Between Families and Institutions

Mental Health and Biopolitical Paternalism in Contemporary China

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For my parents

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INTRODUCTION

Family Ties and Psychiatric Lives

One

One afternoon in fall 2013, I accompanied Mrs. Dong, a woman in her late fifties, to visit her daughter Tingting on a locked psychiatric ward in the southern Chinese city of Nanhua.[1] Two months earlier, Tingting had argued with a colleague and asked her boss for a week's leave to cool off. She had also been turned down by a man she had pursued by buying him many expensive clothes. As Tingting stayed awake night after night and sometimes wandered in the street, Mrs. Dong, who was living with her at the time, grew increasingly worried. With the excuse of a brief check-up to improve her sleep, Mrs. Dong took her to the psychiatric hospital, where she was diagnosed with bipolar disorder and institutionalized.

That fall day, like every other day the previous two months, Mrs. Dong had brought a box of freshly made food, including multigrain porridge, steamed salmon, and stir-fried vegetables, to ensure that her daughter got enough nutrition. Upon seeing us, Tingting, who had been pacing restlessly on the crowded ward, smiled and took the meal box. As soon as she finished eating, however, she demanded that her mother have her released immediately so that she could return to work. “I can’t,” replied Mrs. Dong, “it’s the doctor who makes the decision.” This was not true, I thought, for doctors could only *recommend* hospitalization to patients’ guardians—in this case, the mother. I kept quiet, suspecting it would be difficult for Tingting to challenge the decision, regardless of who had made it.

Sensing Tingting’s irritation, she softened her voice: “Don’t worry. I’ve planned out everything after your discharge.” It turned out that she had sent a resignation letter to Tingting’s company and had bought a small storefront near their home so that they could run an herbal tea stall together. As Mrs. Dong saw it, Tingting’s workplace was too stressful of an environment. In fact, any job that required Tingting to work “outside” on her own would probably expose her to undue stress, unhealthy food, or troublesome relationships. The tight work schedule would also prevent her from adhering to her medications. “Well, from now on life will be more relaxing for you,” Mrs. Dong announced with a beam.

“NO!” Tingting screamed, “I’m 30 years old. I’m not a kid anymore. Why do you want to control (管/*guan*) me when I’m supposed to be independent? Before I was sent here, I had been sorting out the clothes, my work, and my moods. I only needed some more time. You threw me in here and that totally messed me up. Please, leave me alone!”

“You’re sick, Tingting,” sighed Mrs. Dong. “How can I leave you alone (不管你/*buguan ni*)?”

Two

On May 6, 2013, forty-seven-year-old Xu Wei filed suit against his eldest brother and a psychiatric hospital in Shanghai where he had stayed for thirteen years, asking to be released.[2] He claimed that in his twenties, he had traveled to Australia to learn English and work. To earn his tuition, he tried his luck at a casino, where he became addicted to drugs. Failing to renew his visa, he had to return to Shanghai and live with his father. He overcame his drug addiction but soon started feeling that he was being followed. His father took him to the district mental health center, where he was diagnosed with schizophrenia and kept for a year. After his release, he fought with his father over work-related issues and accidentally injured him.[3] His father had him committed again, this time at a run-down hospital on the outskirts of the city (Xishu 2018).

In the hospital, Wei initially attempted suicide by jumping out of a fifth-floor window, but that only fractured his bones. Then he fell in love with a female patient, and they repeatedly tried to escape in the hope of building a family together. Once, they ran as far as the city's train station, only to be intercepted by the hospital staff. After that incident, the woman's family agreed to have her released if Wei was as well. Some doctors at the hospital also thought that Wei was stable enough to live outside, so they reached out to Xu Xing, Wei's eldest brother and guardian since their father's death, to see if he would be willing to sign the release papers. Xing worked in another province and seldom visited Wei. In fact, even Wei's hospitalization was paid for with his own public medical insurance and welfare benefits. Nevertheless, Xing rejected Wei's release, saying, "I'm his guardian! I have to watch over (*guan*) him. I have to be responsible for society!"

Wei suspected that Xing had an ulterior motive: they had inherited their father's two apartments together and Xing had been collecting rent, so he probably did not want to share the profits. The hospital staff turned to Wei's neighborhood committee and other relatives to see if any were willing to become his guardian instead and authorize his release. They all said no, except for Wei's mother, who had divorced Wei's father and left the family three decades before. In early 2012, she filed a request to the district court, hoping to replace Xing as Wei's guardian. The court rejected her request, citing her old age as a concern (Chen 2016b).

Wei did not give up. Browsing the internet with his smartphone, he found Huang Xuetao, a Shenzhen-based and nationally renowned human rights advocate for psychiatric patients. I first learned of Wei's struggles in an online discussion about the district court's ruling that Huang had organized. In the discussion, a law student questioned: "The district court said that Wei's brother had fulfilled his responsibility as a guardian. Does this mean that parents can just lock their children up in psychiatric hospitals, rent out their homes, and go to work elsewhere?"

"Well, the court simply wanted to make sure that the patient was 'carefully watched over' (小心看管/*xiaoxin kanguan*). Those are the exact words in every local mental health regulation throughout the country," another law student explained.

A bewildered social worker then asked: "But patients are humans, not objects, right?"

Shortly after that discussion, Huang found Wei a local attorney to file a lawsuit for him. The filing took place mere days after the first national Mental Health Law (MHL) in China had come into effect on May 1, 2013. The law was groundbreaking in that it declared that people with mental illness are sovereign individuals with rights to autonomy in both hospitalization and discharge. As the case progressed, I visited Wei in his hospital. When we talked, scores of inmates looked at us from afar, and a few approached us to listen in, eyes glistening with hope and curiosity. I asked Wei how he felt about the prospects of his case. He briefly smiled and then blankly stared ahead:

"You know, my brother neglects (不管/*buguan*) me, and I'm like a ball being kicked around . . . When it comes down to it, there has to be someone willing to take responsibility."

At the Crossroads of Madness, Family, and Institutions

For the past few decades in China, people diagnosed with serious mental illnesses (SMIs) have been automatically placed under the guardianship of their close relatives, including spouses, parents, adult children, and siblings. According to a practice called "medical protection hospitalization" that was prevalent until the MHL, a psychiatrist might advise that a patient be hospitalized, and then the guardian would "decide whether to accept the advice or not, and when to finish or withdraw from the hospitalization and treatment" (Shao et al. 2010, 5). A survey has indicated that as of 2003, about 60 percent of psychiatric inpatients in China were admitted by their family members against their will (Pan, Xie, and Zheng 2003). Another survey conducted in a major psychiatric hospital in Southern China shows that 64.6 percent of people who had been hospitalized there for over a year could not be discharged because of their family members' refusals (Luo et al. 2014). Meanwhile, patients' medical treatment, involuntary or otherwise, is typically paid for by their families or by public medical insurance and other welfare subsidies their families have scrambled together. Outside of the hospital, over 90 percent of people diagnosed with SMIs live with, and are supported by, their families (Phillips 1993).

In this context, the two opening stories, which I will continue to unpack in subsequent chapters, are far from unique. Instead, they reveal how Chinese families are entangled in mental health care and its institutional processes. On one end, Tingting's story represents the beginning of such entanglements, where people view their loved ones' everyday life problems—love, work, money, and so on—as mental illness and seek help from psychiatry. On the other end, Xu Wei's story points to a plateau of such entanglements, where the guardian may view the patient as the problem who requires constant management through indefinite hospitalization. One may ask: How do these translations happen? How do they shape the contours of kin responsibility, compelling people to alter the futures of their loved ones as well as their own? On what grounds do people claim or contest the authority to do so? How might patient management blur the lines between care, control, and abandonment? How does it make or break family ties and people's senses of sociopolitical belonging?

Families' entanglements in psychiatry have been brought into sharp relief by relevant policies and regulations, especially the recent mental health legal reform. Starting in 2006, human rights activists such as Huang Xuetao campaigned forcefully against widespread involuntary hospitalization in China, families' involvement in it, and the country's oppressive culture of paternalism supposedly undergirding these phenomena. In response, psychiatrists who had drafted the MHL defended these practices as manifestations of "state paternalism" (国家父权/*guojia fuquan*), which presumably provided "care and love for the sick, the vulnerable, and the disabled even against their own will" (Xie and Ma 2011b). These debates expedited the passage of the MHL, which had been in the making for nearly three decades. As mentioned, the 2013 MHL affirms patient autonomy and the voluntary principle of hospitalization. Curiously, it also upholds families' guardianship of patients. In particular, it grants guardians the rights to consent to patients' treatment and to hospitalize against their will any patients who pose actual or potential danger to themselves or others. Meanwhile, it stipulates that families have the responsibility to provide for, look after, and monitor patients (National People's Congress 2012). Thus, the family, as it has been conceived in the MHL, has become a primary unit to mediate the individual liberty, wellbeing, and population security of the nation. One may ask: How was the idea of family guardianship justified in the legislation process? How does it interact with notions of freedom, authority, rights, and responsibility in discourse and practice? How does the law shape the fate of people like Xu Wei and the country's landscape of mental health care?

All these questions boil down to a simple inquiry: *why has the family occupied such a critical role in Chinese psychiatry, especially during the recent mental health legal reform*? This is the central question of my book. Some readers might see this as a non-question, arguing that the Confucian culture has long determined Chinese families' entrenchment in the care of members with mental illness (Lin and Lin 1980). Nevertheless, historical examinations that I present later in this chapter show constant change in such involvement and its conceptualization.

In this book, I analyze families' involvement in medicine as shifting technological, institutional, and ideological configurations. Note that *configure* here means both to represent by an image and to fashion or compile in a certain form, because how these forces represent the family also shapes how they interact with, intervene into, and regulate it. These configurations are co-constituted with how people in and beyond the household think of madness and normality, how they define and distribute responses to vulnerability and disruptions, their desired order of life and society, and the perceived expertise and power of medicine in achieving that order. Therefore, by tracing an entangled and emergent history of madness, family, medicine, and related laws and policies in China, this book provides a fuller understanding of the affects, ethics, and political economy of care and population governance in China.

Drawing on extended fieldwork as well as archival and media analysis, this book shows that in contemporary China, psychiatric knowledge, together with the state's growing security concerns, constructs people diagnosed with SMIs as chronically risky subjects requiring perpetual, intimate management. In the mental health legal reform and other policy discussions, policymakers have used China's historical legacies and cultural ethics of paternalism to frame measures of patient management as care that the state undertakes for its people. Meanwhile, as paternalistic values circulate from the state to medical professionals and then to families, actual responsibilities for care and management end up falling to families, particularly women and the elderly. This ideological legitimation and structural displacement of biomedically defined responsibilities of population management constitute what I refer to as *biopolitical paternalism*. It produces a wide variety of conflicts and harm within families and aggravates health disparities across the mentally ill population. Yet tensions between the ideological legitimation and structural displacement of biopolitical paternalism also allow people to flip the script (Carr 2010), calling on the state to be a proper parent for its vulnerable children.

Though discovered in mental health, biopolitical paternalism bespeaks the general tenor of governance in contemporary China, given the widespread reconfiguration of the revolutionary "people" into a biologized "population" to be managed (Cho 2010; Dutton 2005), the neoliberal devolution of welfare and health care, and the rise of the security state (Lee and Zhang 2013). Throughout the world in years past, many states promised or enacted paternalistic care for their citizens (Shever 2013; Verdery 1996); now they have similarly relegated responsibilities of care to families and other intimate/

informal relationships (Biehl 2005; Eichner 2017), while expecting or demanding them to act as private paternalistic agents to manage individuals deemed vulnerable or deviant (Soss, Fording, and Schram 2011). Beyond the nation states, international humanitarian and human rights organizations also often impose what they think is good on marginalized communities through a mix of care and control (Barnett 2017). Thus, the concept of biopolitical paternalism helps us detect, in different governance mechanisms, how subjects are constituted and regulated; how responsibilities for care and management are legitimized, distributed, and implemented; and the power effects of these mechanisms.

Historicizing and Politicizing the Family

The Advent of Psychiatry and the Essentialization of Chinese Families

While a historical approach will run through this book, a glance at how families were configured in relation to madness/mental illness before and after the advent of psychiatry in China will start destabilizing the seeming naturalness and inevitability of current practices. For most of the imperial era, a common phenomenology of madness was 乱/*luan*, or chaotic words and behavior. Rather than being located solely in the mind, it was thought to reflect entangled physiological, emotional, and social processes that disrupted the normal flow of life force (气/*qi*). Thus, physicians of Chinese medicine prescribed drugs to restore a patient's organic balance or pacify disordered emotions (Zhang 2007). They might also help establish proper social roles and relations for the person, such as instructing relatives to find a spouse for someone who was thought to be maddened by unfulfilled sexual desires (Simonis 2010). At any rate, because the behavioral, emotional, and social chaos was apparent, and because the physiological disruptions could be diagnosed with medical skills, physicians did not have to rely on the person's relatives to uncover any hidden illness. Because madness was typically seen as a temporary aberrance, families were not expected to make any long-term special arrangements for the person, either at home or somewhere else.

There were also no specific legal arrangements for mad persons in most of the imperial era. Matters began to change when a 1667 Qing law exonerated mad persons who had committed homicide because of their lack of intention, while it required their relatives to compensate the victims' families. As officials came to see madness as a disorder with potential homicidal impulses, they began to fear the dangerousness of all mad persons. A 1732 rule required families to declare any insane member to the local government. In 1766, another rule required relatives to manage (*guan*) the mad persons and restrain them in a safe room, and local officials were to issue locks and chains so that confinement could be strictly implemented. If home confinement was not well enforced and the mad person committed homicide, the relatives would be harshly sentenced (Simonis 2010).

While the medical and popular discourses saw madness as a temporary, curable disorder, the law now saw madness as a permanent threat to society. By requiring the family to control and confine the person, the law sought to turn the family into a disciplinary agent. At any rate, recorded cases of (long-term) confinement were few, both before and after the Qing legal stipulation. As historian Fabien Simonis (2010) suggested, "what 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" (465). Many families ignored the legal stipulation and unchained the periodically mad persons because they saw them as having recovered from temporary madness or because they needed the labor for agricultural work.

In 1898, John G. Kerr, an American Presbyterian missionary doctor, opened the first refuge for the insane in China in the city of Canton (now Guangzhou). He did so mostly with his own financial resources, because other medical missionaries either had deemed the insane persons incorrigible or seen the seemingly serene oriental culture as more suitable to care for them than the high-strung Western civilization. To justify the establishment of the refuge, Kerr and his colleagues often discussed the confinement and other abuses that Chinese families inflicted on insane persons. For example, he stated: "Among the better classes, confinement in a strong room, and often loaded with chains, was all that could be done. 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, and death has been hastened among the poorer classes by the want of care and ill-treatment" (Kerr 1898, 177). Kerr was generalizing from the cases he had observed, and he was probably projecting on China the Roman legal tradition that had allowed *pater familias* or household heads absolute power over other members (Harders 2012). It was a projection because the Confucian concept of filiality actually assumed reciprocal rather than unilateral responsibilities in hierarchical relations by emphasizing the gratitude that one should have toward one's parents for their nurturance (Zito 1997). At any rate, depictions like this framed Chinese families as spaces of harm reflecting the oppressive Chinese culture; they also framed the refuge as a safe space that could rescue and enlighten the insane person as an individual rather than as part of the filial relations. Before long, the discourse of liberating the insane from home confinement had gained dominance among medical missionaries, and they established similar asylums in several other Chinese cities.

By presenting home confinement as a problem inherent to the Chinese family, medical missionaries ignored how the Qing government had mandated it as well as how families had negotiated with or even resisted this mandate. Such omissions in turn allowed them to accept requirements to confine the insane from the local government without critical self-reflection. By 1904, the Kerr Refuge (as it came to be known) had started to admit patients sent and paid for by the police department, and the staff saw this as a sign of official recognition (Selden 1910). By 1909, half of its patients were supported by the government, many of whom had been picked up from the street (Selden 1909a). Along this process, staff at the Refuge built thicker walls to prevent patients from escaping (Selden 1909b) and devised tools such as wire restraining frames to contain them (Ross 1920). Through its government collaboration, missionary psychiatry became a control mechanism, and it began to treat the insane person as a subject of discipline rather than as a universal human.

Inspired by the Kerr Refuge and asylums abroad, the Qing government established an asylum in Beijing in 1908, where social deviants such as vagabonds who had been deemed insane were not so much treated as they were policed and provided for (Baum 2018). Then in the 1910s and 1920s, influenced by Euro-American eugenic thought, some medical missionaries came to see the insane person as a biological body carrying hereditary defects and moral degeneracy, threatening the health of the population (Hofmann 1913).[4] Interestingly, while missionaries criticized Chinese family customs for worsening the heredity of future generations by expecting everyone to marry and reproduce, they also sought to harness the reproductive drive of the Chinese family for eugenic purposes. For instance, they urged the family to heed “stock and seed selection” by investigating the reproductive history of a concubine before taking her in (Ross 1926, 10). As such, missionary psychiatry began to treat the Chinese family as both an object and an ally of intervention, useful for the purposes of population improvement.

Guided by the eugenics discourse, the Republican national and local governments issued laws that mandated the institutionalization of all insane persons and that forbade people from having sex with them (Woods 1923).

Families distressed by war and poverty learned to send their members to the asylum for medical attention and temporary relief (Baum 2018). All these developments were halted and the field severely disrupted by the Sino-Japanese War and the subsequent Chinese Civil War. Around 1949, when the People's Republic was founded, there were only six hundred psychiatric beds and fewer than fifty psychiatrists across the country. Most of these resources were concentrated in five (some report nine) major municipal psychiatric hospitals (Pearson 1995, 11), all in a state of disrepair using only barebones treatment and constraint. Yet the ways psychiatry essentialized and problematized Chinese families' role in causing, treating, and managing madness, along with the ways such configurations enabled the field's development and collaboration with state power, left a lasting legacy that is still impactful today.

The Family and the State, in and beyond Chinese History

Configurations of the family are important not just for the development of psychiatry but also for arrangements of politics and economics (Franklin and McKinnon 2001). In imperial China, filiality was an "organizing trope for connecting cosmic and social hierarchies" in Confucianism (Zito 1997, 58); that is, the father-son relationship was supposed to be a model for relationships between the heavens and humans, lord and subject, and so on. Since the imperial order collapsed at the turn of the twentieth century, nation building and state governance projects have repeatedly mobilized ideas of, and practices from, the family to reconstruct meanings of personhood, state-society relations, and the relationship between tradition and modernity (Barlow 1993). For instance, similar to the contemporaneous medical missionaries, leaders of the 1910s "New Culture Movement" traced many evils of traditional Chinese society to the Confucian patriarchy, contending that it had subjected individuals to inhumane moral codes and outright oppression. From then on, public discourses were suffused with the metaphor of breaking the "iron cage of the feudal family" to achieve individual freedom (Lee 2007). The Nationalist (1912–1949) and Maoist (1949–late 1970s) governments both launched campaigns and policies to fight manifestations of patriarchal oppression such as polygamy and arranged marriages (Glosser 2003). However, because these campaigns sought to strengthen the nation-state, they again emphasized the importance of the family for individual and social development (Stacey 1983). Of course, the Maoist regime did, to an extent, downplay the role of households and instead organized citizens into collectives, including urban work units and rural communes.

In the market reform era following Mao's death, government and public discourses have come to blame collectivization for having produced socioeconomic apathy. They celebrate the family as an essential social unit that simultaneously propels the market economy and provides individuals with a haven because of people's putatively natural desire for a good life for themselves and their loved ones. This turn to the family—or what Yunxiang Yan (2018) has called "neo-familism"—has been accompanied and conditioned by the state's withdrawal from the provision of social welfare. For example, the 1996 Law on the Protection of the Rights and Interests of the Elderly stipulated that "the elderly shall be provided for mainly by their families" (National People's Congress 1996, Article 10), just as state-owned enterprises in urban areas laid off workers en masse and canceled their retirement pensions. Note that the state has not simply retreated from the family; rather, its institutional powers have seeped into family life to produce what it sees as normal, desirable subjects. The most famous example is the one-child policy (1982–2015), which made the married couple a key site of population control and allowed the state to directly intervene into women's reproductive choices (Greenhalgh 2008).

As ideas of the family have been used to shore up various forms of political order, the ensuing social transformations have in turn reshaped the structure and power dynamics of families. Existing research has shown that in late imperial China, the ideal-typical family structure was a patriarchy, characterized by "patrilineal descent and inheritance, patrilocal residence, strong parental authority, and the power of the senior generation (particularly but not exclusively senior males) reinforced by state law and property ownership" (Harrell and Santos 2017, 8). Over the twentieth century, forces like war and urbanization continued to reduce family size and paternal authority. Especially after the establishment of the People's Republic, economic reconstructions, mass education, and the revolutionary ideology boosted women's labor participation rate, raising their status both within and outside of the home. Since the 1980s, ideas of privacy and privatization have increased the appeal of conjugal intimacy and nuclear families (Yan 1997), while the one-child policy has made childrearing the focus of the household (Fong 2004; Kuan 2015; Xu 2017). In recent years, the state's renewed endorsement of Confucian values has exacerbated male domination at home and beyond, while the growing burden of family care has in turn driven many women out of the workforce to become full-time caregivers (Evans 2017).

The extant scholarship has shown how families exist as ideological and institutional constructs, fields of intimate politics, or units of survival and care in times of rapid social transformation. This book brings these dimensions together and illuminates their interconnections by exploring the dynamics between family life and professional expertise, institutions, and law (Kowalski 2016; Povinelli 2006) and by focusing on situations of severe illness and vulnerability, when people's deepest senses of dignity, responsibility, and attachment are at stake (Mattingly 2014). For example, chapter 1 continues to trace how medical discourses, social policies, and the broader political economy have aligned to configure the role of the family in mental health care in the People's Republic, culminating in a hospital-family circuit where patients are bound and kin guardianship is enshrined. Chapter 3 examines how risks and responsibilities highlighted by the psychiatric discourse of SMI intersect with market forces to rework family relations, rendering some ties impossible and others more fragile. Note that sometimes people turn to ties not recognized by the guardianship system—such as an aunt or an unmarried partner—for intimacy and care. This book will examine these "found" or "chosen" families, exploring how they are assembled and what the lack of legal and policy recognition means to them.

Front and center in my multidimensional analysis of the family is gender. After all, as anthropologists of kinship have reminded us, gender helps articulate systems of meaning and mediates pathways of inequality in and beyond the household (Yanagisako and Collier 1987). For instance, although the guardianship system grants family members paternalistic authority in patient management, the fact that aging women are often the primary caregivers means that their exercise of such authority is at best precarious; we can see this in Mrs. Dong's eagerness to deny any power she had in deciding whether or not Tingting would be discharged. Meanwhile, compared to other family members and professionals, these women's vulnerability and proximity to patients may make them more compassionate and more willing to accommodate desires and habits that seem strange or are not approved by psychiatry (chapters 3 and 4). Thus, another dimension of the family less discussed in the literature is a source of improvisation on, and resistance to, officially endorsed subjectivities and relations.

As the title suggests, this book interrogates the complex relationships and productive tensions between familial intimacy and institutional powers. With the term *institutions*, some readers may think of what sociologist Erving Goffman (1961) called "total institutions"—that is, enclosed spaces where groups of people lead formally registered lives, such as closed-door psychiatric hospitals. While these hospitals certainly dominate the landscape of mental health care in China, institutions also include other formal organizations designed, tasked, and contracted by the government to regulate aspects of society, such as community mental health teams and social work agencies in our case. In this sense, family lives are shaped by an array of institutions whose work may or may not be aligned with each other, and this can reveal the effects of their power. Moreover, if we expand the definition of institutions to include recurring practices that enforce norms, facilitate/constrain behavior, and give people identities (Martin 2004), then families are institutions vital for producing and managing individual subjects. Because the family can be seen either as a basic social institution or as a pristine private realm, it affords various imaginations of the state and enables people to constantly draw, redraw, and contest the state's boundaries. Finally, as family members face vulnerability and precarity together, they may deviate from the teachings of governing institutions and engage with each other, as well as the broader society and state, in non-normative ways. These disruptions and improvisations may in turn bring changes to the state and its institutions. Across the world, the family is typically regarded as the most ordinary aspect of people's lives. Meanwhile, "family values"—whatever they are—are used to facilitate and define various forms of body politic (McKinnon and Cannell 2013). Therefore, these dynamics and tensions are relevant far beyond mental health and China.

Madness, Biopolitics, and Care

Constructing and Experiencing Madness/Mental Illness

Like the family, madness/mental illness is a shifting social construct.[5] Since the nineteenth century, psychiatry in Euro-American countries has come to see atypical human feelings and behavior from a disease-specific lens (Rosenberg 2007). Then, since the 1950s, psychiatry has been increasingly dominated by biomedicalization—that is, the reduction of mental illnesses to neurochemical disorders that require treatment with psychopharmaceuticals. In this process, talk therapies and other healing approaches have been separated out and largely deemed inferior (Luhrmann 2011). Many Western scholars have criticized biomedical psychiatry as a form of social control: the behavioral norms that it shores up deny human diversity, the biological reductionism helps to conceal the social injustice that produces distress in the first place (Laing 1965), and the medical treatment falsely claims competence in addressing people's everyday problems (Szasz 1964). Moreover, they argue that the coercive measures deployed by psychiatry—particularly involuntary hospitalization and forced medication—strip people of autonomy, moral responsibility, and opportunities for personal growth, subjecting them to stigma, oppression, and social death (Cooper 1971; Goffman 1961).[6]

In China, more than a century since medical missionaries built the first asylum for the insane, biomedical psychiatry has become an established field. Despite China's recent *psycho-boom*—the growing popularity of the use of counseling and psychological self-help among the public (Huang 2015; Zhang 2020), those resources are not typically available or seen as appropriate for persons diagnosed with SMIs. Instead, medication and hospitalization have become two dominant modes of service for them. This book addresses how meanings of disorder, chronicity, and risk are constructed on the closed psychiatric ward (chapter 2), at home (chapter 3), and in emerging community mental health practices (chapter 4).[7] Inspired by existing critiques of psychiatry, I face the hegemony of biomedicalized and institutionalized psychiatry in China head on, asking what social will it helps to establish (Lovell and Rhodes 2014) and what impact it has on people with lived experience.

While most critiques of psychiatry that have emerged from Western liberal societies concern social constructions of madness and the individual's experience with oppression,[8] I emphasize the dynamic and diverse ways in which madness/mental illness is relationally constructed and experienced—how people identify and understand madness in household life, how they come to desire psychiatric treatment for their loved ones, how psychiatry defines itself by imagining and intervening into family care, and how people draw on, reframe, resist, or supplement psychiatric ideas in everyday familial interactions. Along the way, I will compare the practices in China with those that scholars have noticed in other Asian and Latin American countries, where families are also enmeshed in psychiatry (e.g., Nakamura 2013; Pinto 2014; Reyes-Foster 2018; Rubinstein 2018). At first glance, one major difference seems to be Chinese families' routine use of hospitalization and the legal expectation of it.

As mentioned, this book focuses on people diagnosed with SMIs. In China, the term *serious mental illnesses* is an administrative category, covering schizophrenia, bipolar disorder, paranoid disorder, schizoaffective disorder, epilepsy with psychosis, and intellectual disability with psychosis (Ministry of Health 2012), with the first two diagnoses being the most common in my fieldwork. These individuals are typically called "patients" by service providers, family members, government officials, the public, and even themselves. I struggled with whether to use this term in my writing, because it might risk reinforcing medicalization and equating persons with pathologies.

Nevertheless, alternatives preferred by people who encounter psychiatry in Euro-American contexts—most notably *consumers*, *survivors*, and *service users*—are much less used or even understood in China outside a small circle of advocates. Further, these terms carry their own assumptions—such as the individual's power to choose and the history of open confrontations with institutions—that may not be applicable in our case (Speed 2006). Therefore, I have decided to keep the term *patients*, not to endorse any biomedical reductionism but to track how discourses and practices around it shape personal experiences, such as the restricted choices these individuals face. In fact, because many people refuse to see themselves as having mental illness (chapter 1), using the term *patient* can illustrate how the label is imposed and contested. To reflect these contestations around the truth status of mental illness and to keep the possibilities open, I will also refer to "people *diagnosed* with SMIs" instead of "people with SMIs" whenever appropriate.

Meanwhile, taking a constructivist approach to mental illness does not mean denying individuals' suffering and vulnerability. The suffering and vulnerability are real, whether as a result of bodily processes, traumatizing relationships, social injustice, or the looping effects of psychiatric labeling and institutional segregation (Hacking 2000). This book attends to individuals' help-seeking attempts sympathetically, while analyzing how they are molded by the existing mental health-care system. For instance, the limited venues and modalities of mental health services, coupled with the privatization of health care, mean that families who cannot afford these services are often without help and that psychiatry—however problematic—may be highly appealing to them and sometimes to patients themselves. As scholars and activists seeking to promote the well-being of patients and their loved ones, we need to simultaneously confront psychiatric coercion while acknowledging the lived reality of vulnerability to understand how psychiatric hegemony and health-care shortages coexist and are mediated by intimate relations.

Between Biopower and Care

Through their involvement in mental health services, family members typically see themselves as taking on responsibilities for vulnerable others (Levinas 1988) and exploring visions of the good life (Mol, Moser, and Pols 2010). As such, their actions could be understood through the lens of care. Feminist scholars have long argued that, unlike the assumption of free, equal, and independent individuals dominant in Western liberal thinking, human beings are inherently vulnerable and dependent—though to varying degrees;

as such, care is and should be recognized as the basis of social life (Kittay 1999; Ruddick 1995; Tronto 1993). Empirically, anthropologists have examined which lived moral experiences drive people to care (Kleinman 2009a; Mattingly 2014) and what prevents care (Scheper-Hughes 1993). They have also examined how care is shaped by different ethical frameworks (Stonington 2020) and how it is achieved through routinized actions (Aulino 2016). Inspired by these works, this book interrogates how care is conceptualized in professional knowledge, law, and social policies; how it is shaped by different socioeconomic conditions and service access; and how people attend to their loved ones' needs and desires through words, actions, and material arrangements amid all these forces. Because the personhood of those diagnosed with SMIs is often in question, I also address what kind of moral agency (Myers 2015) family care might afford them and how it might affect their recovery and social inclusion.

While the public tends to assume that care is transparent, apolitical, and naturally loving,[9] the opening vignettes have shown that family actions are more complex than that. After all, the psychiatric services in which families are involved—and implicated—are a mechanism of biopower, for they turn the supposedly "basic biological features of the human species," in particular the risks that mental illnesses pose to patients and the public, into "the object of a political strategy, of a general strategy of power" (Foucault 2009, 1). While most studies of biopower have focused on how formal institutions, professional experts, or the knowledge they instill serve to discipline the individual body or regulate the population, some anthropologists have examined how families in different societies are entangled in the exercise of biopower (e.g., Biehl 2005; Friedman 2008; Stevenson 2014). Bearing this in mind, this book explores how biopower is performed by nonexperts in intimate relations and how the family may work as a model, a site, an instrument, or a product of biopower in contemporary China.[10]

Connecting these two concepts, this book illustrates how biopower requires, enables, inhibits, and transforms different forms of care. On the one hand, in the mental health legislation process, leading psychiatrists and policymakers did envision involuntary hospitalization as benevolent care, precisely because it could supposedly temper patients' risks of illness relapse and violent behavior (chapter 1). A preoccupation with public security risk also prompted the state's investment in developing countrywide community mental health services (chapter 4). In everyday life, psychiatry's promises of normality and order give family members hope, and as we saw in Tingting's case, one of the ways the mother expressed concern for the daughter was to ensure her medication compliance. Thus, care and biopower may be mutually constituted: while biopower sets the goal of care and utilizes people's intimate practices to realize itself, care may be achieved through techniques of biopower.[11]

On the other hand, as biopower transforms family members' desire to care into a mandate of risk management, it may produce or exacerbate conflicts between people receiving and giving such care, inflicting harm on both sides. To secure professional services for their loved ones, family members may find it necessary to adopt and manipulate the category of risk; as they become more attuned to risk, some family members—such as Xu Wei's brother—may choose to have patients hospitalized indefinitely, thereby depriving their social membership (chapter 5). Of course, family members may engage in many other practices to nurture patients' holistic being and to repair the damages wreaked by medication and hospitalization, but such practices are typically dismissed or denounced by psychiatrists.

An analysis of these diverse familial actions and decisions can reveal how epistemological and ethical boundaries between good and bad care—or between care, control, and abandonment—can be fragile and contentious (Pinto 2014) and how such contentions are "coproduced by high-order mandates as well as the local context of practice" in biopower (Brodwin 2012, 15). In this book, when I use the word *caregivers* to refer to family members who assume responsibilities to make arrangements for patients, I fully acknowledge and seek to highlight these contentions.

Guan and the Ethics/Politics of Paternalism

Our two opening stories show how ethical contentions are often registered in the Chinese word 管/*guan*. In Chinese, a single character often constitutes a word in and of itself. Many single-character words are polysemic; that is, they have two or more somewhat related meanings, and only the context in which they are uttered can specify their meaning-in-use. Single characters can also be combined to construct less ambiguous compound words. Depending on the context and the word combination, *guan* can refer to concern for and responsibility toward another individual or to managing, governing, intervening, and control. For example, in the first story, the same actions—the mother hospitalizing the daughter against her will, planning her future, protecting her from potential harm, and ensuring her medical compliance—was seen as control by the daughter but as care by the mother, and both interpretations were expressed in *guan*. As such, *guan* constitutes a keyword whose polysemy "both reflect[s] and influence[s] the processes of contention over ideas and values" (Kipnis 2006, 295; see also Williams 1985).

Despite its polysemy, *guan* has an entrenched meaning for many Chinese speakers—that is, the 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 often accompanied by care, love, and sacrificial labor (Xu 2017). Underlying these practices is an image of children as "weak, vulnerable, and dependent beings" (Saari 1990, 8) who have to be protected and trained in an optimal environment by their more mature and knowledgeable parents. Parents engage in *guan* with the hope that their children can become fully human (成人/*chengren*), act in harmony with the social order (Chao 1994), and eventually no longer need *guan*. Because this *guan* seamlessly connects individual development, parental aspirations, and social order, scholars have argued that *guan* is "the characteristic feature of Chinese socialization" (Wu 1996, 14). Seen in this light, the contention between Tingting and her mother was partly about whether it would be appropriate to apply *guan* to an adult who should have become a full human enjoying relative autonomy or whether madness had turned the adult into a vulnerable, child-like being requiring *guan*.

As we saw in Tingting's story, contentions around *guan* also pertain to how it is practiced with psychiatric techniques and institutional arrangements. This book shows that psychiatrists, community mental health practitioners, and local officials often invoke the language of *guan* as they teach family members to monitor patients' symptoms, risks, and pharmaceutical compliance. Moreover, *guan* has dominated the legal and policy texts produced and promoted by the Central government. In particular, the new MHL highlights *guan* as a principle of mental health work, with the term taking on a specific meaning as management (管理/*guanli*). Interestingly, while the law opens by requiring "all facets of society" to participate in *guan* or comprehensive management of people diagnosed with SMIs (National People's Congress 2012, Article 6), it quickly relegates most of this responsibility to their 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*)."

This book traces the circulation of *guan* between family practices, psychiatric encounters, policy discussions, and legal reform.[12] Acknowledging its polysemy, I explore how people define, evaluate, and contest *guan* in different realms; how family members' desire to parent, to care for the vulnerable, and to search for order are transformed when *guan* is mobilized, emphasized, and reconfigured by medical and legal discourses; and the power effects of these processes on various actors and relations. For instance, when *guan* is reconfigured as a mandate for families to perpetually manage patients' risks using any means, including indefinite hospitalization, it not only exerts heavy constraints on people like Xu Wei but also contradicts their understanding of *guan*, which is hinged on intimate relations, kindred affects, and the production of hope (chapter 5).

While people from all walks of life use the keyword *guan* to express ideas about how mental illness should be dealt with and how families should be involved, psychiatrists, policymakers, and human rights activists also use the keyword *paternalism* to articulate the logics behind their positions. After all, *guan* is commonly seen as an exercise of parental—and especially paternal—authority, responsibility, and wisdom. During the mental health legislative debates, both human rights activists and psychiatrists who drafted the law framed involuntary hospitalization as a manifestation of paternalism, which both sides viewed as a defining feature of the Chinese family, state, and culture; their contention was in whether this paternalism was oppressing or protecting people and whether it should be overthrown or endorsed. In this book, I acknowledge the actors' views while critically analyzing the historical formations, contemporary meanings, and practical operations of paternalism as it undergirds mental health care and governance.

When human rights activists and psychiatrists have invoked the concept of paternalism, they have been partly drawing on discussions in Western political theory and medical ethics about paternalism—that is, whether and when other people, institutions, or the state is justified in interfering with a person's liberty to promote that person's interests (Buchanan 1978; Dworkin 1972; New 1999). Situated in liberal democracies, these discussions all prioritize individual autonomy. This has also been valorized, or at least gestured toward, in China's mental health legislative debates, and it is why patient autonomy has been established as a principle of the MHL. At the same time, Chinese activists and psychiatrists have invoked other paternalistic traditions, including Confucian ideas of paternal authority, filial piety, and family-state isomorphism, as well as the socialist tradition of encouraging or even requiring people to work for, depend on, and develop a paternal identification with the state in exchange for promises of protection, provision, and prosperity (Steinmüller 2015; Verdery 1996). Not all of these traditions endorse individual autonomy, but they each involve an authority structure in which one party decides on what is good for another party and seeks to bring it about in action (Barnett 2017).

In this book, I take an interpretive approach to examine how people define, enact, and value autonomy in practice and what other shapes of subjectivity they envision. In contemporary China, forces of marketization, privatization, and global capital are entangled with "the lingering effects of socialist institutions and practices" (Zhang 2001, 179). Thus, I also take a historical, ideological, and structural approach to ask to what extent the promises of state paternalism are upheld, who actually carries the responsibility for being paternal, and what it looks like to practice paternalism in everyday life. While most existing studies have ignored the gendered dimension in the implementation of paternalism,[13] I explore how women or other vulnerable individuals, as supposed agents of paternalism, might enact or alter it.

As this book will reveal, although drafters of the MHL acknowledged the idea of patient autonomy, they were concerned with the damages it might bring to patients and society, which had presumably happened in capitalist countries. Therefore, they framed the widespread use of involuntary psychiatric interventions in China as a perk of socialism (chapter 1). Indeed, as these interventions continue to dominate the landscape of mental health care, to many people, freedom from them appears to be indicative of neglect (chapter 5). Note that the subject of state paternalism that the drafters of the MHL envisioned was no longer the socialist proletariat but a carrier of pathology and risk needing to be managed. Unable to ensure the state's financial commitment, they relegated the responsibilities of paternalistic action to patients' families. Chapters 2 and 4 show how, outside of the legislative debates, hospital psychiatry and community mental health practices have been expecting and inculcating families to be intimate authorities devoted to risk management, powerful enough to summon patients' compliance. Nevertheless, because the primary caregivers are typically ageing parents or other female relatives, they are often unable and unwilling to act paternalistically as expected. Instead, they may engage in maternal, supplemental practices to address patients'—and their own—vulnerabilities. In addition to these quiet, spontaneous disruptions, chapter 6 shows some caregivers' conscious struggles for what I call "paternalistic citizenship": they demand that the state not only recognize their contribution to managing risk and maintaining public order but also live up to its promises and perform proper paternal *guan* itself—by looking after its vulnerable citizens and repairing any damage wrought by marketization.

Attention to these keywords helps unearth the conditions, operations, and repercussions of biopolitical paternalism. In the neoliberal, postwelfare world, many people long for a paternalistic state (Street 2012) while fearing its potential overreach (Aretxaga 2003), having to rely on the family's warmth but worrying about its precarity and restrictions. My study provides an analytic for teasing out complexities and imagining new possibilities in the logics and practices of governance. Back to mental health, it also allows us to explicate the hopes and fears of people who experience madness and psychiatry to consider whether total control or abstract freedom is really what they need, and it explores how their needs can be addressed through new forms of social policies and public responsibilities. Because these keywords travel widely while undergoing constant reconfiguration and contestation, an ethnographic methodology that traces their circulation in different realms and that engages with different stakeholders is warranted.

Methodological Journey

Encountering Psychiatry and the Family

The journey that led me to the intersection of madness, family, and psychiatry was tortuous. In hindsight, it was a practice of what Donna Haraway (1991) called "situated knowledges," enabled by many chance encounters that revealed people's "contestation, deconstruction, [and] passionate construction" (191) of patienthood and care. It also required much "engaged, accountable [re-]positioning" (196) on my end to foster "webbed connections . . . and hope of [the] transformation of systems of knowledge and ways of seeing" (191–92).

My first encounter with psychiatry was during my undergraduate years in Beijing as a psychology major. In a psychopathology class, students were asked to interview inpatients in a major psychiatric hospital to assess their symptomatic manifestations. The patient to whom I was assigned was a woman who had been hospitalized by her family members for schizophrenia for eleven years. I could easily follow the teacher's instructions and fit the woman's words into the diagnostic manual. Yet I was struck by her despair over her prolonged seclusion and by the entanglements between her illness experience and her troubled family life, such as her stigmatizing childhood experience living with a father who had also been diagnosed with schizophrenia. Since then, I have been intrigued by the psychiatric institution and fascinated by the sociocultural underpinnings of illness experiences. It was this fascination that led me to travel halfway around the world to study cultural and medical anthropology in the United States.

In the summers of 2008 and 2009, I began conducting fieldwork at the Benevolence Hospital, which had 168 licensed psychiatrists, 469 nurses, and

1,920 beds (as of 2009). A flagship psychiatric hospital in the city of Nanhua and even throughout Southern China, it allowed me to observe and analyze Chinese psychiatry in an optimal form. Meanwhile, the crowded space and the staff's heavy caseload at Benevolence resembled most other psychiatric hospitals in China. My initial access to Benevolence was facilitated by a family friend and by my bachelor's degree in psychology from a prestigious university. Although the hospital was biomedically oriented, its administrators and doctors saw my knowledge as potentially beneficial to the inpatients. I was stationed on the adult psychiatry wards, which primarily housed people diagnosed with schizophrenia and other psychotic disorders along with some individuals 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 little was happening in the office, I went inside the locked ward to chat with patients. Most of them liked talking with me, because few staff members had the interest or time to listen to their concerns.

At the time, my interest was in how doctors, patients, and families experienced schizophrenia and how their explanations of the illness were shaped by various cultural knowledges (Ma 2012). During fieldwork, I could not help but realize that most patients on the wards had been forcibly or deceptively hospitalized by their family members and that most were resentful of that experience. Some people complained to me that their "symptoms" had been fabricated by their family members. Others might not question their diagnoses but were afraid of being left in the ward by their family members forever. Listening to their sighs and cries, it was hard for me to look the other way or make cultural generalizations that were disengaged from their struggles.

Gradually, my focus turned to families' involvement in psychiatric care. I returned to Benevolence's adult psychiatry wards and visited its outpatient clinic for brief follow-ups over the subsequent summers and for eighteen months during 2013–2014. Through interviews and observation, I examined why people turned to psychiatry for help, what it meant for family members to care for patients, on what ground they claimed the authority, knowledge, and responsibility to do so, and how such acts were perceived. I also observed the power relations in these practices, such as whose voice had been silenced, whose suffering had gone unrecognized, and the life options and relationships that had either been enabled or thwarted. To understand how individuals' views on ethical practices had been shaped by psychiatry, I observed how doctors solicited patients' illness histories from their family members, how doctors taught patients the nature of their illnesses and the importance of medical treatment, and how family members were inculcated with ways to manage patients. I also examined patients' and family members' reception to, and challenges of, these psychiatric instructions.

Charting the Mental Health Landscape

My new interest in families required me to chart a broader landscape of institutions and agencies involved in serving, monitoring, and challenging families' involvement in psychiatric care. Fortunately, the mental health infrastructure in Nanhua and its province was more established and comprehensive than that of many other parts of China. Since 2004, and especially after 2010, the National Ministry of Health has rolled out a community mental health program across China, which regards family caregivers as crucial allies in the management of people diagnosed with SMIs. Benevolence's staff kindly introduced me to several community mental health practitioners in both urban and rural areas of the city. I was able to observe their everyday work—especially visits to patients' homes—in the summers of 2010 and 2011 and then again during 2013–2014. I paid attention to how these practitioners obtained information about patients' illnesses and risk of violence from caregivers, their discussions with caregivers about the nature of the illness and proper family care, as well as any interventions the practitioners undertook for patients or their families.

Moreover, Nanhua had one of the earliest, and still leading, mental health social work agencies in China called the BeWell Family Resource Center. Built and mainly funded by the municipal government, its founding mission was to serve the family members of people recovering from SMIs and to encourage them to become resources for each other. Typical services included weekly informational meetings, support groups, and individual casework. As of 2014, the center had a registered clientele of over 1,000 caregivers, among whom about 100 were regular participants. Besides serving family members, the center had also developed vocational training classes and a sheltered workshop, at which persons recovering from SMIs could receive vocational training and low-wage employment opportunities. During my long-term fieldwork in 2013–2014, I spent much time at BeWell, participating in its activities as a researcher and volunteer, and observing how notions of family, mental illness, and care were imparted, discussed, and challenged. I also accompanied family members and patients outside the center as they navigated health care and welfare resources, helped each other with various life difficulties, or simply had fun together. From January to May 2014, I lived in the city's largest public housing community, whose residents included over 300 people with psychiatric disabilities and their family members. BeWell had established a branch there to serve them. This "deep hanging out" (Rosaldo 1994) gave me further insight into people's everyday lives, which were partially connected to, but not subsumed by, BeWell or other institutions.

In examining these pioneering institutions in Nanhua, I was less concerned with representing "China" as a whole. After all, it is hard for any situated ethnographic study to do so given the country's internal diversities. Instead, I was interested in exploring potentialities—that is, how new trends in the mental health field might reinforce, destabilize, or remake the meaning of patient care and the family's role in it, as configured by the psychiatric hospital. Meanwhile, over the years, to gain a more balanced view of different socioeconomic conditions, I visited various hospitals, community mental health teams, and (where they existed) social work/rehabilitation centers in other parts of China, from Beijing and Shanghai to provincial capitals like Kunming and to small cities and rural counties in Southern China. My visits ranged from half-day tours for interviews with administrators or senior staff to days or even weeks of observation. This book will draw on these visits to supplement my data from Nanhua.

The present is not just oriented toward the future but also situated in the past. As such, we need to understand how the family has been variably configured since the late 1890s, how these configurations have been shaped by sociopolitical changes and developments in psychiatric expertise, and how they have become discursive and institutional threads that weave into the present. To do so, I consulted archival materials on Chinese psychiatry at Yale Divinity School, the Shanghai Library Bibliotheca Zi-Ka-Wei, and the Needham Research Institute in the United Kingdom. Benevolence's institutional history was not well preserved, but I still managed to learn bits and pieces by reading the generations of books and hospital publications in its library and by checking files on it in Nanhua's municipal archives.

Tracking the Mental Health Law

Just as I was drawn to studying families' controversial involvement in psychiatry, I noticed news articles about people wrongfully diagnosed with mental illness and hospitalized. Some articles also mentioned the protracted course of establishing national mental health legislation. Following this lead, I traveled around China to interview nationally leading psychiatrists who had been involved in drafting the legislation. Interview topics included the family's role in inpatient and community care as set out in the drafts and as perceived by those psychiatrists; the state's responsibilities for patient care and management; and how those experts responded to public controversy surrounding involuntary hospitalization and coercive treatment initiated by families or other agents.

In 2011, I met with staffers of a Shenzhen-based organization called the Equity and Justice Initiative (EJI).[14] As the only organization in Mainland China dedicated to advocating for the rights of psychiatric patients, the EJI had collected cases of psychiatric abuse, connected self-proclaimed victims to legal support, published reports for domestic and international readers, and engaged in public debates with psychiatrists on the mental health legal reform. When conducting fieldwork in Nanhua, I often visited Shenzhen and elsewhere to participate in workshops organized by the EJI. I also traveled with its staff to national and international conferences on the mental health legal reform and on disability rights. Through these interactions, I became familiar with the ideas of EJI staff on the proper relationship between mental illness, family guardianship, and human rights, as well as their plans, strategies, and the obstacles they encountered in promoting patient autonomy. In addition to these face-to-face conversations with key parties, I also tracked public discussions around the mental health legislation as they appeared in the media.

Now that the MHL has come into effect, one needs to examine its interpretation, implementation, and impact in practice. My prolonged fieldwork, spanning from 2008 to 2014, provided an ideal time window to assess both change and continuity in the mental health field. As sociolegal scholars have noted, while the law can transform society and shape people's consciousness, its interpretation is also shaped by culturally and historically embedded social relations (Yngvesson 1988). Moreover, in organizational practices and informal settings, the law is activated far more often than in the courts. It is the decisions made and routines established in these situations that effectively become the law that people implement (Sarat and Kearns 1995). Therefore, besides tracing the few formal legal proceedings that invoked the MHL, I also observed how grassroots health-care professionals, government officials, family members, and patients interpreted and enacted the law; how they invoked it to discuss care and management as well as rights and responsibilities; and what institutional and socioeconomic conditions shaped these interpretations. Of special interest were patient admission and discharge procedures, the two most controversial areas of psychiatric practice as reflected in the legislative debates.

Building Better Worlds

Mental health in China is a contested field, because different parties often hold diametrically opposed views about proper arrangements for patients. Especially during the legislative debates, psychiatrists/policymakers and human rights activists would excoriate each other, and each side saw itself as the righteous spokesperson of both patients and the public. It was tricky for me to navigate between them: for instance, knowing that I was interested in studying families' involvement in hospitalization, some senior psychiatrists in a renowned hospital saw me as a human rights activist unable to understand their position, or worse still, as an American spy intent on digging up dirt on China. As a result, they rejected my application to conduct part of my research in their institution. Therefore, when conducting fieldwork, I had to be careful not to identify myself with any one group, lest it prevent me from accessing others.

Nevertheless, as I gradually earned the trust of my interlocutors, and as I better understood their visions and omissions, I started facilitating dialogues between different parties. For example, the EJI once invited me to its workshop on deinstitutionalization. From previous interactions, I knew that because of its focus on individual autonomy, its advocacy overlooked individuals' experiences of vulnerability and their needs for care. Therefore, instead of attending the workshop alone, I brought along more than thirty interested patients and caregivers. They spoke about their horrific experiences with various institutions and the need for legal oversight. Instead of advocating for complete deinstitutionalization, however, many discussed ways institutions should be improved, alternative services that could be provided, and care networks that might be built beyond one's immediate relatives. Their powerful words shook both the EJI staff and me. Seeing how thoughtful their loved ones were also caused some caregivers present to rethink their equation of mental illness with inability. For another example, as the biomedical model and psychiatric hospitals dominated the mental health field, oftentimes patients and families were unaware of other health or social services available. As a person who had the privilege of visiting different sites and organizations, I often found myself assuming the role of a social worker, connecting my interlocutors to organizations and resources that might benefit them.

Thus, rather than simply studying a preexisting "field," the fieldwork that constitutes this book contains efforts from my various interlocutors and myself to build helpful connections and better worlds together. By charting convergences and ruptures in family care and professional services, I hope this book generates more dialogue, understanding, and collaborative endeavors among people and entities concerned with mental health services, both within and beyond China. As such, it is an exercise of "a *committed and engaged* anthropology" (Forman 1995, 3).

Chapter Organization

A brief roadmap may help readers navigate the complex research journey condensed in this book. As I mentioned, chapter 1 traces how the hospital-family circuit has come to dominate mental health care for persons diagnosed with SMIs in reform-era China. Against this backdrop, it examines how activists and psychiatrists have struggled to define patient rights along with the meaning and legitimacy of paternalism in mental health legislative debates. In the next three chapters, I employ a slightly anachronistic approach and explore family practices in relation to institutions and community agents before the MHL to contrast the abstract legal language with the concrete ways paternalism and the related idea of *guan* have been inculcated, enacted, or resisted. Chapter 2 shows how everyday hospital practices translate people's experiences of chaos into symptoms of a mental disorder, turning family members' desire for *guan* into lifelong responsibility for risk management. Chapter 3 explores how this vision of risk and responsibility reworks family relations, dissolving certain ties while isolating others. Chapter 4 examines how the new national community mental health program, especially its agenda of preventing patients' risks of violence, further mobilizes and shapes family life and how family members engage in practices that simultaneously disrupt and supplement this agenda. In chapters 3 and 4, I highlight how the relational practices of female and feminized caregivers differ from, and supplement, the paternalism practiced by male family members or mandated by state programs.

Chapter 5 returns (or moves forward again) to the MHL and examines its implementation, focusing on how the interplay between interpretations of risk (now the sole criterion for involuntary hospitalization), institutional arrangements, and people's sense of responsibility influences hospital admission and discharge processes. Chapter 6 turns to the collective actions and narrations of family caregivers, especially how they deploy the state's paternalistic promises to stake citizenship claims, individually or together. Finally, the conclusion discusses resonances of biopolitical paternalism in other aspects of contemporary Chinese life, its recent transformations during the COVID-19 pandemic, and its implications for conceptualizing governance and care throughout the world. I also revisit what happened to Xu Wei after the trial and imagine how we could help people like him by disrupting the harm caused by biopolitical paternalism.

Notes

INTRODUCTION

1 Nanhua is a pseudonym, as are the names of most persons and organizations that I study. In China, psychiatric hospitals and other mental health agencies are few and far between, making them easily identifiable. To protect my interlocutors from potential sociopolitical repercussions, I anonymize not only their names, but also the organizations and places where they were located. When necessary, I also change any identifying details or present several persons/organizations/places as one. The only exceptions to the rule of anonymity apply to policymakers, leading psychiatrists, and human rights activists who have spoken publicly about psychiatry and the law.

2 In this case, the pseudonyms Xu Wei and Xu Xing were not made up by me, but widely used by the attorneys, activists, and journalists.

3 Xu Wei said he had merely scratched his father's face, whereas his brothers said he had broken his father's nose (Chen 2016b).

4 Around this time, some psychiatrists in China also started adopting a psychoanalytic lens in their work, to critique and intervene in what they saw as pathogenic dynamics in Chinese families. However, this trend was short-lived and did not pick back up until the 1980s. For a more detailed discussion of this development, see Ma (2014b).

5 Anthropologists have long argued that the ways people name, experience, express, and cope with distress differ across societies and are shaped by cultural systems of meaning (Benedict 1934; Kleinman 1991). Meanwhile, historians have shown that transformations of psychiatry and its understandings of madness/mental illness have been tied to society's changing notions of normality, reason, and morality (Porter 2002).

6 Building on these critiques, a Mad Pride movement has emerged to reclaim and champion people's lived experiences with madness/mental illness over professional knowledge, advocating for an anti-oppressive way of understanding and supporting them (Faulkner 2017; Lewis 2017; Menzies, LeFrançois, and Reaume 2013).

7 We follow historians and anthropologists' advice to not assume that the globalization of psychiatry is a uniform process but to heed how local actors selectively adapt, repurpose, and redefine ideas of psychiatry for their own agendas (Baum 2018; Kitanaka 2011; Zhang 2020).

8 The few critics that do consider the family tend to focus on its collaboration with psychiatric institutions (Goffman 1961) or the medicalization of family problems as individual disorders (Laing 1965).

9 For instance, disability studies scholars Stacy Clifford Simplican (2015) and Tom Shakespeare (2006) have criticized this tendency.

10 According to Michel Foucault, when population and security replaced sovereignty as the new focus of Euro-American governments in the eighteenth century, the family changed "from being a model to being a privileged instrument for the government" (Foucault 2009, 105; Donzelot 1979). Here, I draw inspiration from Foucault's discovery without assuming the same historical trajectory in China.

11 Similarly, Emmanuel Levinas argued that "the will to power is . . . the price which must sometimes be paid by the elevated thought of a civilization called to nourish persons and to lighten their sufferings" (Levinas 1988, 158–59).

12 Anthropologist Jianfeng Zhu and colleagues (2018) have also identified the importance and prevalence of *guan* in China's mental health services. They suggest that the culture of *guan* tends to "objectify and infantilize its subjects" (95) and turns families of people diagnosed with SMIs into agents of power. More needs to be said about the term's ideological purchase on families and the public as well as about its circulation, conceptualization, and contestation in different realms.

13 For example, in his review of paternalism in international humanitarianism and human rights practices, Barnett (2017) acknowledges that women, because of their perceived vulnerability, are often objects of paternalism. Nevertheless, he does not discuss the gendered dimension on the side of its agents. He also treats paternalism and maternalism as nearly synonymous, without examining how they connect or diverge.

14 Given the EJI's uniqueness, there is no point in anonymizing it.

1. CONSTRUCTING FAMILIES, CONTESTING PATERNALISMS

1 Because of the public nature of these cases and the legislative debates, I use either real names or common pseudonyms for people and organizations mentioned in this chapter instead of creating pseudonyms for them.

2 For a brief history of the kickbacks and price markup practices in drug sales in China, see Zhu (2011).

3 This phrase is inspired by Kim Hopper's phrase *the institutional circuit*, which refers to the "largely haphazard and uncoordinated transfers" of people with SMIs "across institutional domains" in the United States (Hopper et al. 1997, 664). Common across the American and Chinese circuits are the shortage of public healthcare provisions and the fragmentation of patients' lives along the circuit.

4 For example, in 2010, administrators of a Shenzhen hospital asked a psychiatrist to secretly diagnose a nurse who had complained about wage disparities, and they then demoted her based on the diagnosis. The nurse sued the hospital and won the case (Liu and Wang 2011).

5 According to a 2009 media review, there had been over twenty reported cases of alleged wrongful hospitalization by families, employers, or local governments (Zhou 2009). The legal analysis report published by the EJI in 2010 reported ten such cases (Huang, Liu, and Liu 2010).