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# Choosing Cures for Mental Ills: Psychiatry and Chinese Medicine in Early Twentieth-Century China

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## Abstract

In the late nineteenth and early twentieth centuries, Western physicians and missionaries opened several psychopathic hospitals in urban China, including the John Kerr Refuge for the Insane in Guangzhou and the Beijing Psychopathic Hospital. Although local families relied on the charitable services offered by these facilities, they generally remained ambivalent about, if not outright resistant to, neuropsychiatric theories and practices. This article examines how and why ordinary families made medical decisions when faced with the problem of mental illness. In contrast to previous research on biomedicine in the Republican period (1911–1949), which has tended to emphasize issues relating to ideology and cultural nationalism, this paper argues that support of (and resistance to) neuropsychiatry was less often framed in terms of identity politics than in terms of far more practical concerns, such as access, intelligibility, and effectiveness. Disparities in how "mental" disorders were conceptualized in Chinese and Western medicine, problems pertaining to translation and communication, and the very ineffectiveness of psychiatric treatment itself help to explain why families may have patronized psychopathic hospitals but remained unconvinced by the epistemic foundations of neuropsychiatric medicine.

## Keywords

China – mental illness – psychiatry – traditional Chinese medicine

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## Introduction

In 1905, the Presbyterian missionary and medical doctor Charles Selden recounted a particularly frustrating episode at the psychopathic hospital he managed in Guangzhou, China. Earlier that year, one of Selden's "disobedient" Chinese attendants managed to smuggle into the hospital a plate of cakes laced with a strong purgative, oil of aleurites cordata. The patients, naturally drawn to the cakes, consumed them quickly—only to be taken seriously ill soon thereafter. Although Selden was angered by the incident, he understood why it had occurred. As Selden explained to his readership, his Chinese attendant was operating under a fundamental misconception about the origins of mad behaviors. In Chinese medical thinking, madness is often attributed to an accumulation of phlegm in the chest. Selden's aide was therefore acting according to a familiar medical imperative: purge the patient, eliminate the phlegm, and heal the madness (Selden 1905).

Selden, of course, did not interpret the situation in a similar way. For him, madness was not a matter of mucus but of mentality, and while the violent purges that ensued might have temporarily quieted his patients, he ultimately believed that the incident was nothing less than injurious to their overall rehabilitation. This particular incident underscored a theme that was to recur throughout the early twentieth century—not just in Selden's hospital in Guangzhou, but anywhere Western psychiatry confronted its Chinese "other." Although Western psychiatrists and neurologists, many of whom had originally traveled to China with a missionary impulse, aimed to replace Chinese views on madness with a more "scientifically" sound neuropsychiatric grounding, they increasingly found that their efforts were not meeting with wide success. While impoverished Chinese families largely appreciated the charitable services of medically trained missionaries, this did not necessarily mean that they became unabashed supporters of psychiatric doctrines and methods. To the contrary, most families remained staunch believers in more traditional assumptions about the causes and treatments of mad behaviors, and their willingness to use the services offered by missionary hospitals was more out of practical necessity than ideological conversion.

When historians have asked why biomedical approaches to treating disease encountered such strong resistance in China throughout the first half of the twentieth century, they have typically framed their response in ideological terms. As scholars like Ralph Croizier (1968) have suggested, intellectuals viewed Chinese medicine as an essential element of their own cultural heritage; relinquishing it in favor of foreign Western practices would have thus meant giving up an important aspect of their national identity. Although

certain members of the Chinese intelligentsia strongly advocated for the complete adoption of biomedicine and the eradication of "superstitious" Chinese practices, this position engendered far more opposition than support. Indeed, as Sean Lei (2014) has argued, the attack on Chinese medicine may have actually strengthened, rather than eroded, traditional practices by causing Chinese medicine practitioners to band together in support of a "National Medicine Movement." In historical accounts of Western medicine in China, then, biomedical practices have generally been framed as a challenge to Chinese identity and a threat to cultural nationalism. On the occasions that intellectuals advocated for its adoption, they typically did so out of an ideological desire for modernity and a political concern over national survival (Rogaski 2004; Andrews 2014).

Scholars who have studied psychiatry in China, more specifically, have focused less on ideological concerns than on issues of social control. Situating themselves in the asylum or psychopathic hospital, social scientists like Neil Diamant (1994), Peter Szto (2002), and Zhiying Ma (2014) have explored how local elites, policemen, and foreign missionaries worked in tandem to confine the insane in municipal institutions, keep troublesome individuals out of public view, and "lure the Chinese away from their time-tested practices" of domestic treatment (Szto 2002, 3). While these works have shed light on the cooperative relationship that arose between local authorities and foreign physicians, they have paid less attention to the agential desires of families and patients. The voices of ordinary people—and the reasons why they decided to patronize psychiatric facilities, undergo biomedical treatment, or resist the attempted hegemony of psychiatric medicine—have therefore remained largely absent from such accounts.[1]

In contrast to the above, this article seeks to go beyond a perspective that frames responses to psychiatric medicine as the outcome of either an ideological desire for cultural nationalism or a municipal desire for social control. Since families actively availed themselves of psychiatric services, they were clearly not averse to the foreign *origins* of psychiatric techniques. Instead, as I will show, it was the foreign *content* of such treatments that generally engendered their skepticism or opposition. Furthermore, since the majority of psychiatric

1 An exception is Hugh Shapiro, who has used medical case records to show how socially marginalized individuals strategically feigned madness in order to obtain safety and succor in foreign-managed psychopathic hospitals. Portraying the hospital as a "haven from violence and privation," Shapiro insightfully demonstrates how women attempted to escape from unhappy marriages by "manufacturing" madness and seeking the charitable aid of foreign institutions (Shapiro 1995, 74; see also Shapiro 2014). I will build upon his analysis in this paper.

patients in Beijing—approximately 60%—were brought to psychopathic hospitals by their families (Hsü 1939), we cannot solely attribute the lure of these institutions to the "cooperative interaction" that arose between municipal authorities, local policemen, and foreign physicians (Diamant 1994, 8). Rather, we must also recognize the agency of ordinary individuals in their decision to either endorse or challenge psychiatric institutions, theories, and practices.

Through an examination of two psychopathic hospitals—the John Kerr Refuge for the Insane in Guangzhou and the Beijing (Beiping) Psychopathic Hospital—this paper will argue that for middle- and lower-class families, support of (and resistance to) neuropsychiatry was less often framed in terms of identity politics than in terms of far more practical concerns, such as access, intelligibility, and effectiveness. Despite relying on the charity of foreign-managed psychopathic hospitals, many families disputed the techniques employed by Western-trained practitioners. Their skepticism can be attributed to multiple causes. First, neuropsychiatry's emphasis on the brain as the site of mental disorder was utterly alien to Chinese understandings of somatic structure; second, foreign physicians could not always articulate their ideas in a language that was intelligible to Chinese-speaking patients; and finally, the treatments offered at these institutions mainly served to manage the mentally ill, but did not consistently cure them. In short, at a time when Western psychiatric treatments were neither understandable nor effective, Chinese families made rational decisions—rooted in their own needs and beliefs—about how to cope with the problems of madness.

## The Chinese Psychopathic Hospital

When medical missionaries first began arriving en masse in China in the early nineteenth century, few were primarily interested in matters of mental health. Most, like the Protestant missionary Peter Parker, established clinics for the treatment of purely physical ailments, such as the removal of cataracts and tumors (Spence 1969, 34–56). It was not until the relatively late date of 1897 that a missionary-run hospital for the specific treatment of mental disorders was first established in the southern city of Guangzhou.[2] The John G. Kerr Refuge for the Insane championed the cause of better treatment for the mentally ill, and assumed the responsibility of offering care, religious therapy, and financial responsibility for even the most hopeless cases (John Kerr Refuge 1922–1923).

2 The date usually given for the establishment of the Kerr Refuge is 1898. In reality, the Refuge was founded in 1897, but did not receive its first patient until one year later.

The missionary Charles Selden, who took over the management of the facility after the death of its founder in 1901, noted with a mixture of disgust and pity that care for the insane in China was all but neglected. Unless the person was criminally mad, the state was content to let the invalid wander the streets; and if the individual did not have a family willing to assume responsibility for his or her treatment, most madmen and madwomen were left to suffer this exact fate. "The insane constitute a very helpless class in China," Selden wrote in the *China Medical Missionary Journal* in 1905 (3). "No provision has been made by China's government or China's people for the insane. If caught upon the street doing anything out of the way, they are arrested and thrown into prison as if they were criminals."

Although the John Kerr Refuge was the earliest institution established in China for the specific treatment of mental cases, by the 1930s foreign physicians and missionaries had erected a handful of other psychiatric facilities in major urban centers. Among these was the Beijing (Beiping) Psychopathic Hospital, erected in 1933 under the patronage of the American-run Peking Union Medical College (PUMC).[3] The PUMC, a premier teaching institution funded largely by the Rockefeller Foundation's China Medical Board, prided itself not only on its cutting-edge therapeutics but also on its high standard of medical research. Physicians who worked at the Psychopathic Hospital were thus not simply interested in treating mental patients, but also in studying the cross-cultural dimensions of neuropsychiatric illness.[4]

Early reports from both of these institutions note that local families were initially reluctant to bring their insane relatives to foreign-managed facilities. They often only did so, therefore, as a matter of last resort. At the Kerr Refuge, a report from 1909 stated that many of the insane had been "kept in their houses until they had become a nuisance" to their families; it was only then that they were "put into the street for the police to pick up and bring to [the Refuge]" (John Kerr Refuge 1909, 4). In Beijing, likewise, most families only sought the services of asylums and psychopathic hospitals because they could no longer afford to care for their insane relatives at home; having exhausted their emotional and financial resources, they had no choice but to turn to the charity of foreign institutions for aid.[5] A journalist named Weng Zhilong 翁之龍 (1931), for instance, observed that approximately 85 percent of patients at Chinese psychopathic hospitals were from the lower socioeconomic classes.

3 Following the Nationalist (Guomindang) government's establishment of Nanjing as the new capital of China, Beijing was renamed Beiping. For reasons of consistency, I will continue to refer to the city as Beijing.

4 Discussions on Chinese culture and mental illness can be found in Lyman 1939; Woods 1929.

5 For example, Beijing Municipal Archives (hereafter BMA) J181-019-32402, BMA J181-019-25183.

And in a survey conducted by the Beijing municipal police in 1927, it was determined that close to 70 percent of admittances to the local asylum could be characterized as either "poor" or "extremely poor."[6] On the contrary, patients who came from families of means were rarely brought to foreign institutions. Rather, they remained in a domestic setting where they could be treated by Chinese medicine practitioners within the comfort of the home.[7]

Most families did not seek the services of foreign psychopathic hospitals until their relatives had already reached a severely weakened state. Physicians observed that their Chinese patients often arrived at the hospital suffering from psychotic symptoms that had been caused by malnutrition, exposure, or infection. Charles Selden and J. Allen Hoffman, superintendents of the Kerr Refuge, remarked that their facility experienced "a large number of deaths" due to the fact that many of their patients had arrived "in a state of physical exhaustion." Coincidentally, the facility also experienced a disproportionately large number of recoveries for the very same reason (John Kerr Refuge 1909, 4). The psychiatrist Richard Lyman noted a similar phenomenon at the PUMC many years later. Families in "comfortable circumstances" rarely admitted their relatives to the facility, he stated. Instead, the vast majority of patients hailed from situations of abject poverty in which their families had "no way to keep them." These types of patients, he continued, generally displayed a high incidence of "purely physical or symptomatic psychoses" due to obvious factors like "nutritional defects and infections.[8]

Even when poverty and serious illness compelled families to bring their relatives to Western institutions, such families often declined to leave the patient under the care of foreign physicians for an extended period. As psychiatric social workers at the PUMC observed, Chinese families felt extreme discomfort with the unfamiliar types of treatments—discussed in more depth below—that were offered by these hospitals, and they therefore frequently refused to assent to invasive procedures like surgery or injections.[9] Once the patient had shown any signs of improvement, moreover, families typically ignored the advice of physicians to keep the individual within the hospital, and instead insisted on the patient's immediate discharge and prompt return to a domestic

6 *Jingshi jingcha gongbao* 京市警察公報 [Capital police bulletin], December 31, 1927; see also March 2, 1927.

7 Rockefeller Archive Center (hereafter RAC), CMB, Inc., Record Group IV2B9, Box 96, Folder 689: Letter from Woods to Greene, June 3, 1922.

8 RAC, CMB, Inc., Box 96, Folder 690: Letter from Lyman to Greene, May 14, 1934.

9 The PUMC began employing Chinese social workers as intermediaries between families and physicians for this very reason (King 1996, 342–344). One such social worker was Song Siming, who published a book on his experiences (Song 1944).

setting (Lyman 1937, 766). In one particularly egregious case, a psychiatric social worker named Francis Hsü (1939, 22) described an insane man who had stabbed over ten people before being arrested and turned over to the Beijing Psychopathic Hospital. Yet, because the man's wife insisted on treating him at home, the municipal police ordered the man to be released from the hospital and returned to the custody of his family.

Due to distrust of foreign treatments, local families routinely insisted on bolstering Western remedies with native techniques. At the Kerr Refuge, physicians described how local families often supplemented biomedical treatments with herbs or broths that they had prepared at home (Selden 1909, 228). (Indeed, such was the case with the Chinese attendant, discussed by Charles Selden above, who poisoned his psychiatric patients with purgative cakes.) In order to avoid this sort of harmful familial interference, regulations at the Beijing Psychopathic Hospital specifically prohibited outside foods and drugs from being smuggled into the facility ("Beiping shi zhengfu" 1934, 687–688). While this statute may have appeared medically necessary from the point of view of neuropsychiatric practitioners, it nevertheless conflicted with traditional modes of expressing care.

When local families resorted to the use of psychopathic hospitals, in other words, they typically did so for matters of cost, expedience, and dire necessity. Unable to care for their relatives within the home, they relied upon the inexpensive or cost-free treatments offered by foreign institutions. Yet, despite their willingness to admit their relatives to psychiatric facilities, such individuals did not necessarily accept the superiority of psychiatric therapies. While some families bolstered foreign treatments with native remedies, others completely abandoned Western medications after their relatives had been discharged from the hospital. How, then, can we explain this continued distrust of neuropsychiatry? Given that local families did, in fact, utilize the services offered by Western institutions, the source of their aversion cannot simply be reduced to an ideological commitment to Chinese cultural nationalism. Rather, I suggest that their ongoing skepticism can be traced to more routine causes: namely, disparities in how "mental" disorders were conceptualized in Chinese and Western medicine, problems pertaining to psychiatric translation, and the very ineffectiveness of psychiatric treatment itself.

## Minds and Bodies

Throughout the early twentieth century, psychiatrists in the United States and Western Europe regularly debated the underlying cause of mental disorders.

While some adopted a purely materialist approach to psychiatric treatment—one that attempted to isolate the source of mental illness within the physical space of the brain—others advocated for a psychobiological approach that considered social factors alongside somatic ones. Despite this diversity in opinion, however, most psychiatrists trained in the Western world shared certain fundamental viewpoints. In particular, they upheld a similar understanding of the structure and function of the human body—one that localized mental activities and mental illnesses within the brain and nerves.

Physicians who worked at the PUMC and Beijing Psychopathic Hospital tended to support a predominantly materialist outlook (Li and Schmiedebach 2015). Under the leadership of Andrew Woods, an American doctor who inaugurated neurological training at the PUMC in 1919, psychiatry and neurology were unified as a single field of medical practice—neuropsychiatry.[10] Physicians were therefore expected to treat psychiatric and neurological disorders as arising from a common somatic origin, and were instructed to turn away patients who exhibited no organic basis for their distress.[11] Perhaps as a reaction to this rigidly materialist view, Woods' successor, the psychiatrist Richard Lyman, attempted to incorporate a more holistic vision of mental illness into his practice. As the student of Adolf Meyer, a psychiatrist who championed a psychobiological understanding of mental illness, Lyman (1937, 768–769) believed that it was necessary to incorporate sociologists and other "nonmedical workers" into psychiatric treatment in order to achieve a more "balanced perspective." Yet, despite Lyman's efforts, many physicians at the PUMC continued to focus their attentions strictly on patients whose mental distress originated from an organic root. As the sociologist Dai Bingham (1939, 5–7) commented, most neurologists at the PUMC regarded the patient as a singularly "biological organism." They consequently turned away patients "who ha[d] no organic disease."

For Chinese patients, particularly those with little education and low socioeconomic status, the materialist construction of mental illness in contemporary neuropsychiatry was far removed from their own understanding of

10 The nosology of mental illness shifted across the first half of the twentieth century. Throughout the 1910s, the PUMC differentiated between "diseases of the mind" and "diseases of the nervous system" in its annual report. By the mid-1920s, however, nervous diseases (such as neurasthenia), brain and nerve diseases (such as paralysis), and mind diseases (such as schizophrenia) were all grouped together under the common physiological classification of "Nervous System"; in 1927, these subcategories were eliminated altogether (PUMC 1919; 1925). On the development of neuropsychiatry, see Brown 2010.

11 RAC, CMB, Inc., Record Groups IV2B9, Box 96, Folder 689: Woods to Greene, June 3, 1922.

madness. As the historian Angelika Messner (2004, 649) has rightly stated, "The notion that all intellectual, mental, and psychic activities would take place exclusively in the brain was alien to the traditional medical discourse in China." Indeed, the brain rarely played a structurally significant role in Chinese medicine; in most cases, processes of thought and cognition were believed to be governed by the heart (Yu 2009).[12] Madness in Chinese medical theory was therefore not considered to be purely "mental" in origin, and practitioners of Chinese medicine subsequently did not isolate the brain as the locus of psychic activity. Rather, when an individual displayed symptoms of madness, Chinese physicians often attributed the cause of the disorder to an accumulation of mucus around the region of the heart. Through purgatives, emetics, and dietary supplements, physicians aimed to expel the pathological mucus and thereby eliminate the cause of the mad behaviors. This underlying belief helps explain why the "disobedient" attendant at the Kerr Refuge had offered purgative cakes to the facility's mentally ill residents; as Charles Selden (1905, 7) concisely summarized, he was "entirely ignorant of the fact that the seat of the disease is in the brain."

In Chinese medicine, the roots of madness were multiple. While neuropsychiatry tended to attribute mental illnesses to a malfunction or lesion in the brain, Chinese thinking on the matter highlighted a diverse array of potential causes: an imbalance of *yin* and *yang*, a depletion of *qi* (vital energy), an excess of emotion, the influence of environmental factors, demonic possession, or simply overuse of the cognitive faculties. Depending upon the perceived source of the disorder, families may have treated the patient in a variety of ways: from acupuncture and drugs to shamanism and prayer. More commonly, however, medical records from the early twentieth century show that families did not distinguish between natural and supernatural causes of madness, and they thereby engaged physicians and religious healers simultaneously (e.g., Zhou 2008; Wang 2009). The etiological heterogeneity of madness in Chinese medicine reflected traditional assumptions about the unification of body, mind, and environment. In the words of the psychiatrist Keh-Ming Lin (1981, 95), Chinese medicine conceptualized the individual as an "integrated organism." In contrast to contemporary biomedicine, which tended to compartmentalize the functions of the various organs and draw a division between body

12 Certain Chinese physicians, such as the Ming-dynasty practitioner Zhang Jiebin (1563–1640), proposed that the *shen* (spirit) could be found within the brain. However, this idea did not gain a significant following, as most people continued to associate *shen* with the heart.

and mind, Chinese medicine did not consistently differentiate between soma and psyche, natural and supernatural.

When called to treat a patient who was mentally ill, therefore, practitioners of Chinese medicine did not localize the cause of the disorder within a single anatomical region. Instead, physicians emphasized the dynamism of the body and the interconnectedness between organs, psychic processes, emotions, and environment. For example, the eminent physician Ma Peizhi (馬培植, 1820–1903), who famously treated the empress dowager Cixi, described a patient who had developed symptoms of *dian* 癲 (depressive madness) after experiencing a severe "fright and fear." The "fright," Ma noted, had caused the patient's *qi* to injure his heart, while the "fear" had caused his *qi* to injure his kidneys. Mucus had then accumulated in the chest cavity, which had caused the patient to develop distorted thoughts, irregular sleep patterns, and unstable emotions. In order to treat the disorder, Ma (2009, 388) focused neither on the patient's "brain" nor on his "mind." Instead, he wrote a prescription that would act to "drain [the mucus] around the heart and warm the gallbladder." In Ma's account, then, physical, mental, and emotional elements had acted in tandem and in a dialogical manner to create a psychosomatic imbalance: one that could only be corrected by recognizing the interdependence between body and mind.

Because Chinese medicine framed mad disorders as the symptomatic expression of an ulterior imbalance, "madness" itself was not consistently envisioned as a discrete pathology. As Martha Li Chiu (1986, 284; see also Chen 2014) argues, there was no mention of "an explicit higher-order category of mental illness" in the Chinese medical canon. Rather, mad behaviors were often framed as the end result of psychosomatic malfunction, excess, or depletion. Nor were symptoms of madness construed as qualitatively different from symptoms that arose due to other types of illnesses. Since Chinese medicine was more concerned with disease "patterns" than disease "entities," physicians did not typically name the disorder according to a standardized taxonomy, but instead described the sequence of events that had caused the particular abnormality to arise (Zhang 2007, 85). Thus, in contrast to biomedicine, which presupposed the uniqueness of "mental illness" and the subsequent need for a specific type of neuropsychiatric intervention, Chinese medicine did not always view madness as an essentially distinctive pathology.

Due to their preexistent beliefs about the causes of madness, Chinese patients continued to articulate their symptoms in a traditional vocabulary even after they entered the psychopathic hospital. Many described how their chests felt stopped up with sputum (McCartney 1927, 89), while others isolated the heart as the biological anchor of "mental" illness (Liang 1939, 254). Some

attributed their symptoms to external pathogenic agents like cold and heat, while others spoke of an imbalance of *yin* and *yang* (Shapiro 1995, 141). And numerous patients, furthermore, insisted that the source of their madness could be traced to the influence of spirits or deceased ancestors. Andrew Woods (1929, 26–27), for example, noted how a coolie woman had convinced herself that "a chicken had 'taken possession' of her," and Richard Lyman similarly discussed a schizophrenic patient whose interview involved the "loose mention of ghosts and spirits" (Shapiro 1995, 139). Although some foreign physicians attempted to make sense of Chinese explanations for madness, others dismissed them outright as "absurd."[13] The epistemic distance between neuropsychiatrists and their Chinese patients was not unbridgeable, but it often convinced local families that their needs were better served elsewhere.

Indeed, because of the major conceptual differences that separated early twentieth-century neuropsychiatry from contemporary Chinese medical theory, many Chinese patients preferred to patronize physicians who had been trained in a more familiar medical epistemology. Practitioners of Chinese medicine often capitalized on this ambivalence toward—or outright discomfort with—Western medicine by marketing their own services as being specifically applicable to the bodies of the Chinese. For example, the Shanghai Specialized Hospital for the Insane (*Shanghai fengdian zhuanmen yiyuan* 上海瘋癲專門醫院), which was established in 1931 by a Chinese medicine practitioner named Gu Wenjun 顧文俊, played on popular distrust of foreign doctors by claiming that their physicians only employed "native" medical techniques, such as acupuncture and *tuina* massage, and only prescribed drugs that were indigenous to China. "This institution," Gu Wenjun (1934, 2) wrote in the introduction to a pamphlet on the facility, "was established for the Chinese people, and uses only Chinese medicine and Chinese herbs." Gu thus marketed his facility as one that could serve the needs of its Chinese clientele more effectively than a facility built upon the precepts of Western medicine.

Although skepticism of neuropsychiatry was certainly widespread among the Chinese people, it was not universal. By the middle of the Republican period, many members of the intelligentsia—particularly those who had studied abroad in Japan or the United States—had begun to adopt a biomedical stance on the nature of mental illnesses. Some, like the politician Song Jiaoren 宋教仁 (1882–1913), sought the services of Japanese medical professionals for the treatment of nervous disorders, while others, like the neurologist Wei Yulin 魏毓麟 (1899–1968), supported the total eradication of "superstitious" Chinese

13 RAC, RG1 Projects, Box 26, Series 601, Folder 240, "Preliminary Report of the China Medical Commission to the Rockefeller Foundation," September 24, 1914.

practices (Wei 1936). But for most members of the lower classes—the very people who tended to fill the wards of charitable hospitals—neuropsychiatry remained far removed from their everyday understanding of bodily function and structure. To these men and women, madness was not a disorder of the "brain," but rather a symptom of some underlying psychosomatic malfunction or cosmological breakdown. It was therefore logical that they would continue to question the assumptions upon which neuropsychiatry was based.

## Translating Psychiatric Concepts into Chinese

In addition to viewing bodily morphology in strikingly different ways, Western physicians and their Chinese patients also encountered fundamental problems pertaining to the translation and communication of psychiatric concepts. Throughout the early twentieth century, American and European physicians struggled to express psychiatric ideas in a language that was intelligible to local families. Because the Chinese language did not contain ready-made words for biomedical models of disease, foreign physicians had to employ either newly-coined neologisms or English language terms. When psychiatry and neurology first began to be taught in China in the early 1920s, students were instructed entirely in English; at the PUMC, likewise, medical records were recorded primarily in English and prescriptions were communicated in that language as well (Messner 2004, 653). However, as time went on, foreigners increasingly recognized the need to develop Chinese terminologies for Western medical concepts if they ever hoped to disseminate these ideas to the population at large. As Richard Lyman (1937, 769) admitted, "It is not too early to start [the] search for Chinese expressions of the more fundamental psychiatric concepts which fit the spirit of the language. The sooner this is done the better."

Most early psychiatric neologisms were not created by Westerners, but rather by the Japanese. As Peng Hsiao-yen has previously shown, Japan had become interested in the study of the mind as early as the mid-nineteenth century, when the scholar Nishi Amane 西周 (1829–1897) first traveled to Holland to study psychology and philosophy. Upon his return, he created neologisms for Western metaphysical concepts by borrowing phrases from neo-Confucian philosophy and Chinese medicine. For instance, when Nishi first attempted to translate the concept of "psychology" into Japanese, he did so by borrowing the term *xingli xue* 性理學 (the study of the principles of human nature) from the Neo-Confucian scholar Zhu Xi 朱熹 (1130–1200). Ten years later, Nishi revised his translation of the concept to *xinli xue* 心理學, or "the study of the principles of the heart-mind." The term *xinli xue* would also become the standard

translation for "psychology" in China, although other terms (notably, *xinling xue* 心靈學, or the study of the "heart and soul") were alternately used throughout the first decade of the twentieth century (Peng 2012, 102–104).

During the Republican period, Chinese neologisms for psychiatric words were neither standardized nor widely understood.[14] Foreign physicians therefore encountered severe difficulties communicating their ideas to Chinese patients in a way that reflected the exact meanings and connotations of psychiatric concepts. Moreover, because Chinese terms for words like "psychology" borrowed heavily from traditional Confucian philosophies, psychiatric neologisms contained a host of associated meanings that foreigners were unaware of; these meanings often diverged considerably from the intended definition of the imported psychiatric term. Indeed, as Angelika Messner (2004, 653; see also Liu 1995, 26) has noted, neologisms for psychiatric concepts "did not change the 'Chinese epistemology' [of madness]," but may have instead bolstered preexistent conceptions of illness as they were understood in Chinese medicine. In other words, when Chinese patients encountered biomedical neologisms, they would have naturally interpreted them through the filter of their own medical assumptions and philosophical views.

While it is quite difficult to deduce how ordinary patients "understood" the psychiatric neologisms that were communicated to them by physicians and social workers, we can nevertheless gain a sense of the ways in which Chinese intellectuals interpreted (or misinterpreted) foreign psychiatric terminologies by examining their writings on the subject. Scholars who had never traveled abroad, and had therefore only encountered psychiatric neologisms in print, tended to make sense of these foreign terms by viewing them through the lens of their own cultural and medical epistemologies. To illustrate this point, let us examine how two intellectuals interpreted and expounded upon the meaning of the Chinese term for "mental illness." The neologism for "mental illness," which was coined in Japan in the mid-nineteenth century and soon thereafter made its way to China, was *jingshen bing* 精神病 (Japanese: *seishinbyō*), or an illness (*bing*) of the mind or psyche (*jingshen*). Although this neologism approximated the underlying essence of the foreign psychiatric concept, it suffered from the fact that the term *jingshen* already existed in Chinese medical theory—but signified something wholly different than the Cartesian "mind."

In Chinese medicine, *jingshen* is considered an essential part of the material body, rather than something that transcends or exists apart from it. The phrase itself refers to two mutually constitutive vital forces: *jing* (essence), a material substance formed in the kidneys that is responsible for functions related to

14 On the variety of neologisms used for any given term, see *Jingshen bing lixue mingci* 1935.

growth, aging, and reproduction; and *shen* (spirit), an immaterial entity that resides in the heart, which is perhaps best understood as a manifestation of one's vital energies.[15] When placed alongside one another in the compound phrase *jingshen*, the term can express two separate, yet also interrelated, ideas. On the one hand, it can signify a sense of the mind, consciousness, spirit, or soul. On the other hand, it can also refer to a person's primordial spirit, life essence, energy, or vitality (Xie 1927). Thus, while "mental illness" in neuropsychiatry is not inevitably life-threatening, an illness or deficiency of the *jingshen* in Chinese medicine can easily prove fatal.

When Chinese scholars encountered the neologism *jingshen bing* for the first time, they often interpreted it through a Chinese medical lens. For example, a self-taught intellectual named Wei Hongsheng 魏鴻聲, who established a mental hospital in Beijing in 1934, published a lengthy tract in which he explained his understanding of the term. As an intellectual who had never left China, did not speak any Western languages, and received his medical training largely on the basis of translated texts, Wei's understanding of *jingshen bing* was naturally inflected with the assumptions and expectations of his own intellectual tradition. In his essay, Wei argued that *jingshen* is the basis of life; if *jing* and *shen* are deficient or lacking, the person will inevitably become sick and die. He began his essay with the premise that "*jing* is stored in the kidneys and produces [the associated element of] water, while *shen* is stored in the heart and produces [the associated element of] fire." The preservation of health, he continued, required a balanced and reciprocal interaction between the heart and the kidneys. When the two fell into opposition, and when fire (from the heart) and water (from the kidneys) failed to aid one another in the sustenance of bodily health, "this is the origin of *jingshen bing*" (Wei 1936, 1–2; see also Wei 1933, 8–9).

Wei's interpretation of the neologism *jingshen bing* effectively revealed his distance from neuropsychiatric epistemology. When invoking the concept of *jingshen*, he was informed less by the Cartesian "mind" or by the biomedical morphology of the human body than he was by Chinese medical theory, which positioned *jing* and *shen* within the vessels of the kidneys and heart, respectively. In order to treat an illness of *jingshen*, then, Wei argued that Western pills, medicines, and surgical techniques would inevitably prove ineffective. Since illnesses of the *jingshen* were "formless" (*wuxing* 無形), material cures would do little to mitigate their effect on the body. Only Wei's specialized *jingshen* therapy (*jingshen zhiliao* 精神治療), which involved guided meditation

15 For a deeper synopsis of these terms, see Zhang 2007, 36–38.

and mesmerism, could successfully treat the root of this type of disorder (Wei 1936, 36–37).

Wei Hongsheng was not the only intellectual to interpret psychiatry through the conceptual framework of Chinese medicine. In a 1931 collection of articles entitled *The Broad Meaning of Mental Illness* (精神病廣義), editor Zhou Lichuan 周利川 (1931, 2) showed a similar tendency. In his preface, Zhou contrasted the "systematic" and "precise" discipline of psychiatry with the superstitious beliefs of Chinese medicine, which involved "mucus, *qi*, and fire; ghosts, spirits, and evil." Yet, despite Zhou's articulated opposition to Chinese medical theory, his interpretation of psychiatric medicine was highly influenced by indigenous doctrines. Referencing Chinese medical classics like *The Divine Pivot* 靈樞 and the *Classic of Difficult Issues* 難經, Zhou argued that mental illness (*jingshen bing*) arises when "people have many doubts or worries, or their thoughts go unsatisfied." Since "the spleen is in charge of contemplation (脾主思慮), and since contemplation provides the origin to the intention and wisdom … [mental illnesses] are all illnesses of the spleen" (2). While Zhou, like Wei Hongsheng, may have claimed to have been influenced by biomedical theory, he nevertheless overlooked the fundamental neuropsychiatric relationship between mental illness and the brain. Instead, his understanding of mental illness remained predominantly informed by classical medical texts—even as he condemned them for being unscientific.

The examples of both Zhou and Wei illustrate how simple acts of translation could perpetuate radically different interpretations of psychiatric neologisms than what the "original" term intended to convey. By showing how illnesses of the *jingshen* required treatments that neuropsychiatry was unable to provide, such discourses not only misconstrued the neuropsychiatric meaning of "mental illness," but may have additionally undermined biomedicine's attempt to achieve a monopoly over its treatment. Similarly, when Chinese patients encountered these foreign terminologies in the space of the psychopathic hospital, they likely misinterpreted the essence of what their foreign physicians were attempting to express. Translational problems such as these, then, may have further served to bolster the preexisting sentiment that Western medicine was fundamentally incompatible with Chinese bodies.

## Claims and Cures

Perhaps the single most important reason why Chinese families remained skeptical of neuropsychiatry had less to do with problems of epistemological divergence or linguistic miscommunication than with more practical concerns.

At the turn of the twentieth century, neuropsychiatry was largely incapable of curing the problems it claimed to understand. In the absence of psychotropic drugs (which were not employed until the 1950s), and in the years prior to the invention of electroshock therapy and the lobotomy, psychiatrists were basically unable to provide long-term cures for chronic suffering (if the above treatments can even be referred to as "cures"). As the historian Roy Porter (1998, 272) has noted, the lack of effective treatments for psychiatric illnesses was ultimately what led to a "new faith … in the madhouse." If physicians could not cure the disease, then the most they could do was manage the patient.

In China, the effort to manage—rather than cure—patients became the foremost concern at Western-run psychopathic hospitals. Since the John Kerr Refuge was both founded and managed by Presbyterian missionaries, a substantial part of its therapeutic regimen centered on religious salvation, the reading of biblical texts, and the recitation of Christian prayers. Although physicians at the hospital recognized that these activities could not necessarily cure severe cases of mental illness, they could nevertheless help to soothe the patient's mind by allowing him to focus his mental energies on a single task. Moreover, by incorporating patients into a Christian community, medical missionaries also hoped to provide patients with a civic network that would remain mutually responsible for one another's welfare outside the context of the facility. The religious approach to managing mental illness was one of the primary techniques employed by practitioners at the Refuge. By the middle of the 1920s, Charles Selden estimated that 80 percent of the Chinese staff had converted to Christianity and that a large proportion of the patient body was well on its way to doing the same (John G. Kerr Refuge 1925, 6).

The Beijing Psychopathic Hospital, while less motivated by an overtly religious impulse, nevertheless also suffered from a lack of "magic bullet" cures. Outside of fever therapy, which was believed to treat general paresis (a neuropsychiatric disease caused by neurosyphilis), the hospital mainly employed treatments that temporarily calmed or sedated the brain and nerves. Throughout the 1930s, physicians at the hospital used barbiturates to induce sleep in insomniacs, and experimented with protracted narcosis on individuals recovering from drug addiction. A frequent treatment employed on agitated and violent patients was hydrotherapy, which consisted of baths, sprays, and wet wraps meant to soothe the nerves or render the patient temporarily immobile.[16] Work therapy (sometimes referred to as occupational therapy) was also a popular form of therapeutic intervention for those who were well enough to perform it. At the hospital, women washed clothes and bedding,

16 For more on hydrotherapy, see Braslow 1997, 40.

while men ground soybeans and spun cloth. Although work therapy was believed to benefit the brains of mentally ill patients,[17] it also served an economically productive purpose: the goods that patients produced helped ensure the hospital's financial solvency ("Weisheng chu" 1935).

Although the practitioners at both institutions were sincere and well intentioned, they were not blind to the fact that many of the treatments they employed were rarely, or only temporarily, effective. Indeed, by the 1930s, it was estimated that the average rate of improvement for mentally ill patients in American psychopathic hospitals was approximately 30 percent (Lamson 1935, 429). Western practitioners in China produced comparable figures. When the Kerr Refuge began compiling statistics on its patients in the first decade of the twentieth century, a report from the years 1907–1908 noted that the rate of cure hovered around 31 percent of those admitted. Nevertheless, the report also acknowledged that "this *somewhat high percentage of cures* is probably due to a larger proportion of manic-depressive cases and to the fewer [*sic*] of paresis than is found at home" (John Kerr Refuge 1907–1908; emphasis added). More typically, over half of the patients who had been admitted to the facility either died or showed no improvement whatsoever (John Kerr Refuge 1925, 8).

The Beijing Psychopathic Hospital fared no better. In 1935, the facility issued a report that attested to the ever-present problems of overcrowding, lackluster rates of cure, and patient recidivism. Between January and June, only 40 patients were discharged as "cured" out of a total of 130 new admittances, while 20 were said to have passed away over this same period; the majority showed either little improvement or no improvement whatsoever ("Weisheng chu" 1935). Nevertheless, these statistics do not take into account the number of apparently "cured" individuals who were readmitted to the facility at a later date. According to sociological statistics compiled at the hospital, approximately 12 percent of cases were admitted either two or three times to the facility over the one-year period from October 1934 to October 1935 (Hsü 1939, 212). As a result of the low turnover rates, the total number of patients at the hospital increased from a low of 144 to a high of 190 over a six-month period in 1935 ("Weisheng chu" 1935). The problem of overcrowding was so urgent, in fact, that one of the chief physicians at the hospital, Richard Lyman, announced that the facility was "dangerously near [to] becoming just a custodial institution" (quoted in Rose 2012, 420).

While physicians at these psychopathic hospitals recognized that they could not effect a decisive cure in a majority of cases, they nevertheless remained frustrated that local families continued to experiment with nonbiomedical

17 On the supposed benefits of occupational therapy, see Eraso 2010.

therapies. Throughout the 1920s and 30s, therefore, they attempted to instruct Chinese families about the benefits of psychiatric medicine and the dangers of Chinese drugs. At the Beijing Psychopathic Hospital, Richard Lyman engaged psychiatric social workers to explain and interpret neuropsychiatric methodologies to Chinese patients so that they would not feel alienated from the therapeutic process. Even after the patient had been discharged from the hospital, some social workers paid follow-up visits to the patient's home to confirm that the family had not disregarded the advice of the physician and reverted, instead, to more traditional modes of care (King 1996, 342–344). In Guangzhou as well, the Kerr Refuge attempted to explain the principles of "mental hygiene" to the local community by holding large-scale educational campaigns at the facility. Two of these campaigns, held in 1922 and 1923, attracted an estimated 50–60,000 onlookers (John Kerr Refuge 1922–1923, 5).

Despite these efforts, however, ordinary people were not necessarily persuaded to abandon their preexistent beliefs about the nature and treatment of madness. Indeed, as Charles Selden was forced to acknowledge following his mental hygiene campaigns, most visitors did not come to the facility out of a genuine interest in psychiatric ideologies; rather, "the greatest attraction was the patients themselves." In order to keep rowdy and curious onlookers at a safe distance from the invalids, the Refuge was forced to "shut [patients] in their rooms" and erect protective barricades (John Kerr Refuge 1922–1923, 5). In Beijing, similarly, physicians like Richard Lyman were continually frustrated by the fact that many patients remained under the care of their families rather than being brought to the facility for routine treatment. As he wrote in a letter in 1934, "Many persons with mental disorder, especially if mild, are kept under the cover of the home and never come into our hands for observations. We have no way at present of knowing how many cases of this sort exist, but our private consultations at the PUMC are uncovering more and more of these patients."[18] The neurologist Andrew Woods noticed the same troubling pattern. Citing an episode whereby a well-to-do family decided to keep their mentally ill father within the home rather than bring him to the PUMC—a place they not only "knew of" but were "favorably inclined toward"—Woods (1929, 542) concluded that "the masses of the Chinese are ignorant of the aim of scientific medicine and of the advantages of entering a hospital for treatment."

Woods's frustration was based on the premise that "scientific medicine" had developed a host of effective treatments. If, however, psychiatric hospitals offered few magic-bullet cures for the problem of mental illness, there was no

18 RAC, CMB, Inc., Record Group IV2B9, Box 96, File 690: Letter from Lyman to Greene, May 14, 1934.

logical imperative for families to exchange their traditional medical regimens for those offered by foreign physicians. For members of the lower classes, in particular, preexistent therapeutic networks likely provided many of the same curative benefits as Western hospitals, but with few of the drawbacks. Native doctors, shamans, and faith healers were often well acquainted with the families of their patients, and could consequently offer a more intimate form of advice than foreign doctors, who did not even speak the same language as the people they were treating. And since Chinese healers shared the same vocabularies and assumptions as their patients, they would have been able to communicate in a way that was both more intelligible and more conceptually familiar.

Indeed, while Chinese intellectuals may have been persuaded to adopt biomedical regimens out of a desire for medical modernity, and while ordinary families may have been willing to experiment with neuropsychiatric procedures out of curiosity or desperation, many were simply not convinced of the benefits or superiority of Western psychiatry. As one commenter brusquely noted, Western doctors "lacked fundamental treatments" for mental illness; consequently, they "could not achieve a complete cure." Relying simply on sedatives and tranquilizers, he continued, psychiatrists could only relieve the symptoms of madness temporarily, but could not eradicate them completely (Yu 1933, 16). The very ineffectiveness of neuropsychiatry as a therapeutic practice, in other words, meant that there was no compelling reason why Chinese families should relinquish their prior medical regimens in favor of a foreign epistemological system.

## Conclusion

In 1937, Richard Lyman remarked that psychiatry was "the Western [medical] specialty last to be recognized in China." While other forms of biomedicine had generally gained some degree of popular attention, the treatment of mental disorders continued to be "absorbed by other agencies," such as the family, the temple, or the Chinese medicine practitioner (Lyman 1937, 768). Why was this the case? In seeking to explain trends in early twentieth-century care-seeking practices, most historians have framed their analysis in terms of a tradition-modernity binary. Those who pursued Chinese therapeutic strategies were doing so out of an ideological interest in preserving their national identity, while those who championed Western medicine were doing so out of a political interest in achieving modernity. For matters of psychiatry, moreover, scholars have shown how local authorities worked with Western physicians to

ensure that mentally ill individuals remained under custody and out of public view; psychiatry, in the historical imaginary, has thus been framed primarily as a method of social control.

In contrast, this paper has stepped outside of a framework that privileges either ideology or control in order to examine the more routine reasons why psychiatric medicine was slow to take root in early twentieth-century China. Although socioeconomically disadvantaged families may have experimented with low-cost or free psychiatric treatments out of curiosity or financial desperation, many continued to patronize religious or Chinese medicine healers at the same time. They did so, I have suggested, for several reasons. First, divergences in the ways in which body and mind were conceptualized in China and the West prevented a common therapeutic orientation toward psychic distress; second, problems of translation may not have simply failed to communicate the basic assumptions of Western psychiatry, but may have actually bolstered long-standing beliefs about the nature of emotional and behavioral abnormality; and third, the fact that early twentieth-century psychiatry had few tools at its disposal to cure (rather than merely manage) the mentally ill meant that there was no logical imperative to convert to psychiatric beliefs and approaches.

Many of these problems continue to plague the practice of neuropsychiatry in China today. As the anthropologist Zhiying Ma has shown, Chinese families frequently challenge or subvert biomedical models of psychic distress by ignoring the advice of neuropsychiatric practitioners and pursuing their own medical remedies. They do so not out of a narrow interest in Chinese "tradition," but rather out of a desire to pursue therapies that appear more familiar and efficacious (Ma 2012). In regions of rural China, furthermore, surveys have shown that a striking majority of the population—approximately 70 percent—has "no knowledge of mental illness." When asked about the source of mental disorders, most respondents attribute the problem to supernatural causes, somatic imbalance, or cognitive overexertion (Ran et al. 2005, 27). Despite campaigns against "superstition," moreover, many rural families continue to patronize shamans and "witch doctors" for the treatment of the mentally ill (Li and Phillips 1990). In contemporary China, in other words, the language and ideology of neuropsychiatry continues to confront enduring conceptions of what madness is and how it should be treated.

In order to understand why these trends have persisted, historians would benefit from integrating the findings of medical anthropology into their analyses. Previously, anthropologists have questioned the globalizability of biomedicine, particularly in relation to questions of psychiatric suffering (e.g., Biehl

2005; Good 1994; Kleinman 1988). As Arthur Kleinman (1980, 24) has noted, psychiatric concepts form part of a "cultural system" which is "anchored in particular arrangements of social institutions and patterns of interpersonal interactions." Responses to illness are therefore not free-floating, but rather rooted in sociocultural modes of being. Ethan Watters (2010) has similarly observed that mental illnesses "are not discrete entities like the polio virus with their own natural histories," but are instead shaped by "the ethos of particular times and places." Both agree that the ways in which people interpret and conceptualize their bodies, societies, and selves deeply affect the types of care-seeking practices that they pursue.

With this in mind, resistance to Western psychiatry in China becomes more complex than just the product of ideological or political concerns related to China's traditional status vis-à-vis the West. More commonly, it was also the product of a rational calculation about the curative benefits and conceptual applicability of psychiatry versus Chinese medicine. If ordinary people challenged the attempted hegemony of neuropsychiatry, it was because of the foreignness of its epistemological underpinnings, the imprecision of its linguistic expression, and its inability to undermine fundamental assumptions about the structure, function, and treatment of the human body that had already been given full articulation in Chinese medical thinking.

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BMA Beijing Municipal Archives
RAC Rockefeller Archive Center

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