Nana refused to see them. Her mother also thought about psychiatry but feared the stigma that the mental illness label would bring to her. During that time, a woman that the family met at a funeral claimed Nana was possessed by a ghost. She performed an exorcist ritual on Nana, but it didn't work. Nana's father then sought help from other women and a

[1] To protect confidentiality, pseudonyms were used in place of participants' names.

[2] At the time of fieldwork, there was no mechanism for the psychiatric department and the social work department to collaborate, so patients or their family members needed to contact social workers if they wanted this service.

local temple, also to no avail. After a year's deterioration, a relative who was a nurse urged them to send Nana to a psychiatric hospital, which they did.

Demonic possession is a common interpretation of madness in rural China (Ng, 2020). As individuals hear or see something beyond the physical world, seeking help from a temple or a spirit medium seems to be a logical treatment (Yang, 2006; Lee and Kirmayer, 2022). Retired nurse Zhou at F Hospital mentioned that at the onset of mental illness, people in her village typically thought about ghost possessions, and they would seek help from the village temple. She recalled one patient in the 1980s:

> A man in my village lost his mind (*so*[4] *zo*[2]). My young brother gave his family members my address and they sent him to F Hospital … The mother of the patient was very superstitious, and she went to a local temple to request a tea bag blessed by gods. She gave the tea bag to me, asking me to put it in her son's drinks, but I did not do that. After the patient recovered, I showed the tea bag to the mother and told her that it was not the tea that had worked but the pharmaceutical treatment. [I said that] our treatment should be scientific.

Here, we can see how the nurse established the epistemic superiority of psychiatry over the family's religious practices. The psychiatric training made her proud of her job; she deemed psychiatric treatment as effective to cure mental illness and religious healing such as drinking gods' tea as superstitious. By not following the family's request to give the patient the tea, she used the patient's recovery as evidence to persuade the family that mental illness was a scientific issue and should be treated biomedically. By actively referring fellow villagers to the hospital, she could be seen as trying to change the understandings of madness among the rural public as a whole, who was generally regarded as more backward and superstitious.

Efforts by Nurse Zhou and colleagues achieved limited effects. After learning more knowledge about psychiatry in the hospital and seeing the improvement of Nana's symptoms, the mother came to see psychopharmaceuticals as useful. However, through follow-up interviews, we learned that Nana's mother, like many people in rural China, had become a Christian lately (Qi et al., 2014). She attributed the recent relapse of Nana's symptoms to Nana not joining the church meetings as she had suggested. Her understanding of madness thus seemed to be hybrid: while she appreciated psychopharmaceuticals' efficacy in symptom control, it was religion that gave her an answer to the existential questions of "Why me?" "Why now?" (Taussig, 1980:4), that brought her a sense of moral agency in terms of knowing what to do to right the wrong.

4.2. Controversies around Traditional Chinese Medicine

As mentioned, Chinese medicine has existed and evolved in China for thousands of years. Nowadays, in contradistinction with western medicine or *xiyi,* it is typically called Traditional Chinese Medicine (TCM) or *zhongyi*, and it is still well received and widely practiced by the general public to treat all kinds of conditions. As discovered in the fieldwork, before sending patients to the hospital, many family members had attempted to take them to see practitioners of TCM. For example, Ah Hui, a 23-year-old man who had been diagnosed with schizophrenia for six years, recalled that at the onset of his illness, his mother took him to a TCM doctor. Because he complained about a headache, the doctor tapped on his head and then prescribed him with herbal concoctions to make and drink back home. Unfortunately, his condition deteriorated, which led to his first hospital admission, followed by two others over the years.

Indeed, in the initial stage of mental illness, patients often first notice physical symptoms, such as headaches, abdominal pain, heartburn and the like, which lead them or their family members to seek help from TCM. As mentioned, Arthur Kleinman (1986) noticed a tendency in 1980s′ China for patients to somaticize. More than two decades later, Yanhua Zhang (2007) and Zhiying Ma (2012a) noticed separately that Chinese patients with mental illness had no trouble experiencing and identifying emotional distress, and that emotional distress and physical discomfort were entangled processes for them. Either way, because TCM sees the bodily, psychic, and social aspects of human life as all interconnected and guided by the flow of *qi*, because it focuses on treating the whole person rather than just the specific symptoms, it is understandable that people tend to turn to it in the first instance. Besides, because TCM's treatment of what biomedicine sees as mental illness and physical disfunction is similar, it does not carry the stigma of going to a psychiatric hospital or seeking help from a psychiatrist.

Psychiatry in China has gone through a complicated history in relation to TCM. Because Chairman Mao praised TCM as "a great treasure house" and advocated for an integrated medicine, psychiatrists in the Maoist era often used herbs, acupuncture, and moxibustion together with psychopharmaceuticals and electroshock therapy (Chao, 1965). In the market reform era that started in the 1980s, most psychiatrists have gradually de-emphasized and even rejected the use of TCM, for they see biomedicine as globally validated and TCM as unable to even correctly recognize the nature of mental illness, which is neurochemical imbalance.

It is understandable that TCM might not be the most effective at controlling the disturbing behavior of mental illness, as can be seen in Ah Hui's case. However, when psychiatrists celebrate the quick and powerful effect of psychopharmaceuticals, they often gloss over the fact that many patients have to take the medications for years, and the medications' heavy side effects might interfere with patients' daily life and make them look "abnormal"; even so, it is not uncommon for patients to have relapses and re-hospitalizations, like Ah Hui. These downsides are not lost on patients' family members. Influenced by the legacy of integrated medicine, they often ask psychiatrists to prescribe TCM to alleviate the side effects of psychopharmaceuticals, and they might also bring homemade medicinal soup to the ward to help their loved ones achieve the balance of *qi*. Most psychiatrists whom the authors encountered would allow families to do so and comply with their requests[3]: while a few psychiatrists appreciate TCM's effects in keeping the body in harmony, if not in treating mental illness itself, most of them see it simply as a placebo to please the consumers. As such, the use of TCM in mental healthcare is very much circumscribed.

4.3. Silence on suffering

Qiong, an inpatient diagnosed with bipolar disorder, had two children and was in her late forties. She had the habit of expressing herself through writing letters, and she used to give those letters to her doctors when they made their rounds. Her doctors would return the letters after scanning them very briefly. Later a hospital social worker got to know her, kept the letters, and encouraged her to continue writing. In her letters to the social worker, Qiong repeatedly recounted her traumatic life story: when she was eighteen, the police informed her brother that she and another "bad woman" in the village had sought improper relationships with men, even though she was just a pretty girl quietly working in the factory. Her brother believed in what the police said, rejected her explanations, accused her of "losing face for the family," and ostracized her. The accusations and ostracization greatly distressed her. She wrote:

> I didn't play with those bad sisters … How could he believe in others but not me? … I felt painful.

She started hearing voices, developed bad headaches, lost motivation, and had to quit her job in the factory. Her father then took her to the psychiatric hospital.

[3] Psychiatrists and other biomedically-trained doctors can prescribe traditional Chinese medicines prepared in ready-to-use forms.

After the police call and especially her first hospitalization, villagers constantly gossiped about her. Because of the gossips, she was abandoned by her first boyfriend, sexually assaulted by a villager, hospitalized again for an ensuing breakdown, and forced to marry another villager after discharge. Her husband later passed away, leaving her to care for their two children alone, one with a significant disability. She wrote:

> I don't have a place in the village … After getting married, my daughter's illness, my own illness, and the death of my husband, they [villagers] hate me even more [thinking that I am ominous] … As I see it, there are really some people who treat patients with mental illness like the dead.

All these adversities exacerbated her distress, leading to yet another hospitalization, during which the first author met her. Through these letters, Qiong was pointing to the social death that she and some other people with mental illness experienced, in particular the exclusion and oppression that women faced at the intersection of mental health stigma, patriarchy, and gender-based violence. The letters also allowed Qiong to defend herself by offering her own account of her life, morals, and distress.

In societies with patriarchal traditions, it is not rare for women to experience mental illness resulted from or exacerbated by intimate trauma and gender injustice like Qiong (Ma, 2014b; Pinto, 2011). In China, Ma (2012b) previously found that some psychiatric staff, especially the female ones, were to some extent able to understand the female patients' social suffering and help them demand support from family members through psychoeducation. In Qiong's case, while her current doctors paid little attention to what she had to say, some of her previous doctors did check in with her periodically and encourage her to be reintegrated into society by taking a job. Still, few doctors, if any, tried to address the social origins of her suffering, and her treatment plan always revolved around the use of psychopharmaceuticals. (While social workers provided her with sympathetic ears, they were not consulted for her treatment; nor did they have room to address the structural injustice she faced.) Granted, psychiatry alone cannot dramatically change the patients' social situations and the deep-seated cultural dynamics that give rise to them, but it seems that the profession's bottom line is to see patients as carriers of pathologies rather than persons with longings and pains (Jenkins and Barrett, 2003); the rest are personal variations. By focusing only on treating the symptoms, psychiatry may be said as condoning structural injustice and reinforcing social control (Kleinman, 1991). At the very least, it fails to help patients gain a sense of moral agency by acknowledging the stories they tell about themselves and validating their autobiographical power (Myers, 2016).

4.4. Vernacularization of psychiatry

In F Hospital, both Mandarin and Cantonese were commonly used; some medical staff from other regions would learn Cantonese to better communicate with local patients. In fieldwork, we found that the staff, like other local people, often used a few Cantonese words to refer to mental illness and the patients. The first was *so*^{4}, meaning confused, slow to react, and idiotic. In Cantonese, *so*^{4} is used as an adjective to describe somebody without a clear mind, usually with a sense of contempt. Men and women with mental illness are called *so*^{4} *lou*^{2} (foolish man) and *so*^{4} *po*^{4} (foolish woman), respectively. In fact, veteran staffers told the first author that the local public had long called F Hospital as *so*^{4} *lou*^{2} *ji*^{1} *jyun*$^{6\text{-}2}$ (a hospital for the fools) and those who worked for patients there as *so*^{4} *lou*^{2} *ji*^{1} *sang*^{1} (doctors for the fools). These terms indicate the discrimination towards the psychiatric hospital, its patients, and even its staffers among the local society.

Interestingly, while the psychiatric staff faced prejudice in association with patients, it was not rare for them to express such prejudice against patients. On the wards, staffers often said: "He/she (a patient) is idiotic." (/keui^{5} so^{4} zo^{2}/). In this sentence, *so*^{4} functions not as an adjective but as a verb, and the adverb *zo*^{2} means that the action has already happened. As an adjective, *so*^{4} denotes a state that may be limited in time or scope; that is, the person might only be foolish in certain aspects, and they might regain mental clarity after a period. However, *so*^{4} *zo*^{2} as an idiom signifies a change in the person that could be total and permanent. Additionally, *so*^{4} is often used on people with intellectual disabilities, whose condition is supposed to be permanent (Chu et al., 2017), whereas *so*^{4} *zo*^{2} signifies a drastic loss of mental capacity in people with mental illness. In any case, the fact that both groups share the same label of *so*^{4} means that they are assumed—by the general public and by psychiatric professionals alike—to be mentally incapable. For instance, Nurse Zhou mentioned that a doctor's son *so*^{4} *zo*^{2} (had become foolish/mad) and could not earn a living by himself; the doctor thus had to work even after retirement to provide for his son. While it is not rare for people with mental illness to depend financially on their aging parents in China because of the lack of welfare provision and the widespread discrimination that excludes them from the labor force, the use of *so*^{4} *zo*^{2} in Nurse Zhou's comment attributed all the dependence and suffering to the patient's mental illness, not the structural conditions.

Because of the shared local context, *so*^{4} and *so*^{4} *zo*^{2} allow the psychiatric staff to communicate with patients, family members, and other community members in a way that is easily comprehensible to them. In so doing, the staff's casual use of these words helps turn madness from a temporary state, which patients and family members often assume when they first seek help from the hospital, to a chronic condition that needs long-term services. Ma (2020) has argued that Chinese psychiatry turns serious mental illness into a chronic condition requiring constant risk management. Here, we further illustrate *how* psychiatry does that—partly by integrating local idioms of madness into its own parlance to individualize the problem of mental illness and to highlight the total, permanent change.

Another Cantonese word that the psychiatric staff often used to talk about mental illness was *ci*^{1} *sin*^{3}, literally meaning lines being stuck together, with the "lines" referring to the nerves (Chu et al., 2017). *So*^{4} and *ci*^{1} *sin*^{3} are largely interchangeable, except that the former is also found in Mandarin (*sha*) whereas the latter is not. Interestingly, while many disorders are related to the brain or neurological system, the hospital staff only used *so*^{4} on patients treated by the psychiatric department. One day the first author ran into Jia, a retired nurse. As they were chatting in front of a psychiatric ward, several people ran to them and asked whether they knew where they could find their family member who had just been admitted by the police. The first author asked if they knew which department it was—psychiatry or neurology. The visitors said it might be psychiatry but they were not sure. Jia responded: "These two are different. Neurology is for neurasthenia [weakness of the nerves], and psychiatry is related to *so*^{4}." He pointed to his head when he said *so*^{4}, and the visitors quickly echoed by saying the patient was *nou*^{5} *so*^{4} (having a problem with the brain). Jia said that it should be the psychiatry department and told them how to find the patient. Here, both the lay persons and the professional used *so*^{4} to refer to a problem with the brain, but the professional saw that as the specialty of psychiatry. The distinction he made between psychiatry and neurology then helped conjure the essence of mental illness in contradistinction with other disorders.

Other medical staff also used *so*^{4} to make similar distinctions. When the first author first arrived at the F Hospital in 2016, she had questions about the difference between the departments of clinical psychology[4] and psychiatry. A nurse who had worked there for more than twenty years told her that it was an easy distinction, as psychiatry treated the top of our body—the brain—and clinical psychology treated the heart.

[4] The Department of Clinical Psychology is mainly staffed by psychologists. It provides psychological assessment and treatments, such as counselling, for patients.

Moreover, when the first author wanted to find out whether there was a coordinating meeting for patients and staffers to talk about the care plan together, a staffer who had worked in the hospital for a long time told her (in Mandarin):

> There is no use in talking to those idiots (*sha zi*)[5] … No, those living in the neurology department are not idiots, neither are those admitted to the [clinical] psychology department. Those are poor people with some problems in their hearts, like anxiety or depression. But those live in the psychiatry department are idiots.

As mentioned earlier, TCM conceptualizes mental illnesses as problems of *qi* similar to other more physical disorders. With its holistic philosophy, it does not attribute mental illness to any particular bodily location. When Western medicine arrived at China in the 19th century, it mistakenly argued that Chinese medicine attributed mental illness to the heart alone, which it contended was wrong because it should be a problem with the brain and nerves (Shapiro, 2003). In any case, as we found in F Hospital, the staff divided the body into parts and assigned different parts to different specialties: neurology, psychology, and psychiatry. These specialties were not just distinct from each other, but they formed a hierarchy in the minds of the staff, where patients treated in the psychiatry department were located in the bottom because they were presumably *nou*^{5} *so*^{4} or foolish in the brain. In other words, in comparison with Kleinman's (1986) previous analysis of somatization as a Chinese tradition, here it is contemporary psychiatry that is somaticizing distress, reducing the complex, multifaceted issue to one of the brain. If, in 1980s′ China, people emphasized the physical aspect of distress to avoid stigma and political repercussions, then psychiatry's somatization of distress today risks enabling contempt and reinforcing stigma. As this somatization is done through appropriating and redefining local terms, the stigma also becomes deceptively familiar and hard to resist.

4.5. *Predicaments and possibilities of gene explanations*

Psychiatry not only dismisses, ignores, incorporates, and transforms local understandings of mental illness as we have seen, but it also advances its own discourse and practice to shore up its authority. Because it can quickly control symptoms, psychiatry has gained a dominant authority in treating mental illness, and psychiatric professionals have convinced many patients and families to accept their explanations. However, as the number of remissions and re-hospitalizations increase, professionals are confronted with questions about the efficacy of psychiatry. As we found in fieldwork, they often respond by framing mental illness as a "genetic issue."

On the 2016 Hospital Open Day, family members of patients were invited to visit F Hospital. After touring the facilities and observing the rehabilitation programs, they had a chance to communicate with several hospital leaders and physicians. An older woman stood up and asked in tears what had happened to her son, who had been admitted many times and was still in the hospital. Her emotionally charged interrogation was echoed by other family members who also could not understand why their loved ones had not been cured or improved if mental illness was a disease treatable by drugs, as psychiatrists had claimed. One physician responded by saying that mental illness was caused by genes and so far there was no cure to it. He further said everybody had a kind of gene that could lead to madness. The audience was silent; the idea of mental illness as destined by gene seemed to offer little hope or comfort.

As Tanya Luhrmann (2007) argued, biomedical psychiatry conceives of mental illness as "random bad genetic luck," uncontrollable and unpredictable like "being struck by lightning" (139), and this idea deprives patients (and families) of agency in the recovery process. Such genetic explanations are becoming hegemonic in psychiatry in China and elsewhere thanks to their compatibility with mainstream medical research. At F Hospital, for instance, doctors began collaborating with a research center to explore the genetic pathogenesis of mental illness and the use of gene testing to facilitate treatment. The scientific quality and the hegemonic status of gene explanations mean that patients' and families' accounts of what had happened and what worked were left to the margins.

Of course, recognizing the role of genes does not have to mean ignoring sociocultural factors in causing and treating mental illness; some professionals have begun to take a more holistic approach. Over the past decade, social workers have emerged as a new profession in China's mental health field to address patients as social beings (Tong, 2012; Ding, 2011; Gao and He, 2017), and some institutions started to hire a few social workers. At F Hospital, social workers were charged with helping new inpatients adapt to the institutional life by organizing activities on the ward or in the rehabilitation center. For challenging cases, some doctors or nurses might ask social workers to help engage patients in the pharmaceutical treatment. In addition, social workers were asked to work with doctors to follow up on discharged patients, supporting family members or neighborhood committees in reintegrating them into their communities. However, when the social workers went beyond those tasks to actively facilitate the discharge of patients who had been hospitalized for a long time, they were seen as introducing "disturbing factors" to ward management and such service was thus stopped.

Despite their secondary and restricted role in the hospital, social workers at the F Hospital tried hard to provide psychoeducation to patients and families in a way that would instill knowledge, hope, and agency. In 2019, the first author saw the parents of a patient just admitted to the hospital inquire a social worker about why their son was mentally ill, for they felt powerless about the newly arrived diagnosis. With more than three years' experience working in the hospital, the social worker Mei reiterated psychiatrists' argument by saying that everyone had a gene for mental illness. However, she added that the gene would only be activated when there were certain stimulating factors in the external environment. The patient's mother sounded a little confused and asked: "What I should do?" Mei then told her that there was a threshold for this "crazy gene" to be activated, and protective factors in the environment would help to reduce the likelihood of activating this gene and triggering mental illness. The parents seemed relieved as they realized that they could build a protective environment to help their son.

Previously, Ma (2012a) argued that by uttering the "diathesis-stressor model," which sees mental illness as an interaction between genetic disposition and stressful life events, Chinese psychiatrists played down the social and environmental factors as less specific, less impactful, and even less real. However, now that social workers are entering the mental health workforce, it seems that they are slowly changing the emphasis, helping to build a more comprehensive picture of mental illness, and asserting patients' and family members' agency. These new professionals are still marginalized in psychiatry and their expertise is not yet integrated into patients' treatment. The question, then, is how to amplify their voices and shore up the importance of non-genetic or epigenetic factors for understanding and treating mental illness.

5. Conclusions

This article discusses how the staff in a Chinese psychiatric hospital responded to the experiences, explanations, and practices around mental illness from patients and families while asserting their own. We see that psychiatric professionals attempted to replace local knowledge, such as TCM and religious ideas, with biomedical knowledge. The quick effect of psychopharmaceuticals to calm patients might win the support of patients and families, but the side effects of medications, repeated relapses, and re-hospitalizations might gradually incur confusions and doubts about psychiatry's ultimate efficacy. As a result, patients and

[5] *Sha zi* is the mandarin equivalent of *so*^{4} *lou*^{2}/*so*^{4} *po*^{4} in Cantonese.

families might openly question psychiatry or quietly seek alternatives, as seen in the religious interpretation by Nana's mother of her relapse. Moreover, it was not rare for patients and families to seek help from TCM in the first instance given its holistic and non-stigmatizing approach. Although TCM has been marginalized or even dismissed in professional mental healthcare these days, it was common for patients and families to use it to counteract the side effects of psychopharmaceuticals.

Psychiatry has long been criticized for its objectification of patients and the neglect of their lived experiences (Jenkins and Barrett, 2003; Kleinman, 1991). Indeed, we find that doctors kept quiet about patient's experience, did not acknowledge their understandings of what might have caused their mental illness, and could not respond to the social exclusion they faced that hindered their recovery. Moreover, in their communications with family members about the nature of mental illness, psychiatry utilized words from the local dialect, including those that carried negative connotations, to create a distinction and hierarchy among illnesses and specialties. Those practices, when coupled with the authority of psychiatric professionals, would entrench the stigma faced by people with mental illness. On top of the casual, vernacular comments on mental illness, the genetic explanation advanced by psychiatric staff helped form a professional culture that could disempower patients and families.

To address these issues, improve the quality of mental healthcare, and make clients feel culturally safe and respected in clinical encounters, psychiatric staff should develop a more holistic approach that takes into account the biological, psychological, and sociocultural aspects of mental illness as well as their interactions. This can be achieved by engaging in open, in-depth, and empathic communications with patients and their families to understand their beliefs, experiences, and concerns. Social workers as a new profession in China's mental healthcare seem to be doing some of this work, but their number needs to grow, their expertise respected, and their insights better integrated into a multidisciplinary treatment plan. Furthermore, incorporating TCM into treatment plans, when appropriate, may help alleviate side effects and provide a more acceptable and comprehensive approach for patients and their families. Finally, as members of the local society, psychiatric staff should develop a critical awareness of the language that they use as well as the power dynamics, such as gender inequality, that surround them and their clients every day. They should strike a careful balance between trying to communicate with clients in a comprehensible way and using their professional authority to help reverse the culturally ingrained language or practice that marginalizes and oppresses people with mental illness.

CRediT authorship contribution statement

Zhuyun Lin: Methodology, Investigation, Writing – original draft, Funding acquisition. **Zhiying Ma:** Conceptualization, Writing – review & editing, Supervision.

Declaration of competing interest

The authors declare no competing interest.

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