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Mental Health in China and the Chinese Diaspora: Historical and Cultural Perspectives

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Editor

Mental Health in China and the Chinese Diaspora: Historical and Cultural Perspectives

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Foreword

Developments in psychiatry and mental health are gaining more visibility across the globe as rapid changes in policies are shaping services and practices in most countries. Mental health is also assuming growing importance at different levels of care. Developments in China, and among the Chinese diaspora that is to be found in virtually every country across the world, are of greater significance than at any time in the past.

It is widely acknowledged that efforts to develop and reform mental health systems, in order to improve mental health programs and services, are subject to historical, cultural, and contextual influences. The structure and objectives of any national mental health system determine whether population mental health is promoted and protected and whether persons with mental disorders have affordable and equitable access to high-quality services. An understanding of the strengths and weaknesses of contemporary mental health systems, and of the possibilities for their further development, relies on understanding the history and the political, economic, and cultural factors that prevail in any country.

This book provides a comprehensive account of issues that are likely to shape the future development of the Chinese mental health system, and of how mental health systems in resettlement countries have, or have not, responded to the particular needs of Chinese immigrant communities. The book deals first with the development of the Chinese mental health system over the past 150 years and key contemporary issues, such as China's first national mental health law and the national mental health plan. It then moves to a consideration of mental health and the Chinese diaspora, beginning with an overview of Chinese emigration, and then exploring what is known, and what is not known, about the mental health of, and mental health services for, Chinese immigrants in selected countries with large Chinese immigrant communities.

Harry Minas is an acclaimed and much-admired author and editor. He has brought together a group of China scholars with deep knowledge of Chinese history and culture, historical and contemporary currents in mental health system development in China, and the circumstances – from a mental health perspective – of Chinese immigrants in a diverse selection of countries.

Anyone with an interest in the origins of and current developments in the Chinese mental health system or mental health in the Chinese diaspora will find in this book a valuable examination of these issues. It is my hope and expectation that *Mental Health in China and the Chinese Diaspora* will have a wide international audience.

Dr. Afzal Javed
President
World Psychiatric Association

Acknowledgement

I would like to acknowledge the indispensable contribution of my friend and colleague Milton Lewis to this book. Troubled by the fact that it had not been possible to include a chapter on China in our book *Mental Health in Asia and the Pacific: Historical and Cultural Perspectives*, Milton suggested that we jointly edit a book on China and, further, suggested that we should also consider the large Chinese diaspora. After jointly setting out on this task, unavoidable circumstances unfortunately resulted in a decision by Milton to withdraw as co-editor of this volume. Despite this, his insight and wisdom have driven the creation of the book, which would not have been written without him.

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Chapter 1
Introduction

Harry Minas

Mental health systems are the social arrangements that are designed to promote and protect mental health and respond effectively at an individual and population level to mental disorder (World Health Organization 2010). They are always the product of particular political, legal, economic and cultural circumstances, all of which change over time, sometimes abruptly, as is the case in the current Covid-19 pandemic, but more often slowly, usually over decades (Cohen et al. 2014; Minas and Lewis 2017).

Efforts to develop and reform these systems, in order to improve mental health programmes and services, are subject to the same contextual influences (Minas and Cohen 2007). Such efforts are unlikely to be successful if the population has limited understanding of mental health and illness, if persons with mental illness are stigmatised and experience multiple forms of discrimination, are excluded from education and employment, socially marginalised and impoverished and, as a result, make little demand for mental health services. In such circumstances political leaders are unlikely to regard mental health as an important health, social and economic priority and unlikely to support the investment required for mental health system development.

Mental health systems, consisting of governance arrangements, financing, human resources, facilities, programmes and services and information for management and monitoring, are complex systems (Minas 2014). Political engagement and leadership is particularly important (Caldas de Almeida et al. 2014). Population demand for high-quality mental health services, evidence of need and available, affordable solutions to current problems are also crucial for effective mental health system development and reform (World Health Organization 2009, 2010; Patel et al. 2014).

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The scale, structure and operations of national and local mental health systems determine whether population mental health is promoted and protected and whether persons with mental disorders have affordable and equitable access to high-quality assessment, treatment, rehabilitation and social support services. An understanding of the strengths and weaknesses of contemporary mental health systems, and of the possibilities for their further development, requires an understanding of their history, and of the political, economic and cultural forces that shape them (Minas and Lewis 2017).

Until the middle of the twentieth century, mental health services throughout much of the world were provided in large, poorly resourced and often remotely located mental hospitals (Porter 2006; Cohen et al. 2014). Many people with severe mental disorders spent very long periods in such hospitals, which often were places of confinement, providing little treatment and even less care. This is, unfortunately, still the situation in many parts of the world (Cohen et al. 2016). A conjunction of factors, including the discovery of psychotropic drugs and increasing concerns about the poor conditions in mental hospitals and frequent abuses of the rights and dignity of patients, gave rise to a broad-based reform movement, particularly in wealthier Western countries, promoting community-based rather than institutional care (Uffing et al. 1992).

This process of de-institutionalisation began much later in low- and middle-income countries but is now a stated goal, although not yet a reality, throughout the world. A key driver of this process is the recognition that states have primary responsibility for protection of the rights of persons with mental illness and that these rights include access to affordable and effective mental health treatment and care. International organisations such as the World Health Organization, international instruments such as the Convention on the Rights of Persons with Disabilities (CRPD) (United Nations 2007) and aspirational goal setting such as Universal Health Coverage (UHC) (Patel and Saxena 2019) and the goals established as part of the Sustainable Development Agenda (SDGs) (Izutsu et al. 2015) provide the impetus for reform and the technical support for implementation that is required for effective reform.

Mental Health System Development in China

During the period that is the focus of this book, from the mid-nineteenth century to the present, China has experienced three great political, economic and cultural revolutions. The first was the collapse of the Qing Dynasty (1644–1912) and the establishment of the Republic of China (1912–1949). The second was the establishment in 1949, after a protracted civil war, of the People's Republic of China and the almost 30-year leadership of Mao Zedong. The third, an economic, social and cultural revolution in the absence of fundamental political change, began with the reforms initiated by Deng Xiaoping in 1978. These reforms opened China to the rest of the world, transformed the national economy, massively reduced poverty and

created the foundations for a modern, prosperous, powerful and confident China. A fourth, the consolidation of China as a pre-eminent global power and economy, is currently in progress.

Throughout Chinese history, until the late nineteenth century, institutions for the insane did not exist (Chap. 2, Simonis). Chinese doctors frequently used both biological methods (herbs and drugs of various kinds) and psychological methods, while the ill persons were cared for by their families (Simonis 2014). Confucian morality clearly identified the family as being responsible for the care of insane family members, and the family was held directly responsible for the care of a mentally ill family member and if a mentally ill family member occasioned any harm or damage. This responsibility of the family continues and is enshrined in the current Chinese mental health law (Chen et al. 2012).

Before and during the last of the Chinese dynasties, the Qing, philosophy and medicine were intertwined and highly developed (Chap. 2, Simonis). Although there were not sharp distinctions between physical and mental health, what is now called mental disorder was clearly recognised, and responses to persons suffering from mental health problems were clearly described. Traditional medical practices were grounded in sophisticated and comprehensive theory, widely accepted, and have persisted in contemporary China, particularly in rural regions, and among the communities of the Chinese diaspora (Hsiao et al. 2006a, b).

Conceptions of mind, madness, disorder, healing and treatment have varied greatly at different historical periods (Chap. 2, Simonis; Chap. 3, Wang; Chap. 4, Gao; Chap. 5, Huang; Chap. 10, Yang). Increasingly medicalised conceptions of mental health and illness have become prominent in the context of broader political and cultural shifts that have occurred in recent times, under the influence of various types of physicians in the late imperial period, medical missionaries in the transition from the late Qing to the early Republican period (late nineteenth century to the early twentieth century) and Western and Chinese psychiatrists and institutions during the Republican era and over the course of the second half of the twentieth century.

Profound political changes in China have been a feature of Chinese history from the late nineteenth century until the People's Republic was established in 1949, often following periods of intense armed conflict and massive social and economic dislocation. The Taiping Rebellion lasted 14 years (1850–1864), engulfed 17 provinces and resulted in the death of 20–30 million. The Boxer Rebellion (1900–1901), which sought to expel foreign missionaries and other foreigners from Chinese soil, was put down largely by foreign (Japanese, Russian, British, American, French, Italian and Austro-Hungarian) forces and fatally wounded the Qing Government, and was followed by the proclamation of the Republic of China by Sun Yat-sen in 1912.

The end of the Qing Dynasty ushered in a period of political instability and warlordism and, following the Russian revolution in 1917, the rise of communist movements in different parts of China. The Communist Party of China was formally established at its first national congress in Shanghai in 1921.

Following the death in 1925 of Sun Yat-sen, the founder of Kuomintang (KMT – the Chinese Nationalist Party), Chiang Kai-shek succeeded as leader until the defeat of the KMT in 1949. Chiang expelled communists from the KMT and, in 1928, reunified most of China with the national government based in Nanjing. Japan invaded China in 1931 and gradually occupied increasing amounts of Chinese territory. Although the Nationalist and Communist Parties suspended hostilities to fight the Japanese in 1937, the defeat of Japan in 1945 was followed by resumption of civil war between the Nationalists and Communists. Mao Zedong's victorious communist forces proclaimed the People's Republic of China on 1 October 1949. The Nationalists, still under the leadership of Chiang Kai-shek, retreated to Formosa and established their government in what is now Taiwan.

Throughout several thousand years of Chinese history, there have been periods of great prosperity and advancement in every field of human endeavour. The Chinese economy has, over very long periods, been among the world's largest and most advanced, with periods of rapid population increase, the creation of large and sophisticated urban centres and manufacturing and technological innovation. The so-called rise of China that has been the focus of international attention, wonder and dismay for the past few decades should be seen in historical context as a return to former pre-eminence rather than as something new.

There have, however, also been periods of sharp economic decline, often in the context of internal conflict and social disorder, and of famine, the deadliest of which occurred during the Great Leap Forward (1958–1962). During such periods there has been large-scale emigration, particularly from China's coastal provinces. Chinese immigrants have settled, over hundreds of years and sometimes in large numbers, in most parts of the world.

There was a great deal of activity in mental health during the Republican era (Chap. 3, Wang), as part of the general push for modernisation, development of science and establishment of international relationships in science and medicine. After a long interregnum following the establishment of the People's Republic, during which the primary activity in the field of mental health was the building of mental hospitals (Chap. 4, Gao), the Chinese Government began to turn its attention to the mental health needs of the population, rather slowly in the first two decades after the death of Mao Zedong and rapidly picking up the pace of development in the first two decades of this century (Chap. 5, Huang).

While China has moved to a reliance on Western biomedicine as the foundation of its health and mental health systems, there have been repeated calls by governments to continue to develop Traditional Chinese Medicine (TCM) and to integrate the best of TCM and Western biomedicine, including in the recent National Mental Health Work Plan (Xiong and Phillips 2016), without any significant integration of the two approaches.

Prior to the beginning of the economic reforms in 1978, major developments in public health focused on publicly funded initiatives on sanitation, illness prevention and immunisation and health insurance coverage for basic medical services. While this resulted in greatly improved public health, there was little attention to mental health.

Since the beginning of the economic reforms, the transition from a centrally planned to a market economy, more than 400 million people have been lifted out of poverty, accounting for 75% of poverty reduction in the developing world (Liu and Griffiths 2011). A predominantly rural and agrarian society has been transformed into an increasingly urbanised society and an industrial and services economy. While national economic growth has been impressive, it has also been uneven, with widely varying development in different provinces, and in different areas within provinces, and major differences between rural and urban areas. The challenge of equity continues to be a major preoccupation (Yip and Mahal 2008; Lin et al. 2011; Liu and Griffiths 2011).

The contemporary mental health system in China was made possible by the reforms initiated by Deng Xiaoping in the late 1970s and early 1980s, with the support of the Chinese Communist Party and Chinese society (de Oliveira and Leite 2014). The most consequential of these reforms were the changes in the economic system and the "open-door" policy that promoted international engagement. Chinese psychiatry began to flourish, re-established sustained contact with Western clinicians and scientists for the first time since the Republican period and began actively looking for models of mental health service that could be relevant to and adapted to Chinese circumstances. A very productive engagement with the World Health Organization in the field of mental health (Wang 2017) has contributed substantially to growing capability in mental health policy development, the creation of a mental health legal architecture and in mental health service design and delivery. Rapidly increasing numbers of students went abroad, mostly to the USA, Australia and the UK, to study. Scientific activity began to increase slowly and has rapidly increased in both quantity and quality over the past 30 years (Zhang et al. 2017), as have large-scale mental health service initiatives (Ma 2012).

Mental Health of the Chinese Diaspora

One of the consequences of the intermittent periods of conflict, civil disorder, economic decline and periods of famine has been large-scale emigration from China to neighbouring countries in South East Asia and further afield. There are now almost 50 million people of Chinese origin living in almost 150 countries (Chap. 11, Poston and Zhang). The largest numbers are in South East Asian countries. Seven ASEAN countries have a total of 28 million people of Chinese origin, with each having more than 1 million, and there are more than 8 million in Indonesia alone. Among Western countries there are 4.5 million people of Chinese origin in the USA, 1.5 million in Canada and 1 million in Australia.

Countries with large numbers of people of Chinese origin vary in a number of important ways. They have different system of government, levels of economic development, cultures and mental health systems (Kirmayer and Minas 2000). They also differ considerably in their attitudes towards, and policies concerning, migrants and ethnic minorities, ranging from benign neglect to outright racism. There are

also differences in the patterns of Chinese migration. Some, particularly those in South East Asia, have experienced migrations from China for hundreds of years. In others, including the USA, Canada and Australia, substantial migration began in the nineteenth century and continues to the present.

Knowledge about mental health of immigrant communities and services tailored to the specific needs of immigrant and ethnic minority communities is poorly developed globally. Even countries that like to see themselves as valuing multiculturalism, such as Australia, Canada and the USA, have limited data on the mental health of immigrant communities (Minas et al. 2013) and have, in fact, done little to ensure that all residents, regardless of their origins, have equitable access to effective and culturally appropriate services (Minas et al. 2007, 2008). Most Southeast Asian countries with very large Chinese minorities collect little or no data and have no specific programmes that address the particular needs of ethnic minority communities.

Globally there is growing attention to the issue of migration in general and to the health, including mental health, of immigrants. While migrants are "entitled to equal access to preventive, curative, and palliative health care [and] have rights to the underlying social, political, economic, and cultural determinants of physical and mental health" (Abubakar et al. 2018), there is no country where these rights have been fully realised. In 2018 the United Nations adopted the Global Compact on Refugees and the Global Compact for Safe, Orderly and Regular Migration. Many countries have failed to sign up to these compacts. In 2019 the World Health Assembly adopted a 5-year Global Action Plan (GAP) to Promote the Health of Refugees and Migrants. Despite these international efforts, there is a long way to go before the provisions of the WHO's Global Action Plan are implemented.

Structure of the Book

The first objective of this book, in Part I, is to examine the development of the mental health system in China with particular attention to the historical and cultural context of this development. China's recorded history goes back to the Shang Dynasty (1700–1046 BC). The focus here is from the final decades of the Qing Dynasty (1644–1912) to the present. The arc of Chinese history shifted decisively in the late nineteenth and early twentieth centuries. The collapse of the Qing Dynasty brought an end to almost 4000 years of imperial rule and was followed, throughout the twentieth century, by massive political, economic and cultural transformations.

The first section of Part I presents the development of the mental health system in China sequentially, divided into four historical periods from the latter part of the Qing Dynasty to the present. It consists of four chapters that focus, respectively, on the final period of the Qing Dynasty (Chap. 2, Simonis); the Republican period, from 1912 until the establishment of the People's Republic of China in 1949 (Chap. 3, Wang); the first four decades of the People's Republic until the death of Mao

Zedong in 1976 (Chap. 4, Gao); and finally the post-reform period, from the late 1970s until the present (Chap. 5, Huang).

The second section consists of two case studies: the history of mental health and psychiatric services in Hong Kong, under British rule, from 1850 to 1960 (Chap. 6, Wu), and the development of a single psychiatric hospital, from its establishment in Canton in 1898 as the John Kerr Refuge for the Insane, the first mental hospital in China, to its current form as a major psychiatric treatment, education and research centre, the Affiliated Brain Hospital of Guangzhou Medical University (Chap. 7, Li and Ran).

The third section consists of three chapters that examine specific contemporary mental health system development issues. The first chapter provides an introduction to the content of China's first national Mental Health Law and identifies key issues related to its implementation (Chap. 8, Minas). The second chapter in this section briefly traces the antecedents of the development of China's current mental health policy, the National Mental Health Work Plan 2015–2020, the structure and content of the Plan, and the Plan from a mental health systems perspective (Chap. 9, Minas). The third of the three chapters examines the recent emergence of ideas of "therapy" and the political and cultural dimensions of these developments (Chap. 10, Yang).

The second objective, in Part II, is to examine the extent to which the mental health systems of several countries in Southeast Asia (Malaysia, Indonesia and the Philippines) and the Pacific (Canada and Australia) have responded to the mental health needs of the Chinese diaspora communities that form a substantial part of their respective populations.

The first chapter in this section presents a historical overview and current data on overseas populations in Indonesia, Malaysia, the Philippines, the USA, Canada and Australia, and the numbers of Chinese immigrants throughout the world, and how these migrations have changed over time (Chap. 11, Poston and Zhang). Subsequent chapters give an account of mental health of Chinese communities in Malaysia (Chap. 12, Ting, Foo and Tan), Indonesia (Chap. 13, Pols and Suci), the Philippines (Chap. 14, Tan), Canada (Chap. 15, Gao) and Australia (Chap. 16, Minas).

References

Abubakar, I., Aldridge, R. W., Devakumar, D., Orcutt, M., Burns, R., Barreto, M. L., Dhavan, P., Fouad, F. M., Groce, N., Guo, Y., Hargreaves, S., Knipper, M., Miranda, J. J., Madise, N., Kumar, B., Mosca, D., McGovern, T., Rubenstein, L., Sammonds, P., Sawyer, S. M., Sheikh, K., Tollman, S., Spiegel, P., Zimmerman, C., & UCL–Lancet Commission on Migration and Health. (2018). The UCL-Lancet Commission on Migration and Health: The health of a world on the move. *Lancet, 392*(10164), 2606–2654.

Caldas de Almeida, J. M., Minas, H., & Cayetano, C. (2014). Generating political commitment for mental health system development. In V. Patel, H. Minas, M. Prince, & A. Cohen (Eds.), *Global mental health: Principles and practice*. New York: Oxford University Press.

Chen, H., Phillips, M., Cheng, H., Chen, Q., Chen, X., Fralick, D., Zhang, Y., Liu, M., Huang, J., & Bueber, M. (2012). Mental Health Law of the People's Republic of China: Translated and

annotated version of China's new Mental Health Law. *Shanghai Archives of Psychiatry, 24*(6), 305–321.

Cohen, A., Patel, V., & Minas, H. (2014). A brief history of global mental health. In *Global mental health: principles and practice*. New York/Oxford: Oxford University Press.

Cohen, A., Chatterjee, S., & Minas, H. (2016). Time for a global commission on mental health institutions. *World Psychiatry, 15*(2), 116–117.

de Oliveira, H. A., & Leite, A. C. C. (2014). Chinese engagement for Global Governance: Aiming for a better room at the table? *Revista Brasileira de Política Internacional, 57*(special edition), 265–285.

Hsiao, F. H., Klimidis, S., Minas, H., & Tan, E. S. (2006a). Cultural attribution of mental health suffering in Chinese societies: The views of Chinese patients with mental illness and their caregivers. *Journal of Clinical Nursing, 15*(8), 998–1006.

Hsiao, F. H., Klimidis, S., Minas, H. I., & Tan, E. S. (2006b). Folk concepts of mental disorders among Chinese-Australian patients and their caregivers. *Journal of Advanced Nursing, 55*(1), 58–67.

Izutsu, T., Tsutsumi, A., Minas, H., Thornicroft, G., Patel, V., & Ito, A. (2015). Mental health and wellbeing in the sustainable development goals. *Lancet Psychiatry, 2*(12), 1052–1054.

Kirmayer, L. J., & Minas, H. (2000). The future of cultural psychiatry: An international perspective. *Canadian Journal of Psychiatry, 45*(5), 438–446.

Lin, D., Li, X., Wang, B., Hong, Y., Fang, X., Qin, X., & Stanton, B. (2011). Discrimination, perceived social inequity, and mental health among rural-to-urban migrants in China. *Community Mental Health Journal, 47*(2), 171–180.

Liu, S., & Griffiths, S. M. (2011). From economic development to public health improvement: China faces equity challenges. *Public Health, 125*(10), 669–674.

Ma, H. (2012). Integration of hospital and community services—the "686 Project"—is a crucial component in the reform of China's mental health services. *Shanghai Archives of Psychiatry, 24*(3), 172–174.

Minas, H. (2014). Human security, complexity and mental health system development. In V. Patel, H. Minas, A. Cohen, & M. Prince (Eds.), *Global mental health: Principles and practice*. New York: Oxford University Press.

Minas, H., & Cohen, A. (2007). Why focus on mental health systems? *International Journal of Mental Health Systems, 1*(1), 1.

Minas, H., & Lewis, M. (Eds.). (2017). *Mental health in Asia and the Pacific: Historical and cultural perspectives*. New York: Springer.

Minas, H., Klimidis, S., & Kokanovic, R. (2007). Depression in multicultural Australia: Policies, research and services. *Australia and New Zealand Health Policy, 4*, 16.

Minas, H., Klimidis, S., Ranieri, N., & Stuart, G. (2008). Relative prevalence of psychological morbidity in older immigrants. *International Journal of Culture and Mental Health, 1*(1), 58–72.

Minas, H., Kakuma, R., Too, L. S., Vayani, H., Orapeleng, S., Prasad-Ildes, R., Turner, G., Procter, N., & Oehm, D. (2013). Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion. *International Journal of Mental Health Systems, 7*(1), 23.

Patel, V., & Saxena, S. (2019). Achieving universal health coverage for mental disorders. *BMJ, 366*, l4516.

Patel, V., Minas, I. H., Cohen, A., & Prince, M. (Eds.). (2014). *Global mental health: Principles and practice*. New York: Oxford University Press.

Porter, R. (2006). *Madmen: A social history of madhouses, mad-doctors and lunatics*. Stroud: Tempus.

Simonis, F. (2014). Medicaments and persuasion: Medicaltherapies for madness in nineteenth-century China. In H. Chiang (Ed.), *Psychiatry and Chinese history*. London: Pickering and Chatto.

Uffing, H. T., Ceha, M. M., & Saenger, G. H. (1992). The development of de-institutionalization in Europe. *The Psychiatric Quarterly, 63*(3), 265–278.

United Nations. (2007). *Convention on the Rights of Persons with Disabilities (CRPD)*. From https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html.

Wang, X. (2017). Objectives of China and the global mental health work plan. *Shanghai Archives of Psychiatry, 29*(2), 111–112.

World Health Organization. (2009). *Improving health systems and services for mental health*. Geneva: World Health Organization.

World Health Organization. (2010). *Monitoring the building blocks of health systems: A handbook of indicators and their measurement strategies*. Geneva: World Health Organization.

Xiong, W., & Phillips, M. R. (2016). Translated and annotated version of the 2015-2020 National Mental Health Work Plan of the People's Republic of China. *Shanghai Archives of Psychiatry, 28*(1), 4–17.

Yip, W., & Mahal, A. (2008). The health care systems of China and India: Performance and future challenges. *Health Affairs (Millwood), 27*(4), 921–932.

Zhang, J., Chen, X., Gao, X., Yang, H., Zhen, Z., Li, Q., Lin, Y., & Zhao, X. (2017). Worldwide research productivity in the field of psychiatry. *International Journal of Mental Health Systems, 11*, 20.

Part I
Mental Health in China

Chapter 2
Madness in Late Imperial China: Law, Medicine, and Ritual

Fabien Simonis

Abstract This article surveys judicial practices, medical doctrines, and ritual therapies surrounding madness (*kuang*, *diankuang*, *dian*, *feng*) in the Qing dynasty (1644–1912). Even without psychiatry and specialized institutions like mental asylums, Chinese people of that era possessed a rich array of ways to discuss crazy behavior, mad words, and insane people. For the first time, the legal system began to treat homicides committed in a state of madness as a distinct kind of crime. These new laws in turn stirred debates on how to control mad men and women and led to the first policy calling for the preventive confinement of mad persons in Chinese history. Meanwhile, physicians speculated on the causes of madness, which they understood chiefly as a behavioral disorder. They attributed mad symptoms mainly to phlegm and inner fire, but also sometimes to depletion, and treated patients with emetics, purgatives, or tonics (sometimes in combination) depending on the cause they identified. Scattered evidence also exists about how madness was handled in less literate circles, often but not always through religious ritual. Note that ritual treatments were important in all social groups, including among highly educated physicians. Though some physicians attributed possession symptoms to the action of phlegm, many also believed in ghosts and used a mix of medical and ritual methods to expel the possessing agent.

Keywords Madness · *Kuang* · *Dian* · *Diankuang* · Chinese medicine · Chinese law · Phlegm · Qing dynasty · Possession · Mental illness

Even without psychiatry and specialized institutions like mental asylums, Chinese people living under the Qing dynasty (1644–1912) possessed a rich array of ways to discuss crazy behavior, mad words, and insane people (Ng 1990; Messner 2000; Ch'en 2003; Simonis 2010). For the first time under the Qing, the legal system started treating homicides committed in a state of madness as a distinct kind of crime. This legislation in turn stirred debates on how to control mad men and women

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and led to the first policy calling for the preventive confinement of insane people in Chinese history. Meanwhile, physicians recorded how they treated mad patients with minerals, plants, and animal parts that they decocted according to a rich medical lore. Mad figures proliferated in novels and short stories, and we can even glean anecdotes about eminent people who spoke or acted strangely. Scattered evidence also exists about how madness was handled in less literate circles, often but not always through religious ritual.

Madness was rarely understood as a hidden affliction or as a disposition of the entire self, but rather as a sudden or intermittent disorder manifested by overtly abnormal acts, easily diagnosed by nonexperts. In most contexts, madness meant "chronic susceptibility to obvious, temporary mad fits" (Padel 1995: 35). Both law and medicine paid attention to these fits rather than to the intervals. We know very little about psychological malaise and light behavioral irregularities, because they were judicially irrelevant and were almost never medicalized.

To "re-socialize" the systems-based approach to global mental health that informs this book, I stay close to how people in various fields understood what they referred to as *kuang* 狂, *dian* 顛/癲, or *feng* 風/瘋, three words that are close to "mad" or "madness" in English. I start with the judicial field, because legal policies were an important backdrop of (and often posed contrast with) familial, medical, and ritual ways of handling mad acts and mad people. I leave the complex issues surrounding "madness" as a category and as a research object to other writings (Simonis 2010; Simonis forthcoming; see also Gomory et al. 2013).

A quick note on one key Chinese term: *dian*. In the earliest medical sources, *dian* 癜 – composed of the "disease" signific 疒 and the phonetic component 真, which also carried the meaning of both "top" and "toppled" – meant "seizure sickness" (Harper 1998: 538) or "falling sickness" (Unschuld 1986: 528). *Dian* 顛 – "upturned," "upended," "on its head" – started to refer to eccentricity in early imperial times and eventually came to mean something as broad and vague as "craziness" (Simonis 2010: 47–53). By the Tang dynasty (618–907), the compound *diankuang* (first written 癜狂, then 顛狂, and eventually 癲狂) meant madness or insanity in medical, legal, and religious documents alike.

Law, Policies, and Society

In 1669, the Qing created a new law on "killing because of madness" (*yin feng sha ren* 因瘋殺人 or *feng bing sha ren* 瘋病殺人). (This kind of precedent-based law is often called a "sub-statute" [*li* 例] to distinguish it from the statutes [*lü* 律] that formed the backbone of the Code.) Legislators likened this new "penal denomination" (*zuiming* 罪名) to "accidental killing" (*guo shi sha ren* 過失殺人) because they saw both crimes as lacking any harmful intention. Mad homicides were treated as purely inadvertent, just like accidents.

Until the end of the Qing, only people so crazed that they had been entirely noncognizant (*wuzhi* 無知) of the act of killing were legally considered mad. Madness

had to be absolute. Physicians were hired by local courts, not to recognize insanity but to ascertain that it was not faked. They did so by palpating the pulse of the ostentatiously mad killer (Simonis 2010). For almost 90 years after 1669, most homicides committed in a fit of insanity were sentenced under "Killing because of madness" regardless of the victims' identity or number. And until 1740, mad killers were simply released after paying 12.42 ounces of silver to compensate the victim's family, just as in cases of accidental killing. (For more on Qing laws concerning the insane, see Nakamura 1973; Chiu 1981; Ng 1980, 1990; Rosner 1991; MacCormack 1992; Hao 2002; Alford and Wu 2003; Simonis 2010.)

In 1731 in Sichuan, a crazed man killed a neighbor's wife and three younger members of her family (*Cheng'an zhiyi* 成案質疑 [1755] 19.42a–b). Killing three or more people from the same household was normally punished by dismemberment (*lingchi* 凌遲), the harshest punishment in the Code (Jones 1994: 273), but here the mad killer was only asked to pay about 50 ounces of silver to his neighbor, 12.42 ounces per victim. This light penalty contrasted with the utmost gravity of the act as defined by law. Having been told of this discrepancy, the emperor did not modify the punishment for multiple homicides committed in a state of madness. Instead, in 1732, he endorsed a preventive rule to prevent similar crimes from happening again. A law from 1689 already imposed a beating on family heads when an improperly guarded mad relative killed someone. The 1732 law now required families to declare their mad members to the local authorities. They were still to be kept at home, but "chained up" (*suogu* 鎖錮) rather than vaguely guarded. When an undeclared mad person committed a crime, his relatives, his neighbors, and the local leaders would all receive a beating, and the local magistrate would incur sanctions for failing to enforce the preventive measures.

In 1766, another mad homicide with three victims from a single family compelled officials to intensify prevention again. If a family did not have an empty room in which to lock up a mad member, the madman would now be shackled and confined in the county jail; the local government would also provide chains and locks to families that lacked the necessary equipment (Mad women could remain at home). According to the rule, a declared madman had to be locked up for several years without fits before he could be liberated. In practice, nonviolent madmen were often quickly released.

Preventive laws were stiffened in 1732 and 1766 because the threat of manic people was made salient by the mildness of their punishment. In the decades separating these two laws, officials also started to handle mad killers differently. In 1740, the Ministry of Punishments decided that people who had killed because of madness would be handed to their relatives for confinement instead of being released. Starting in 1753, mad killers could only be returned to their family 1 year after recovery. And after 1762, they were to be permanently jailed (*yongyuan jiangu* 永遠監禁) in the county prison. Imprisonment was not a regular punishment in Chinese law, but as the Ministry observed, "madness illness alternately flares up and heals; it is difficult to guarantee that it will not flare up again [even] after 1 year of imprisonment" (*fengbing yuan xi shi fa shi yu, ba jin yu nian nan bao qi bu fu zai fa* 瘋病原係時發時愈 霸禁逾年 難保其不復再發; Wu 1992 [1886]: 802). This

policy remained in place until 1908. Only in the late nineteenth century could mad killers apply for release, though only after spending 5 years in prison without a mad fit. The madmen Western missionaries found in Chinese jails in the late nineteenth century were likely either convicts or men who had been preventively confined because they suffered from violent fits of insanity.

Meanwhile, mad homicides started to drift away from the crime of "accidental killing" to which they had been likened. One of the most important tasks of Chinese imperial law was to punish criminal acts in proportion to their gravity. Gravity was assessed by measuring the degree of intention of the crime, the closeness of kinship between offender and victim, and any other circumstance that officials found relevant. For decades, "lack of cognizance" (and thus lack of intention) had been the dominant factor in deciding punishment for killings committed while mad, but starting in the 1750s, the closeness of offender and victim started to become central. In 1756, the sentence for the insanity-induced killing of a second-degree senior relative (e.g., an older brother) became "immediate decapitation," but with an automatic postponement to "after the Autumn Assizes," an annual judicial session during which a committee would decide whether the sentence would be executed or commuted. In 1761, the Qianlong Emperor (r. 1735–1799) legislated by edict that all cases of parricide (including those committed while crazy) would heretofore be punished by dismemberment. In 1776, even multiple killings started to be punished by death, though the death sentence was often not executed. Whenever a death sentence was commuted, the mad killer was imprisoned permanently. By 1850 nine sub-statutes discussed various kinds of mad homicides; by then, the 1669 law on "Killing because of madness" applied only to the killing of a single person unrelated to the killer.

The preventive policy first announced in 1689 and elaborated in 1732 and 1766 was never systematically enforced, in part because it carried punishment only if a mad person killed someone or committed suicide. Confinement in official prisons also entailed extra expenses to feed the "madman" and to ensure that he was not mistreated (Ng 1990: 72–73). By the nineteenth century, the population was generally aware of the policy, and many families declared their mad members for fear of getting into trouble, but most did not. People locally identified as "mad" were kept at home, chained up, caged, or locked up, usually for the duration of their fits.

Either most people thought of madness as a manageable disorder, or they were compelled to treat it as such out of economic or practical necessity (Simonis 2010: 509–543). What the law saw as the most dangerous aspect of madness – its unpredictable intermittency – was often precisely what convinced people *not* to declare a mad relative. Simply put, most "mad people" were healthy most of the time: they could be freed as soon as they got better and start contributing to the household again. Neighbors and local leaders who agreed not to declare probably thought it was not worth risking neighborhood conflict to avert a danger (a killing) that they perceived as slight.

Note that even though the social diagnosis of "madness" was resilient, the mad identity was not broadly institutionalized. Even people identified as mad in their community and registered as such with the local authorities could marry and have children, and no laws or customs seem to have prevented them from signing contracts or owning property.

Medical Understandings of Madness: Fire and Phlegm

At no time was legal confinement (preventive or punitive) considered therapeutic, but even families who chained up a mad member at home hoped to cure their relative from insanity. The two main groups of therapies were medical and ritual, though as we shall see these two categories were permeable, so that families could seek the help of both physicians and exorcists without cognitive dissonance. Even though the life of mad people was not significantly medicalized, medical conceptions shaped broader understandings of body and illness so deeply, and so much of them has survived into modern times, that medical approaches to madness deserve a detailed look.

Madness was once considered largely a wind disorder. In the influential *Treatise on the Origin and Symptoms of the Illnesses* (*Zhubing yuanhoulun* 諸病源侯論), completed in 610 CE, the main entry on mad symptoms is called *feng kuang* 風狂 or "wind mania." It explains insanity nonmentally: mania occurs when blood and *qi* depletion allows wind to invade the yang aspects of the body, disturbing the inner balance of yin and yang *qi*. Most formularies compiled before the twelfth century attributed madness to wind, so much that the word *feng* ("wind") itself came to mean madness in broader usage: "cardiac wind" (*xin feng* 心風) was another word for insanity; "wind monk" (*feng seng* 風僧) meant "crazy monk."

By the twelfth century, medicine had concretized the meaning of wind. Song (970–1279) physicians identified saliva (*xian* 涎) and phlegm (*tan* 痰) as the tangible agents of wind illnesses: they surged into the chest during "wind strokes," triggered convulsions by rushing to the head, and foamed from the mouth of epileptics. Liu Wansu 劉完素, a physician who lived in the north after the Jin (1115–1234) conquest of the northern half of the Song empire, meanwhile distinguished between real gushes of air and more metaphorical inner "winds"; he reinterpreted the latter as inner heat or fire. By the fourteenth century, the once all-encompassing category of "wind illnesses" had collapsed, and its content had been redistributed into phlegm and fire disorders (Simonis 2015b). The term *fengkuang* still meant "madness," but it eventually lost its association with wind, just as "lunacy" no longer evokes the moon.

From about the fourteenth to the nineteenth century, most physicians attributed mad acts to the invasion of the heart by phlegm and inner fire (Simonis 2010). Few heeded a sixteenth-century writer's protest that if phlegm could indeed cause madness, then everyone with phlegm would become crazy (Zhao 1648 [1528] 23b–24b, in Ma 1999: 259; Zheng 2003, vol. 12: 474–475). Even the main advocates of "warming and replenishing" (*wenbu* 溫補), a movement that advocated replenishing vitality with "warming" tonics, usually recommended aggressive "cooling" therapies for insanity. Zhang Jiebin 張介賓 (1563–1640), for instance, agreed that madness was chiefly caused by fire and should be treated with attacking drugs. Li Zhongzi 李中梓 (1588–1655) used both attacking and replenishing drugs to treat *kuang*, integrating the most common treatment for madness with a typical *wenbu* concern for preserving vitality (Simonis 2010: 252–259).

Many physicians blamed phlegm even for possession-like symptoms (Simonis 2015b). This notion of phlegmatic possession was first proposed by Zhu Zhenheng 朱震亨 (1282–1358), nicknamed "Danxi" 丹溪. (See Zhu's essay "On there being depletive and phlegmatic illnesses that resemble affliction by evil" [*xubing tanbing you si xiesui lun* 虛病痰病有似邪祟論] in Zhu 1347.) The doctrinal dominance of Zhu's syncretic medicine from the fourteenth to the sixteenth century helped disseminate this explanation widely (Simonis 2015a). As an eighteenth-century editor remarked, "this is what is called 'phlegm [causes] many strange symptoms', not something to be marveled at" (*ci suowei tan duo guai zheng yi bu wei qi* 此所謂痰多怪證亦不為奇; Yu 1959 [1778]: 185, under "Demonic infestation" [*guizhu* 鬼疰]).

The phrase "phlegm confusing the cardiac orifices" (*tan mi xinqiao* 痰迷心竅), omnipresent in the late-imperial medical literature, illustrates how phlegm could trigger insanity. Whereas the nineteenth-century psychiatric and medicolegal phrase "lesion of the will" (Eigen 1999) uses the language of physical injury to describe the impairment of an abstract function, "phlegm confusing the cardiac orifices" describes a cognitive effect on a physical structure. This physical heart that served as the seat of consciousness could indeed be attacked (and its functions impaired) by inner fluids: fire rising from the liver from pent-up anger, phlegm lodged in the chest after indulging in rich foods, or "failed blood" (*baixue* 敗血) left over from childbirth (on postpartum madness, see Simonis 2010: 392–405). In *tan mi xinqiao*, sticky phlegm, a mucus-like substance, caused madness and confusion by occluding the apertures in the heart through which the numinous fluids enabling consciousness were supposed to circulate.

In line with these conceptions, manic behavior could be ended by removing the lodged fluids that caused it. Inducing the patient to vomit phlegm while draining fire with purgatives was by far the most common treatment for insanity. A medical editor in the 1890s was not exaggerating when he claimed that "as soon as physicians see mental bewilderment, most of them apply themselves to [treating] phlegm and fire" (*shiyi yi jian shenzhi hunluan duo congshi yu tanhuo* 世醫一見神志昏亂 多從事於痰火; note by Fang Renyuan to Wang 1897, fasc. 2, in Qiu 2001 [1936], vol. 4: 307B). Treatment was usually short: one or a few doses of an emetic or a purgative often sufficed to conclude to success or failure. Late imperial physicians used mostly decoctions, but pharmacists and peddlers sold ready-made pills that had similar effects. Physicians with a wealthier clientele also prescribed "warming" and replenishing drugs to bring the patient back to full health, usually after purging and inducing vomiting first.

These attacking regimens diminished the manic symptoms often enough to confirm the validity of the diagnosis. Similarly aggressive treatments were once common throughout the world. The ancient Greeks dispensed noxious hellebore to the demented to trigger vomiting (Padel 1995: 48–53). European physicians also imposed long courses of emetics on their mad patients before the nineteenth century (Scull 1975; Quétel and Morel 1979: 79–83). And in 1815 and 1816, "mad-doctors" working in British asylums even told a parliamentary commission that purges and vomits had proven historically successful in the treatment of insane people (Scull 1993: 192–194).

In China, the idea that madness was caused by phlegm and could be treated with emetics grew deep roots outside medicine and remained central to Chinese medical treatments of psycho-behavioral disorders well into the twentieth century. In the novel *The Scholars* (*Rulin waishi* 儒林外史, Chap. 3), Fan Jin swoons out of consciousness when he hears he has passed the examinations: "Phlegm gushed upward and confused his cardiac orifices … he vomited the phlegm and became lucid again" (*tan yong shanglai mi le xinqiao … ba tan tu le chulai jiu mingbai le* 痰湧上來 迷了心竅…把痰吐了出來 就明白了). An eighteenth-century official reasoned that "killing because of madness" was devoid of criminal intention "because people with madness illness are confused by phlegm and [thus] act insanely; they cannot control themselves" (*gai yi fengbing zhi ren tanmi diankuang bu zi zhuchi* 蓋以瘋病之人 痰迷顛狂 不自主持; Shen 1759: fasc. 24, cited in Nakamura 1973: 212n8). Another posited that "when people with madness illness have a fit, they become confused by phlegm and their acts are insane" (*yuan fengbing zhi ren jufa tanmi xingdong diankuang* 原瘋病之人 舉發痰迷 行動顛狂; palace memorial by Jiang Zhou 蔣州, dated 22 November 1754 [9th day of the 10th month of the 19th year of Qianlong]; First Historical Archives [Beijing], Secretarial copies of palace memorials collection [Lufu zouzhe 錄副奏摺], microfilm 086.0403). Nineteenth-century medical missionaries report that Chinese patients attributed mad symptoms either to possession or to phlegm attacks. Police sources and psychiatric records from the twentieth century contain similar accounts (Baum 2017 and 2018).

"Phlegm confusing the cardiac orifices" has largely disappeared from modern Chinese, but expressions like *yi qiao bu tong* 一竅不通 ("to know nothing about [something]," lit. "not one orifice is open") and *kai qiao* 開竅 ("to get thinking," "to become inspired"; lit. "one's [heart's – or perhaps brain's] orifices open up") remind us of an old conceptual metaphor in which thought and health depended on flow and blockage meant stupidity, doubt, or even madness.

Emotions and "Constraint"

Chinese physicians discussed several other "psychiatrically relevant illnesses" (Ågren 1982) which they did not call "madness." Though cases of madness could be attributed to emotions, excessive emotions themselves were rarely called *diankuang*. Medical writers discussed emotions as a group mostly when they wanted to single out emotional symptoms or, more rarely, to emphasize the emotional roots of non-emotional disorders like indigestion or coldness of the limbs. Even medical thinkers who thought that emotional disorders were special or that "emotionless drugs cannot cure emotional disorders" still grounded emotions in the functioning of the body (Simonis 2014). They understood emotions as movements of *qi*. Each major emotion was associated with a specific organ, which could either host the emotion or be pushed out of balance by that emotion if it became excessive.

A minor tradition explained how emotions could be used to curb other emotions. Each organ was associated with one of the Five Phases (*wuxing* 五行) and with an

emotion (the heart with joy and the Fire phase, for instance), and they curtailed one another according to the cycle of mutual conquest of the Five Phases. Because Metal conquers Wood and Water conquers Fire, sorrow (Metal/Lungs) could overcome anger (Wood/Liver), and fear (Water/Kidneys) could put an end to joy (Fire/Heart). This kind of therapeutic manipulation, which has been called "emotional counter-therapy" (Sivin 1995) and "therapy by counter-affect" (Simonis 2010), is undergoing a revival in modern China (Zhang 2007; see also Ch'en 2014).

Medical understandings of depressed feelings were also somatically grounded. An important term in that regard is *yu* 鬱, which refers at once to depressed affect and to the heaviness in the chest that accompanies this affect. Of the many translations that have been proposed for *yu*, "constraint" best reflects this underlying physical experience of blockage. That sensation was attributed to the stagnation of fluids inside the chest: phlegm, but also and increasingly the *qi* of repressed emotions (Scheid 2013).

These notions of illness were more than conceptual schemes: they were inextricably tied to embodied experience and constantly confirmed by bodily feelings, which they in turn contributed to explaining. Chinese medical views on *yu* – and the conceptions of body and illness these views rest upon – are the roots of Arthur Kleinman's findings that modern Chinese patients express social and mental suffering as bodily dysfunctions rather than as psychological disorders, a phenomenon he called "somatization" (Kleinman 1977, 1980). One of the reasons for the success of "neurasthenia" (*shenjing shuairuo* 神經衰弱) in Chinese popular conceptions – anthropologists now treat it as a native Chinese category – is that it also roots depressed affects in physical dynamics. For many Chinese patients, these disorders were not only "somatized" – as when something non-somatic is *made* somatic or interpreted somatically – but somatic all the way down (or all the way in).

Ghosts and Ritual Therapies

Though few recorded cases of ritual therapy survive (compared with legal and medical case files), the main recourse for mad behavior in late imperial China was probably nonmedical. Madness was when a person's actions patently stopped being guided by normal purposes. These abrupt changes in behavior were easily attributed to external entities, such as the souls of dead people, emanations of animal spirits (often foxes), and the goblins and wraiths that were thought to roam along trade routes, near old temples, or in old houses.

Animal emanations were among the most commonly identified agents of possession in Daoist texts. Whereas ghosts typically looked menacingly hirsute, foxes, at least in popular literature, preferred to assume an alluring human shape to dupe maidens and seduce young scholars. This view was not limited to Daoist contexts. Invited to treat a woman who was dreaming of a man garbed in white, a sixteenth-century physician from Zhejiang blamed a white dog who lived in the house. He ordered the dog killed and instructed that its blood and bile be used to coat pills that

the patient swallowed with the help of a blood-replenishing decoction. (Case by Yu Tuan 虞摶 (1438–1517) in Jiang 1782 [1549/1591]: 8.73b.)

Malevolent spirits were widely blamed for suicide attempts, a common sign of madness. As an early nineteenth-century physician typically said of his nephew: "he said there was a female ghost in his belly telling him to seek death and that he could not but obey" (*wei yan you nügui zai qi fuzhong jiao zhi xun si bu de bu yi* 惟言有女鬼在其腹中 教之尋死 不得不依). (Case by Li Wenrong 李文榮 [b. 1772] in fascicle 1 of Li 1998 [ca. 1835]: 175A–176B.) This transfer of agency from self to something other was also recognized in a law for "soldiers who commit suicide after encountering a specter" (*bingding yusui zijin* 兵丁遇祟自盡; Xue 1970 [1905]: 861, a law Xue found in the *Administrative Regulations of the Ministry of War* [*Bingbu zeli* 兵部則例]). Despite a strict ban on suicides in the army, this law granted an indemnity to the soldier's relatives as if he had died of illness.

Supernatural attributions generally pointed to ritual therapies. Sufferers or their relatives could appeal to a variety of specialists: Daoist priests who lived in the community, Buddhist monks who were hired to chant sutras, and local exorcists who used an array of techniques to expel malevolent forces. A common Daoist ritual was to burn a piece of paper inscribed with a talismanic character, mix the ashes in water, and spit that empowered water on the possessed person to drive away the ghost. A possessing spirit could also be appeased by a ghost-feeding ceremony or by an offering of paper money.

In some regions of southern China, people could put their mad relative on trial at a temple of the Emperor of the Eastern Peak (Dongyue miao 東嶽廟) or at a City God temple (Katz 2009: 105–107). These "trials of the insane" (*shen fengzi* 審瘋子), one of a few "penitentiary rites that mimic the judicial system" (Katz 2009: 105), tried and judged either the mad person or the possessing ghost, who often had been wronged by the insane man or woman in this or a previous life. Many such local traditions have probably been lost. The explanation for the ritual points to the common belief (which still survives today) that madness and other misfortunes are occasioned by karmic debt or retribution for evil deeds committed in this or a previous life.

Even the most educated physicians often recommended medicinal recipes against ghosts (Simonis 2010: 326–366; Ch'en 2008). As we saw above in the case of the white dog, physicians used a mix of drugs and ritual to expel tormentors. A physician named Xu Dachun (1693–1771) combined the gesture of the exorcist with the power of medicinal drugs when he instructed a female patient to spit a mineral concoction at a ghost that had been pestering her. If possession had been occasioned by prior depletion (an ancient view that has survived until the present), replenishing after exorcism made a relapse less likely. One physician called this strategy "shutting the door after expelling the thieves" (Simonis 2010: 354–355). Vengeful spirits were considered more difficult to extirpate. A few physicians claimed they could banish these resentful souls, but most preferred not to discuss them, or simply granted that karmically driven ghosts were immune to medical interventions.

Conclusion

The use of medical drugs was not limited to elite circles, and the belief in invisible beings was by no means the preserve of the non-educated masses. Even scholarly physicians from the culturally sophisticated Lower Yangzi region could share popular beliefs in ghosts, and many developed medical means to counter them. "Religious" and "medical" explanations remained mutually intelligible because they usually referred to the same symptoms with similar terms: Taoist texts could call *diankuang* an illness and attribute it to demons, while medical writers explained "spectral affliction" by the action of phlegm. Physicians who interpreted possession medically were thus not only criticizing less prestigious idioms of illness: they were also trying to assimilate them into higher-order explanations in order to convince patients to seek the help of physicians to treat possession symptoms. Michael MacDonald's claim (1981: 8) that in seventeenth-century England "the natural and supernatural approaches coexisted uneasily, championed by rival groups of professionals, to be sure, but not yet incompatible to many minds" thus applies well to Qing China.

Throughout the Qing, common people often traced the onset of madness back to specific events: frightful incidents (such as near drowning or an attack by bandits), severe lack or sudden loss of money, grief following the loss of a child, etc. Though these social explanations – which must have been common in all early modern societies – were almost never mentioned in religious and medical texts, they could be integrated into medical and supernatural accounts. Medical explanations simply sought the physical substrate of the strong emotions that had triggered mad behavior, whereas supernatural attributions spoke of frightened souls, opportunistic possession, or karmic retribution to make sense of suffering, to provide a "why" for these otherwise unpredictable catastrophes (Littlewood 2002). Then as today, cultural conceptions fed back into the way people interpreted their own symptoms and suffering, but these conceptions were multiple, and they competed and interacted in complex ways.

References

Ågren, H. (1982). The conceptual history of psychiatric terms in traditional Chinese medicine. In L. Guohao, Z. Mengwen, & C. Tianqin (Eds.), *Explorations in the history of science and technology in China* (pp. 573–581). Shanghai: Chinese Classics Publishing House.

Alford, W. P., & Wu, C.-C. (2003). Qing China and the legal treatment of mental infirmity: A preliminary sketch in tribute to Professor William C. Jones. *Washington University Global Studies Law Review, 2*(1), 187–192.

Baum, E. (2017). Chinese psychiatric welfare in historical perspective. In B. Carrillo, J. Hood, & P. Kadetz (Eds.), *Handbook of welfare in China* (pp. 64–78). Cheltenham/Northampton: Edward Elgar Publishing.

Baum, E. (2018). *The invention of madness: State, society, and the insane in modern China*. Chicago: University of Chicago Press.

Ch'en Hsiu-fen 陳秀芬. (2003). *Medicine, society, and the making of madness in imperial China* (PhD dissertation). School of Oriental and African Studies, University of London.

Ch'en Hsiu-fen 陳秀芬. (2008). Dang bingren jiandao gui: shilun Ming-Qing yizhe duiyu "xiesui" de taidu 當病人見到鬼:試論明清醫者對於「邪祟」的態度. *Guoli Zhengzhi daxue lishi xuebao* 國立政治大學歷史學報, *30*, 43–86.

Ch'en Hsiu-fen 陳秀芬. (2014). Qingzhi guoji, fei yao ke yu": Shilun Jin-Yuan-Ming-Qing de "yi qing sheng qing" liaofa 情志過極,非藥可癒—— 試論金元明清的「以情勝情」療法. *Xin shixue* 新史學, *25*(1), 1–50.

Chiu, ML. (1981). Insanity in imperial China: A legal case study. In A. Kleinman and Tsung-yi Lin (Eds.), *Normal and abnormal behavior in Chinese culture* (pp. 75-94). Dordrecht, Holland: D. Reidel.

Eigen, J. (1999). Lesion of the will: Medical resolve and criminal responsibility in the Victorian era. *Law and Society Review, 33*, 425–460.

Gomory, T., Cohen, D., & Kirk, S. A. (2013). Madness or mental illness? Revisiting historians of psychiatry. *Current Psychology, 32*(2), 119–135. https://doi.org/10.1007/s12144-013-9168-3.

Hao Bingjian 郝秉键. (2002). Qingdai jingshenbingren guanzhi cuoshi kaoshu 清代精神病人管制措施考述 [Measures for the management and restraint of the mentally ill in the Qing dynasty]. *Qingshi yanjiu* 清史研究, *2002*(2), 46–57.

Harper, D. (1998). *Early Chinese medical literature: The Mawangdui medical manuscripts*. London: Royal Asiatic Society.

Jiang Guan 江瓘 (Comp.). (1782 [1549/1591]). *Mingyi leian* 名醫類案, in 12 fascicles. Compiler's preface from 1549; colophon announcing first printing from 1591. 1782 edition from *Siku quanshu*.

Jones, W. C. (Trans.), with the assistance of Tianquan Cheng and Yongling Jiang. (1994). *The great Qing code*. Oxford: Clarendon Press; Oxford and New York: Oxford University Press.

Katz, P. (2009). *Divine justice: Religion and the development of Chinese legal culture*. London/New York: Routledge.

Kleinman, A. (1977). Depression, somatization, and the new "cross-cultural psychiatry". *Social Science and Medicine, 11*, 3–10.

Kleinman, A. (1980). Neurasthenia and depression: A study of somatization and culture in China. *Culture, Medicine, and Psychiatry, 6*, 117–190.

Li Wenrong 李文榮 (from Dantu 丹徒 county in Jiangsu). (1998 [ca. 1835]). *Fang Yuyi cao* 仿寓意草, in 2 fascicles. Preface dated 1835, but contains later cases. Re-edited in Qiu Qingyuan 裘慶元 (1998 [1923]), *Sansan yishu* 三三醫書, vol. 3 (Beijing: Zhongguo Zhongyiyao chubanshe), based on an 1887 edition.

Littlewood, R. (2002). *Pathologies of the west: An anthropology of mental illness in the west and America*. Ithaca: Cornell University Press.

Ma Jixing 馬繼興, et al. (Eds.). (1999). *Riben xiancun Zhongguo xigou guyixue congshu* 日本現存中國稀覯古醫學叢書. Beijing: Renmin weisheng chubanshe.

MacCormack, G. (1992). The legal treatment of insane persons in late imperial China. *The Journal of Legal History, 13*(3), 251–269.

MacDonald, M. (1981). *Mystical Bedlam: Madness, anxiety, and healing in seventeenth-century England*. Cambridge: Cambridge University Press.

Messner, A. (2000). *Medizinische Diskurse zu Irresein in China (1600–1930)*. Stuttgart: Franz Steiner Verlag.

Nakamura Shigeo. (1973). "Seishimbyōsha no keiji sekinin" 精神病者の刑事責任 (The criminal responsibility of the mentally ill [in the Qing dynasty]). In his *Shindai keihō kenkyū* 清代刑法研究 [Research on the criminal law of the Qing dynasty] (pp. 183–213). Tokyo: University of Tokyo Press.

Ng, V. (1980). Ch'ing laws concerning the insane: An historical survey. *Ch'ing-shih wen-t'i, 4*(4), 55–89.

Ng, V. (1990). *Madness in late imperial China: From illness to deviance*. Norman and London: University of Oklahoma Press.

Padel, R. (1995). *Whom gods destroy: Elements of Greek and tragic madness*. Princeton: Princeton University Press.
Qiu Qingyuan 裘慶元 (1873–1947) (Ed.). (2001 [1936]). *Zhenben yishu jicheng* 珍本醫書集成. Beijing: Zhongguo Zhongyiyao chubanshe.
Quétel, C., & Morel, P. (1979). *Les fous et leurs médecines de la Renaissance au XXe siècle*. Paris: Hachette.
Rosner, E. (1991). Zur Straffreiheit Geistesgestörter im chinesischen Recht der Ch'ing-Zeit [On the immunity from prosecution of the mentally disturbed in Qing-period Chinese law]. *Oriens Extremus, 34*, 37–55.
Scheid, V. (2013). Depression, constraint, and the liver: (Dis)assembling the treatment of emotion-related disorders in Chinese medicine. *Culture, Medicine, and Psychiatry, 37*, 30–58. https://doi.org/10.1007/s11013-012-9290-y.
Scull, A. (1975). From madness to mental illness: Medical men as moral entrepreneurs. *Archives Européennes de Sociologie, 26*, 218–251.
Scull, A. (1993). *The most solitary of afflictions: Madness and society in Britain, 1700–1900*. New Haven: Yale University Press.
Shen Rutun 沈如焞 (Comp.). (1759). *Li'an xuzeng quanji* 例案續增全集, in 41 fascicles.
Simonis, F. (2010). *Mad acts, mad speech, and mad people in late imperial Chinese law and medicine* (PhD dissertation). East Asian Studies, Princeton University.
Simonis, F. (2014). Medicaments and persuasion: Medical therapies for madness in nineteenth-century China. In H. Chiang (Ed.), *Psychiatry and Chinese history* (pp. 55–70). London: Pickering & Chatto.
Simonis, F. (2015a). Illness, texts, and "schools" in Danxi medicine: A new look at Chinese medical history from 1320 to 1800. In B. A. Elman (Ed.), *Antiquarianism, language, and medical philology: From early modern to modern Sino-Japanese medical discourses* (pp. 52–80). Leyden: Brill.
Simonis, F. (2015b). Ghosts or mucus? Medicine for madness: New doctrines, therapies, and rivalries. In J. Lagerwey & P. Marsone (Eds.), *Modern Chinese religion I: Song–Liao–Jin–Yuan (960–1368 AD)* (pp. 603–639). Leiden: Brill.
Simonis, F. (forthcoming). *Kuang: Madness, body, and behavior in Chinese medical history*.
Sivin, N. (1995). Emotional counter-therapy. In N. Sivin (Ed.), *Science in ancient China: Researches and reflections* (II: pp. 1-19). Aldershot (Hampshire, England) and Burlington (Vt., USA): Ashgate.
Unschuld, P. U. (1986). *Medicine in China: Nan-Ching, the classic of difficult issues*. Berkeley: University of California Press.
Wang Tailin 王泰林 (1798–1862; *zi* Xugao 旭高). (1897). *Wang Xugao linzheng yi'an* 王旭高臨證醫案. Posthumous edition annotated by Fang Renyuan 方仁淵. In Qiu 2001 [1936]: vol. 4.
Wu Tan 吳壇. (1992 [1886]). *Dai Qing lüli tongkao jiaozhu* 大清律例通考校注, in 40 fascicles. Annotated edition of Wu's *Dai Qing lüli tongkao*, which was completed in the late Qianlong reign (1736–1796). Beiijng: Zhongguo zhengfa daxue chubanshe.
Xue Yunsheng 薛允升 (1820–1901). (1970 [1905]). *Duli cunyi* 讀例存疑 [Lingering Doubts in the Study of the Sub-Statutes], in 54 fascicles. Edited for posthumous publication by Xu Shiying 許世英, Beijing Liulichang: Hanmao zhai, 1905. I cite from *Duli cunyi chongkan ben: fu zuozhe zhuanlüe ji Qinglü tiaoli bianhao biaomu* 讀例存疑重刊本, 附作者傳略及清律條例編號標目 [A Typeset Re-Edition of *Duli Cunyi*, With a Biography of the Compiler and Numbering and Titles Added to the Sub-statutes], collated by Huang Jingjia 黃靜嘉 (Taipei: Chengwen, 1970).
Yu Zhen 俞震 (b. 1709). (1959 [1778]). *Gujin yian an* 古今醫案按 [Medical case files ancient and present, with commentaries], in 10 fascicles. Shanghai: Shanghai kexue jishu chubanshe.
Zhang Yanhua. (2007). Transforming emotions with Chinese medicine: An ethnographic account from contemporary China. Albany: State University of New York Press.
Zhao Jizong 趙繼宗 (*jinshi* 1490). (1648 [1528]). *Ruyi jingyao* 儒醫精要 [The Essentials of Scholarly Medicine]. A 1648 Japanese edition kept at the Naikaku bunko (内閣文庫; Japan's

Diet Library) is photo-reproduced in Ma 1999: 247–70 and re-edited in simplified characters in Zheng 2003, vol. 12: 453–91.

Zheng Jinsheng 郑金生 (Ed.). (2003). *Haiwai huigui Zhongyi shanben guji congshu* 海外回歸中醫善本古籍叢書 (12 vols). Beijing: Renmin weisheng chubanshe.

Zhu Zhenheng 朱震亨 (1282–1358). (1347). *Gezhi yulun* 格致餘論 [Words Bequeathed by the Ancients on the Perfection of Knowledge Through the Investigation of Things].

Chapter 3
Psychiatry in Republican China

Wen-Ji Wang

Abstract The present study examines the evolution of the discipline of psychiatry in Republican China. First, at a time when a unified medical education system was lacking and when the country was subject to competing foreign interests, different schools of psychiatry co-existed, and the development of psychiatry was uneven in this enormous country. Whilst the American-influenced Peking Union Medical College stood out as the catalyst of neuropsychiatric teaching, given its emphasis on building psychiatric hospitals as centres of mental hygiene networks, the international city of Shanghai provided an environment in which European, American and local Chinese forces competed in defining and managing mental illness. Second, the study traces the multiple roles of psychiatrists and other health professionals as developers of medical science, providers of mental health services and experts of modern technologies of the self. Despite very limited resources, Chinese psychiatrists and other health professionals conducted a variety of psychiatric, psychological and sociological studies. Outside the confines of mental institutions, they also disseminated modern technologies of the self, eagerly transforming madness into a manageable psychological, sociological and behavioural problem. Nevertheless, different health models and social groups still played crucial roles in defining madness and in providing mental health services in various ways. Finally, given that many diverse ideas of psychiatry and mental health took root in China in the first half of the twentieth century, the chapter argues that there was continuity rather than abrupt change in psychiatry between the Republican and socialist periods.

Keywords History of psychiatry · Republican China · Mental health

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Condition of Madness and Mental Health in General

In the first half of the twentieth century, the conception and regulation of madness in China involved an array of social groups. As in the late imperial period, madness was largely associated with deviance, crimes and threats to the social order (Ng 1990). Newspapers, police records and psychiatric case files repeatedly recorded cases of disturbances and damages caused by mad people to their families, communities and the society at large (Baum 2018a, b; Wang 2017b). In an era where medical and institutional support was scarce and fragmented, the responsibility of regulating madness was mainly in the hands of families and local communities.

The multiple health models available during the Republican period (1912–1949) provided diverse ways of managing and conceptualising madness. The family of the mentally unsound, especially from rural areas, often turned to *wise women*, Taoist priests and folk healers for help given the long-standing relationship amongst madness, karma and possession as ingrained in the local culture (Lyman 1937; Wei 1936). With its holistic approach, traditional Chinese medicine does not clearly distinguish mental, physical and behavioural illnesses from one another. Medicinal decoctions were the most preferred and adopted therapy in this most popular form of health model (Simonis 2014). Patent medicines claiming to be effective against "brain diseases" (腦病, *nao bing*) and neurasthenia were frequently advertised in the newspapers (Wang 2016). Those people living in or nearby large cities and those coming from higher educational backgrounds gradually came to regard madness as a form of mental illness, the treatment of which depended on the availability of modern biomedical therapies (Shapiro 1995). Nonetheless, due to their scarcity, Western medicine and neuropsychiatry were not considered top choices for Chinese people in general (Baum 2018a).

Uneven Development of Psychiatry

The development of modern psychiatry during the Republican period was subject to the interplay amongst several social and political forces. During a period in which medical resources and government support were limited and mental illnesses were highly stigmatised, psychiatry was extremely underdeveloped as a medical discipline (Bowman 1948; Lyman 1937; Pearson 1991). Even into the late 1940s, departments of neuropsychiatry could only be found in universities and medical colleges based in cities such as Beijing, Shanghai, Changsha, Guangzhou, Chengdu and Nanjing, and psychiatry was not a favourite subject amongst medical students. In contrast to Japan (Suzuki 2003) where laws for the mentally ill were enacted in 1900 and 1919, no national plan for the treatment and management of mental patients was in place in Republican China. Psychiatric hospitals and asylums, the number of which was disproportionately small for the country's population size, were built by local governments, foreign missionaries, philanthropic organisations

or entrepreneur social elites within or near large cities. Before the founding of the People's Republic of China in 1949, less than 1000 hospital beds were available in the entire country (Cheng 1948b). Accordingly, families, local communities and members of the medical community continuously called for the building of additional mental institutions throughout the country (Wang 1920).

Just as China was politically divided into "spheres of influence" since the late Qing dynasty, the development of psychiatry was subject to different types of foreign influence in the first half of the twentieth century (Wang 2016; Wu 2019). Both the John G. Kerr Refuge for the Insane, which was the first psychiatric asylum in the country, and the Elizabeth Blake Hospital, which was the first Western hospital with departments dedicated to neurology and psychiatry, were built by American missionaries in Guangzhou and Suzhou, respectively, in the late nineteenth century (Lyman 1937; Szto 2002), although the influence of these institutions and their medical staff on the dissemination of psychiatric findings to the Chinese society is yet to be determined. Additionally, notwithstanding that the John G. Kerr Refuge for the Insane has been credited as the first modern mental institution in China, its founding at the end of the nineteenth century can be seen as a product of the age of asylums, with its emphasis on the rational regulation of patients and their daily activities. In the first decades of the twentieth century, the international city of Shanghai provided an environment in which European, American and local Chinese forces competed in defining and managing mental illness. Mental institutions with different purposes, therapeutic philosophies and sizes co-existed at the time. Starting from the early 1930s, departments of neuropsychiatry were established at several universities and hospitals in this city, including the National Medical College of Shanghai, St. John's University, Women's Christian Medical College and Red Cross Hospital (Wang 2019; Westbrook 1953). Under the auspices of the Rockefeller Foundation, the Peking Union Medical College (PUMC) followed the Johns Hopkins model, and its Department of Neuropsychiatry served as a training centre for psychiatric personnel in China since the 1920s (Baum 2018b; Pearson 2014; Shapiro 1995). The Peiping Municipal Asylum for the Insane, which had been under the control of the Police Department, was remodelled into a psychopathic hospital in 1933 to serve as an instructional site for PUMC students (Fan 2013).

Insofar as many Chinese elites went to Japan—regarded at the time as a main source of modern scientific knowledge in East Asia—to receive medical training since the late Qing dynasty, Japanese and German psychiatric ideas were being widely circulated in newspapers and magazines during the first half of the Republican era, on matters such as the importance of eugenics and the negative impacts of hereditary predisposition, social pathologies and masturbation. The exact number of Chinese medical doctors trained in Japan and later specialised in neuropsychiatry is nevertheless hard to determine. In terms of institutions, with increasing Japanese influence in Manchuria (or the three provinces of northeast China), mental hospitals and teaching facilities were established and under the control of the Japanese. The Dairen Seiai Hospital and the South Manchurian Medical College also became hubs for colonial psychiatric studies, including the problems of mass migration and acclimatisation (Matsumura 2010). Additionally, the Russians established mental

hospitals and mental wards respectively in Harbin, Shenyang (then Mukden) and Shanghai (Lyman 1937; Westbrook 1953).

Chinese psychiatrists were also keen to promote their profession. The majority of psychiatrists practising during the Republican era and early socialist period were under American or European influence, and some went abroad for studies. Psychiatric facilities, regardless of their origins, in large cities such as Beijing, Shanghai, Guangzhou and Changsha, became important places where limited mental health services could be provided. Whilst most of these Chinese psychiatrists stayed in Japanese-occupied territories after the breakout of the second Sino-Japanese War in 1937, psychiatrists and medical psychologists, including Cheng Yu-Ling and Ting Tsan, relocated to cities in rear areas, such as Chengdu and Chungking, and introduced psychiatric ideas to the remote parts of the country (Wang and Huang 2019). After the end of the World War II and at the height of the Chinese Civil War, the late 1940s saw a brief boom of initiatives. A psychiatric hospital was built in the capital city of Nanjing by the Ministry of Health in 1947 with the help of the World Health Organization. The newly repatriated Cheng Yu-Ling headed the hospital, and a group of well-trained and experienced psychiatrists, medical psychologists and social workers joined in to form a comprehensive team. Although short-lived, a mental hygiene plan drawn up by Cheng shows how Western-trained psychiatrists and other health professionals envisioned the future of mental health for the war-torn country with the help of foreign experts (Bowman 1948; Chen 1997; Cheng 1948b; Liu 1948). The Nanjing Psychopathic Hospital would later become another important site for psychiatric training for decades to come. Only months before the Communist party took power, psychiatrist Suh Tseng-Hua and lay psychologist Huang Chia-Yin (1949) from Shanghai proposed a similar but grander plan, which involved the training of psychiatric professionals and auxiliary workers, the building of various kinds of mental health facilities, the production of psychiatric medications and equipment and the promotion of psychiatric education.

Considering its prominence during the Republican era, the Department of Neuropsychiatry of the PUMC warrants further discussion. With the support of the Rockefeller Foundation, Andrew H. Woods served as the first head of the Neurology and Psychiatry Department of the PUMC in 1920 (Baum 2018b, 118–119; Zhen 2008). Although Woods and his successor, Richard S. Lyman, were both trained as neurologists and several of their former Chinese students later turned to neurological studies (Li and Schmiedebach 2015; Lyman 1935; Woods 1929), the PUMC became the most important place for developing psychiatry and promoting mental hygiene in China. Woods (1920, 1921, 1923) underscored the necessity of training psychiatric professionals, establishing psychiatric teaching in medical schools and building institutions for the insane and mentally defective people of China. Lyman, a disciple of the then leader of American psychiatry, Adolf Meyer, closely followed his mentor's psychobiology and developed a sociological and psychodynamic approach to studying the mental illnesses and personality formation of the Chinese during his years in Beijing from 1932 to 1937 (Lyman 1938; Rose 2012; Wang 2016). This trend was coupled with the contemporary growth of a mental hygiene

movement in the country and its focus on social and environmental factors in mental health. Apart from routine psychiatric social work, mental hygiene work was experimented within local high schools and a factory in the late 1930s by medical psychologists and social workers from the PUMC (Wang 2016; Wang and Huang 2019). The interest of the PUMC in public health (Bu 2014, 2017) and mental illness prevention and the collaboration amongst different psychiatric personnel during the 1930s and 1940s resulted in the implementation of several models across different cities.

Whilst the PUMC dominated in Beijing and the reorganisation of its psychopathic institution was associated with the rise of a Nationalist government with a scientific vision (Baum 2018b), the development of psychiatry in Shanghai was highly dynamic and multidimensional. Two private hospitals for the Chinese, namely, the Chinese Public Sanatorium and the Shanghai Hospital for the Insane, and a couple of psychiatric wards for the city's foreign residents, namely, the Victoria Nursing Home and the Russian Orthodox Confraternity Hospital, existed prior the mid-1930s. Whilst the Vienna-trained neurologist Fanny G. Halpern was instrumental in establishing the Mercy Hospital and promoting neuropsychiatric education in several universities from the early 1930s, the PUMC- and Johns Hopkins-trained Suh Tseng-Hua taught at the National Shanghai Medical College and designed his own mental health network. For a time, Shanghai was the most vibrant site for developing mental hygiene in the whole country. The Committee on Mental Hygiene of Shanghai was established with the support of different social groups in June 1938 (Wang 2017a; Westbrook 1953). Tension nevertheless emerged amongst different schools of psychiatric thought (Wang 2016). Moreover, Suh and other social reformers in the city had different plans for mental hygiene. Whilst Suh focused on the training of psychiatric professionals, the International Women's Organisation, local Chinese communities and the social welfare department of the Chinese municipal government collaborated in providing mental health services to residents in the forms of mental hospitals, child guidance clinics and mental hygiene lectures (Wang 2019).

Psychiatrists and Their Multiple Roles

The history of psychiatry in China has attracted much research attention over the recent years (Chiang 2014). Some researchers have chronicled institutional or conceptual transformations (Li and Schmiedebach 2015; Pearson 2014), whereas others have adopted a sociohistorical approach in exploring the multiple functions of psychiatrists during a period of drastic social and political changes. Emily Baum (2018b) has argued that the concept of madness was "invented" by different social forces to meet their interests and needs; Wen-Ji Wang (2017b) has highlighted the importance of mental institutions as places in which the social, familial, moral and psychophysical orders were maintained by and negotiated amongst diverse social groups; and Harry Yi-Jui Wu (2019) has examined the "multiplicity" of psychiatry,

which he defined as comprising infrastructure, knowledge content and diverse social functions. The following section traces the roles of Chinese psychiatrists as developers of medical science, providers of mental health services and experts of modern technologies of the self.

Developers of Medical Science

Academic publications in the field of psychiatry during the Republican period illustrate the transformations in research interest. Whilst foreign medical doctors from the 1900s to 1920s often commented on psychiatric epidemiology, asylum management and treatment of the insane (McCartney 1927; Selden 1905, 1909, 1913; Woods 1929), psychiatry, starting from the 1920s, was gradually established as a medical subdiscipline associated with universities and medical colleges. This alliance produced studies of a different nature from the previous decades. As mentioned above, neuropsychiatrists in China during this period were largely neurologically inclined. For instance, amongst the 18 publications produced by the PUMC neuropsychiatry staff between October 1932 and October 1935, more than three-fourths focused on subjects relating to neurology, pathology and physiology. Suh Tseng-Hua worked on Walter's bromide test and examined the deficiency of the septum pellucidum, Hsu Ying-Kuei examined the effects of X-rays on the spinal cord and Cheng Yu-Lin studied lymphoepithelioma in the nervous system, spinal muscular atrophy and paralysis (Lyman 1935, 54–55). This focus on neurology was expected to persist until the 1950s and 1960s.

Considering that the PUMC Department of Neuropsychiatry adopted a multidisciplinary approach, psychological and social studies were also conducted in the 1930s. Sociologists, psychologists and social workers collaborated with psychiatrists on a wide range of subjects, including personality, thoughts, verbal expressions of emotion, social and personal factors related to mental disorders and social and personality characteristics, to determine how patients adjusted to their environment after being discharged (Lyman 1935: 55; Lyman et al. 1939). For instance, in their sociological study of 300 mental patients from the PUMC, Chou Li-Chiu and Lu Yi-Chuang found that social factors were responsible for the outbreak of mental disorders in nearly all cases (Chou and Lu 1939). The Chicago-trained sociologist and lay psychoanalyst Dai Bingham also studied psychiatric cases from the PUMC to probe into the social formation of Chinese personality from a more theoretical perspective (Wang 2006). Similar developments occurred in other parts of the country, but with a lesser intensity.

Furthermore, the invention of what sociologist Andrew Scull (2015, 295–313) referred to as "desperate remedies" (e.g. malaria fever therapy, insulin shock therapy and electroconvulsive therapy) in Europe during the first decades of the twentieth century ushered in an atmosphere of optimism in the international psychiatric profession. China in the 1930s and 1940s also witnessed an increase in the number of studies on psychiatric treatments. Halpern's (1939) experiment on the insulin therapy of schizophrenics in the fall of 1936 started a trend in which this newly

introduced treatment was used by Chinese psychiatrists in various hospitals across the country. Clinical reports on the treatment of schizophrenia, epilepsy, general paresis and other disorders were also published during this period (Huang 1943; Hsia et al. 1945; Suh et al. 1941, 1942).

Providers of Mental Health Services

The aforementioned visions of scientific modernity and professional advancement were also manifested in the development of various institutions. With the support of different sectors of the society and contemporary therapeutic optimism, Chinese and foreign psychiatrists were both keen to transform, as Fanny Halpern put it, archaic "asylum-type" institutions into "real" hospitals for "mental diseases" (Anonymous 1935). According to Cheng Yu-Ling (1948b), in as much as psychiatric professionals were in great demand in China, a potential solution was to guarantee a close collaboration between psychopathic hospitals and medical colleges. For these rising experts of the human psyche, mental hospitals should not be places that incarcerated the incurable insane but modern establishments in which state-of-the-art research and treatments could be conducted and experimented with and where mental hygiene works, including social service work, child guidance clinics and psychiatric training programmes, could be implemented (Wang 2017b, 2019). This development in clinical psychiatry is consistent with some contemporary accounts (Anonymous 1943; Lo 1944).

As historians of psychiatry and madness in modern China have repeatedly observed, this modern medical profession nevertheless only played a minor role in the provision of mental health services during the Republican era. Mental patients were primarily cared for by their families and local communities—a trend which would continue until the end of the century, if not later (Pearson 1995; Yang 2017). Even the establishment and operation of psychiatric institutions in the first half of the twentieth century were principally products of the collaboration, negotiation and compromise amongst different social groups (Diamant 1993; Szto 2002). The Peiping Psychopathic Hospital in the 1930s served multiple social functions, namely, as a means to maintain social order and to advance modernity for the state, as a basis for developing modern psychiatry as a medical profession, as a place for managing intractable families and members of the general public and as a safe haven for those who were trying to escape from traditional family and social roles (Baum 2018b; Shapiro 1995, 2014). The founding of the Mercy Hospital in Shanghai in 1935 involved three municipal governments, local philanthropic and religious organisations, the National Medical College and its neuropsychiatric experts and the support of the local Chinese and foreign communities (Wang 2019; Westbrook 1953). In this sense, this study resonates with the recent historical studies that have emphasised that "the handling of the insane should be seen not as monolithic and monopolistic but as a mixed economy of care provision, with inputs from the private sector, charity and the sate" (Porter 2003: 5).

It is noteworthy that, in spite of the efforts made by psychiatrists, auxiliary mental health professionals and other social groups, mental hospitals in Republican China were not favourably perceived by the society at large (Kisch 1936), which was not an uncommon phenomenon, considering that similar institutions in Western countries were often plagued by problems of overcrowding and inadequate facilities. Official documents from the Chinese Municipal Government of Shanghai also suggest that, in the mid-1940s, the Mercy Hospital was forced to accept an increasing number of incurable and violent patients sent by local communities and police departments (Wang 2017b).

Experts of the Technologies of the Self

Whilst the resources for psychiatric care were so limited that psychiatrists and other health professionals were unable to provide adequate services to the Republican society at large, they received much attention with the help of the country's burgeoning publishing industry and aspiring young reading population. As psychiatry stood on more solid ground, the latter half of the Republican period saw an increasing number of psychiatric and socio-psychological commentaries on various subjects, including psychiatric diseases (Hsia 1942; Wei 1936), mental hygiene (Cheng 1947b; Halpern 1947; Suh 1939), emotions (Suh 1946), child guidance (Kuei 1946; Lin 1937), sex education (Hsia 1947), marriage counselling (Cheng 1948a) and venereal diseases (Cheng 1947a).

Like-minded sociologists, psychologists and intellectual elites also used newspapers, magazines and popular lectures to further the cause of the mental hygiene movement and to promote a socio-psychological way of thinking. Popular magazines such as *Xifeng* (西風, West Wind Monthly), *Jia* (家, *Home*) and *Xizhonghua* (新中華, *New China*) became the powerful media through which mental hygiene ideas and technologies of the self could be experimented with (Blowers and Wang 2014; Wang 2011; Wang and Huang 2019; Zheng 2019). For instance, Ting Tsan, a medical psychologist who headed the Mental Hygiene Laboratory of the National Institute of Health in the 1940s, frequently lectured and wrote on mental hygiene with the view that a rational reconstruction of the country could be realised. The topics Ting discussed included father-son relationship, marriage guidance, psychological normality, neurasthenia, problem children, war orphans, youth's self-cultivation, racial discrimination, pride and inferiority and homosexuality (Wang and Huang 2019). By turning everyday social evils and personal troubles into psychological and psychiatric problems and by questioning the traditional moral values and rules of conduct, psychiatrists and their co-workers sought to demonstrate that their ailing and troubled nation was in great need of modern technologies of the self.

Conclusion

As a result of continuous social and political upheavals and lack of government support, psychiatry in Republican China was tremendously underdeveloped. However, this state of affairs was common in the contemporary non-Western world, including other East Asian societies. Although psychiatry flourished as an academic medical discipline in Japan in the first half of the twentieth century, this most modernised Asian nation as a whole continued its age-old tradition of leaving the responsibility of caring for the insane to family members and local communities (Suzuki 2003). Since China's resources were devoted to health issues that were seen as more important and urgent, psychiatry and psychiatric institutions remained at the margins of medicine and social interest, as in colonial Korea and Taiwan (Jin 2012; Wu and Cheng 2017; Yoo 2016). Instead of analysing those factors that led to the limited development of psychiatry in modern China, this study examines how the discipline evolved in a specific social and political environment.

The development of psychiatry and mental institutions in major Chinese cities during the Republican era was closely related to the professionalisation of modern medicine and the support of the local government. At a time when a unified medical education system was lacking and when the country was subject to competing foreign interests, different schools of psychiatry co-existed. The American-influenced PUMC nevertheless stood out as the catalyst of neuropsychiatric teaching given its emphasis on conducting neurological studies and building psychiatric hospitals as centres of mental hygiene networks. Outside the confines of mental institutions, psychiatrists and other auxiliary specialists spread the gospel of modern technologies of the self, eagerly transforming madness into manageable psychological, sociological and behavioural problems. However, different health models and social groups still played crucial roles in defining madness and in providing mental health services in various ways.

For the past decades, historians of psychiatry and madness in modern China have tended to focus on the process through which psychiatry evolved as a medical discipline or on the ways in which the meaning of madness was invented by or negotiated amongst different social forces. This chapter attempts to not only describe this dual process but also, by giving attention to its original context, portray psychiatry as a larger enterprise. Under both the influence of the international mental hygiene movement and a style of socio-psychological thinking, psychiatrists in the first half of the twentieth century were expected to work closely with psychologists, social workers and nurses. This idea also took root in Republican China. The cross-disciplinary collaboration not only made the work of preventing mental disorder more feasible in a country without sufficient resources, the psychiatric and psychological thinking was able to exert greater social influence through the mental health network and facilities which auxiliary health professionals helped to build. What historian Nancy Tomes (2008: 657) describes, in another context, as "a profusion of mental health facilities and practitioners" would continue its trend into the socialist China, as some veteran psychiatrists recalled in the 1990s (Chen 1997).

Finally, psychiatry in Republican China was often denigrated as a product of imperial and bourgeois influences during the early socialist period, and its history was largely deemed negligible afterwards (Kleinman 1986; Lee 2011; Lin and Eisenberg 1985). However, the development of this discipline in Republican China created centres for further development, and most Chinese psychiatrists introduced above—except for Cheng Yu-Lin, who eventually left for the USA via Taiwan—remained in the country after the founding of the PRC and would train generations of neurologists and psychiatrists to come (Xu 1995).

References

Anonymous. (1935, October 20). Insane in China to be aided soon. *China Press*.

Anonymous. (1943). Canguan jingshen bingyuan yinxiang ji (My impression of visiting the psychopathic hospital). *Funu zazhi (Women's Magazine), 4*(7), 16–19.

Baum, E. (2018a). Choosing cures for mental ills: Psychiatry and Chinese medicine in early twentieth-century China. *Asian Review of World Histories, 6*, 8–32.

Baum, E. (2018b). *The invention of madness: State, society, and the insane in modern China*. Chicago: The University of Chicago Press.

Blowers, G., & Wang, S. X. (2014). Gone with the *West Wind*: The emergence and disappearance of psychotherapeutic culture in China, 1936-68. In H. Chiang (Ed.), *Psychiatry and Chinese history* (pp. 143–160). London: Pickering & Chatto.

Bowman, K. (1948). Psychiatry in China. *American Journal of Psychiatry, 105*(1), 70–71.

Bu, L. (2014). John B. Grant: Public health and state medicine. In B. Andrews & M. B. Bullock (Eds.), *Medical transitions in twentieth century China* (pp. 212–226). Bloomington and Indianapolis: Indiana University Press.

Bu, L. (2017). *Public health and the modernization of China, 1865–2015*. London: Routledge.

Chen, X.-S. (1997). Chuqi de nanjing naoke yiyuan (Nanjing psychopathic hospital in its early days). *Linchuang jingshen yixiao zazhi (Journal of Clinical Psychiatry), 7*(5), 304–305.

Cheng, Y.-L. (1947a). Liangzhong kepa de xingbing (Two dreadful venereal diseases). *Jia (Home), 21*, 353–354.

Cheng, Y.-L. (1947b). Shenjing cuiruo yu xinli weisheng (Neurasthenia and mental hygiene). *Xifeng (West Wind), 95*, 445–450.

Cheng, Y.-L. (1948a). Qingnian hunyin wenti (Marriage problems of young people). *Yi Chao (Medical Tides), 2*(5), 16–19.

Cheng, Y.-L. (1948b). Peizhi jingshenbingxiao rencai zhi jianyi (Suggestions for training psychiatric professionals). *Yi Chao (Medical Tides), 2*(3–4), 2–3.

Chiang, H. (Ed.). (2014). *Psychiatry and Chinese history*. London: Pickering & Chatto.

Chou, L. C., & Lu, Y. C. (1939). A sociological study of Chinese mental patients. In R. S. Lyman, V. Maeker, & P. Liang (Eds.), *Social and psychological studies in neuropsychiatry in China* (pp. 31–116). Peking: Peking Medical College/Henri Vetch.

Diamant, N. (1993). China's "great confinement"?: Missionaries, municipal elites and police in the establishment of Chinese mental hospitals. *Republican China, 19*(1), 3–50.

Fan, T.-W. (2013). Cong shourong dao zhiliao: Wei yu-lin yu beiping jingshenbing liaoyangyuan de chuangjian (From custody to scientific therapy: Wei Yu-lin's contribution to the founding of the Peiping Municipal Psychopathic Hospital). *Zhonghua yishi zazhi (Chinese Journal of Medical History), 43*(6), 345–350.

Halpern, F. G. (1939). Insulin shock treatment of schizophrenia. *American Journal of Psychiatry, 96*(5), 1153–1165.

Halpern, F. G. (1947). Renshi ziji (Know thyself). *Zhonghua jiankang zazhi (The National Health Journal of China), 3*(4), 23–27.
Hsia, C.-Y. (1942). Jingshenbing de wenti yu yufang (Mental illness problems and their prevention). *Zhonghua jiankang zazhi (The National Health Journal of China), 4*(1), 5–7.
Hsia, C.-Y. (1947). Tan ertong xing jiaoyu (On child sex education). *Zhonghua jiankang zazhi (The National Health Journal of China), 9*(3), 7–8. 16.
Hsia, C.-Y., Suh, T.-H., & Chang, W.-C. (1945). Quanshen mabi xing jingshenbing zhi jiantao: Fu bashiyi li zhi bingan fenxi (A study of general paresis of insanity: With an analysis of 81 cases). *China Medical Journal, 31*(1–2), 14–34.
Huang, Y.-C. (1943). Jingshen fenlie zheng yong kediazou (Cardiazol) chounifa zhiliao zhi yi bingli baogao (The Cardiazol shock treatment of schizophrenia: A case report). *China Medical Journal, 29*(1), 53–39.
Jin, J.-W. (2012). Zai zhaohu zhiliao yu geli shourong zhijian: Zhimindi Taiwan de jingshen bingyuan (Between cure and incarceration: Psychiatric hospitals in colonial Taiwan). In J.-W. Jin (Ed.), *Kanbujian de zhimin bianyuan: Rizhi Taiwan bianyuanshi douben (Invisible colonial margins: Readings in the history of margins in colonial Taiwan)* (pp. 144–159). Taipei: Taiwan Interminds Publishing.
Kisch, E. E. (1936). Feng ren yuan (Lunatic asylum). *Xinrenshi (New Knowledge), 1*(3), 186–188.
Kleinman, A. (1986). *Social origins of distress and disease: Depression, neurasthenia, and pain in modern China*. New Haven: Yale University Press.
Kuei, C.-L. (1946). Zeyang jiaoyu wenti ertong (How to educate problem children?). *Funu (Women), 4*, 13–14.
Lee, S. (2011). Depression: Coming of age in China. In A. Kleinman et al. (Eds.), *Deep China: The moral life of the person* (pp. 171–212). Berkeley: University of California Press.
Li, W., & Schmiedebach, H.-P. (2015). German wine in an American bottle: The spread of modern psychiatry in China, 1898–1949. *History of Psychiatry, 26*(3), 348–358.
Lin, M.-Y. (1937). Jige guanwu ertong xinli weisheng de wenti (Questions concerning child mental hygiene). *Jiankang jiaoyu (Health Education), 2*(3), 2–7.
Lin, T.-Y., & Eisenberg, L. (Eds.). (1985). *Mental health planning for one billion people: A Chinese perspective*. Vancouver: University of British Columbia Press.
Liu, C.-T. (1948). Jieshao nanjing jingshenbing fangzhiyuan (Introducing Nanking psychopathic hospital). *Yi Chao (Medical Tides), 2*(3–4), 40–41.
Lo, F. (1944). *Fengkuang bayue ji (Insane for eight months)*. Shanghai: Zazhishe.
Lyman, R. S. (1935). *Report of neuropsychiatry in Peiping*. October 1932 to October 1935. Beijing: The PUMC.
Lyman, R. S. (1937). Psychiatry in China. *Archives of Neurology and Psychiatry, 37*(4), 765–771.
Lyman, R. S. (1938, May 6). *Richard S. Lyman to Agnes M. Pearce*. Rockefeller Foundation Collection, CMB, Record Group IV2B9, Box 91, Folder 696.
Lyman, R. S., Maeker, V., & Liang, P. (Eds.). (1939). *Social and psychological studies in neuropsychiatry in China*. Peking: Peking Medical College/Henri Vetch.
Matsumura, J. (2010). Eugenics, environment, and acclimatizing to Manchukuo: Psychiatric studies of Japanese colonists. *Niho Ishi Gakkai (Journal of the Japanese Society for the History of Medicine), 56*(3), 1–33.
McCartney, J. L. (1927). Neuropsychiatry in China. *Archives of Neurology and Psychiatry, 18*(1), 87–95.
Ng, V. W. (1990). *Madness in late imperial China*. Norman and London: University of Oklahoma Press.
Pearson, V. (1991). The development of modern psychiatric services in China, 1891–1949. *History of Psychiatry, 2*(6), 133–147.
Pearson, V. (1995). *Mental health care in China: State polices, professional services and family responsibilities*. London: Gaskell.

Pearson, V. (2014). The development of psychiatric services in China: Christianity, communism, and community. In B. Andrews & M. B. Bullock (Eds.), *Medical transitions in twentieth century China* (pp. 146–170). Bloomington and Indianapolis: Indiana University Press.

Porter, R. (2003). Introduction. In R. Porter & D. Wright (Eds.), *The confinement of the insane: International perspectives, 1800–1965* (pp. 1–19). Cambridge: Cambridge University press.

Rose, A. C. (2012). Racial experiments in psychiatry's provinces: Richard S Lyman and his colleagues in China and the American South, 1932–51. *History of Psychiatry, 23*(4), 419–436.

Scull, A. (2015). *Madness in civilization: A cultural history of insanity from the Bible to Freud, from the madhouse to modern medicine*. London: Thames & Hudson.

Selden, C. C. (1905). Work among the Chinese insane and some of its results. *China Missionary Medical Journal, 19*(1), 3–4.

Selden, C. C. (1909). Treatment of the insane II. *The China Medical Journal, 23*(4), 221–232.

Selden, C. C. (1913). Conditions in south China in relation to insanity. *American Journal of Psychiatry, 70*(2), 411–426.

Shapiro, H. (1995). *A view from a Chinese asylum: Defining madness in 1930s Peking* (PhD dissertation). Harvard University.

Shapiro, H. (2014). Operatic escapes: Performing madness in neuropsychiatric Beijing. In B. Ellman & J. Tsu (Eds.), *Science and technology in modern China, 1880s to 1940s* (pp. 297–325). Leiden: Brill.

Simonis, F. (2014). Medicaments and persuasion: Medical therapies for madness in nineteenth-century China. In H. Chiang (Ed.), *Psychiatry and Chinese history* (pp. 55–70). London: Pickering & Chatto.

Suh, T.-H. (1939). Jingsheng weisheng (Mental Hygiene). *Zhonghua jiankang zazhi (The National Health Journal of China), 1*(2), 19–22.

Suh, T.-H. (1946). Lun qinggan yu qingxu (On feelings and emotions). *Xifeng (West Wind), 83*, 496–500.

Suh, T.-H., & Huang, J.-Y. (1949). Jingshenbing fangzhi fangan (Plan for mental illness prevention). *Zhonghua jiankang zazhi (The National Health Journal of China), 6*, 3–7.

Suh, T.-H., Chang, W.-C., & Hsia, C.-Y. (1941). Jingshen fenlie zheng zhi yidaosu xiuke zhiliao (The insulin shock treatment of schizophrenic patients). *China Medical Journal, 27*(9), 527–544.

Suh, T.-H., Hsia, C.-Y., & Chang, W.-C. (1942). Fuquan jingmai zhushe dui chixu jingluanzheng zhiliao zhi texiao (Treatment of epileptic status with intravenous injection of paraldehyde). *China Medical Journal, 28*(12), 411–419.

Suzuki, A. (2003). The state, family, and the insane in Japan, 1900-1945. In R. Porter & D. Wright (Eds.), *The confinement of the insane: International perspectives, 1800–1965* (pp. 193–225). Cambridge: Cambridge University press.

Szto, P. P. (2002). *The accommodation of insanity in Canton, China: 1857–1935* (PhD dissertation). University of Pennsylvania.

Tomes, N. (2008). The development of clinical psychology, social work, and psychiatric nursing: 1900-1980s. In E. R. Wallace & J. Gach (Eds.), *History of psychiatry and medical psychology* (pp. 657–682). New York: Springer.

Wang, W.-B. (1920). Fengrenyuan zhi chongyao yu beiyi (The importance and benefits of asylums for the insane). *Guangji Yibao (Guangji Medical Journal), 5*(1), 9–12.

Wang, W.-J. (2006). "Dangxia weiren zhi daren": Dai Bingham de suren jingshen fenxi ("This all-important job of being human at the present": Bingham Dai's lay psychoanalysis). *Xinshixue (New History), 17*(1), 91–142.

Wang, W.-J. (2011). Xinli de "xiaceng gongzuo": Xifeng yukan yu 1930–40 niandai dazhong xinli weisheng lunshu (*West Wind Monthly* and the mental hygiene discourse in Republican China). *Keji, yiliao yu shehui (Taiwanese Journal for Studies of Science, Technology and Medicine), 13*, 15–88.

Wang, W.-J. (2016). Neurasthenia and the rise of psy disciplines in Republican China. *East Asian Science, Technology and Society: An International Journal, 10*(2), 141–160.

Wang, W.-J. (2017a). Hanfen yu shanghai jingshen weisheng (Fanny G. Halpern and mental hygiene in Shanghai). In G. Pan (Ed.), *Laihua youtai nanmin huibian. Juansan: Jiechu renshi (Compilation of Jewish refugees in China. Volume 3: Distinguished figures)* (pp. 42–56). Shanghai: Shanghai Jiao Tung University Press.

Wang, W.-J. (2017b). Fengkuang, jigou yu minguo shehui (Madness, institutions and society in Republican China). In S.-Y. Liu & W.-J. Wang (Eds.), *Dongya yiliaoshi: Zhimin, xingbie yu xiandaixing (A history of healing in East Asia: Colonialism, gender and modernity)* (pp. 77–98). Taipei: Linking Publishing.

Wang, W.-J. (2019). An international teamwork: Mental hygiene in Shanghai in the 1930s and 1940s. *History of Psychology, 22*, 289. https://doi.org/10.1037/hop0000078.

Wang, W.-J., & Huang, H.-Y. (2019). Mental health. In H. Chiang (Ed.), *The making of the human sciences in China: Historical and conceptual foundations* (pp. 460–488). Leiden and Boston: Brill.

Wei, Y.-L. (1936). Duiwu jingshenbingren ying zhuyi de shixiang (Notes concerning mental patients). *Weisheng yue kan (Hygiene Monthly), 2*(1), 4–6.

Westbrook, C. H. (1953). Psychiatry and mental hygiene in Shanghai. *American Journal of Psychiatry, 110*(4), 301–306.

Woods, A. H. (1920). *Peking Union Medical College and the problem of insanity in China*. Rockefeller Foundation Archives, Collection CMB, Record Group IV2B9, Box 96, Folder 689.

Woods, A. H. (1921). The menace of insanity to popular government. *The National Medical Journal, 7*(4), 201–206.

Woods, A. H. (1923). A memorandum to Chinese medical students on the medico-legal aspects of insanity. *The National Medical Journal, 9*(3), 203–212.

Woods, A. H. (1929). The nervous diseases of the Chinese. *Archives of Neurology and Psychiatry, 21*(3), 542–570.

Wu, H. Y.-J. (2019). Psychiatry. In H. Chiang (Ed.), *The making of the human sciences in China: Historical and conceptual foundations* (pp. 489–509). Leiden and Boston: Brill.

Wu, H. Y.-J., & Cheng, A. T.-A. (2017). A history of mental healthcare in Taiwan. In H. Minas & M. Lewis (Eds.), *Mental health in Asia and the Pacific: Historical and cultural perspectives* (pp. 107–121). New York: Springer.

Xu, T.-Y. (1995). Woguo xiandai jingshenbingxiao fazhan shi (A history of modern psychiatry in our country). *Zhonghua shenjing jingshen ke zazhi (Chinese Journal of Neurology and Psychiatry), 28*(3), 168–176.

Yang, J. (2017). *Mental health in China: Change, tradition, and therapeutic governance*. Cambridge: Polity.

Yoo, T. J. (2016). *It's madness: The politics of mental health in colonial Korea*. Berkeley: University of California Press.

Zhen, C. (2008). *Andrew H. Woods in China and the United States: A medical history study at the Rockefeller Archive Center*. https://rockarch.issuelab.org/resources/30962/30962.pdf. Accessed 10 July 2019.

Zheng, F. (2019). In the name of psy-disciplines: The development of mental hygiene in Republican China. In I. Lyubchenko & F. A. Papps (Eds.), *Schizo: The liberatory potential of madness* (pp. 101–111). Leiden: Brill.

Chapter 4
Mental Health and Psychiatry During the Maoist Era: 1949–1976

Zhipeng Gao

Abstract This chapter reviews China's mental health and psychiatry during the Maoist Era between 1949 and 1976. First, it introduces major historical events, including the massive expansion of psychiatric provision after the founding of the People's Republic of China in 1949, the 1958 mental health conference, and the Cultural Revolution (1966–1976). Second, on epidemiology, it presents the general characteristics of mental illness in China, with emphasis given to schizophrenia and neurasthenia. Third, with regard to institutionalized treatment, it covers the hospitalization of mental patients, Western and Soviet theraputic approaches, and the unique speedy synthetic therapy. Fourth, it explains mental health in Chinese cultural perspectives, including how traditional Chinese medicine understood mental illness and several culture-bound syndromes. Finally, it features how China's socialist movement influenced the population's mental health and gave rise to a unique therapy based on political indoctrination, as well as the political abuse of psychiatry. Overall, this chapter suggests that socialist China's approaches to mental illness consisted of an amalgamation of four systems: traditional Chinese medicine, Western biomedical theories, Soviet influence, and political education.

Keywords China · Cultural Revolution · Mental health · Psychiatry · Socialism

Major Historical Developments

Professional Growth

The establishment of the People's Republic of China in 1949 had profound impact on psychiatry. While the exact numbers vary according to separate reports, there is no denial of the massive expansion of psychiatric services (Ho 1974; Koran 1972; Lazure 1964; Pearson 1995; Taipale and Taipale 1973). As of 1949, mental hospitals

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were available in four major cities only, hosting fewer than 100 psychiatrists to serve a 500 million population of the country (Cerny 1965; Ho 1974; Walsh 1978). This was a dire situation, given that estimates of severe mental illness varied from 1 in 1000 to 1 in 400 in China (Walsh 1978). Yet, by 1959, 60 new mental institutions had been built, while the number of psychiatric beds had increased from approximately 1000 to more than 11,000 (Ho 1974; Parry-Jones 1986). By 1959, there were at least 15 times the number of psychiatrists as in 1949 (Lazure 1964; Z. Wu 1959).

The increase of psychiatric care provision benefited from academic growth. The Institute of Psychology of the Chinese Academy of Sciences contained a Division of Medical Psychology, which provided much intellectual resource for psychiatric research (Brown 1980). In 1951, the Chinese Society for Neurology and Psychiatry was created. In 1955, this society inaugurated its journal, *Chinese Journal of Neurology and Psychiatry*. By 1960, all the 50 medical colleges had a department of psychiatry, and the number of teachers had increased tenfold since 1949 (Ho 1974; Lazure 1964). China's pharmaceutical plants were able to produce a variety of psychotropic drugs, including chlorpromazine, taractan, perphenazine, trifluoperazine, haloperidol, imipramine, phenelzine, chlordiazepoxide, and diazepam (Xia and Zhang 1987). Nonetheless, it should be pointed out that mental illness remained stigmatized and psychiatry had a low status within medicine (Kleinman and Mechanic 1981; Munro 2000). As of 1959, psychiatric beds represented only 4% of all hospital beds, which was significantly lower than the American case (Lazure 1964). Many job candidates avoided mental health care as a profession (Ho 1974).

Major Approaches to Mental Illness

Socialist China's approaches to mental illness generally consisted of an amalgamation of four systems, including traditional Chinese medicine (TCM), Western biomedical theories, Soviet influence, and political education, the priority of which shifted over time (Xia and Zhang 1987). Before 1949, Western theories, e.g., that of Adolf Meyer, were widely adopted in China (Cerny 1965). After 1949, the socialist state required psychiatrists to distance themselves from Western theories. For instance, psychoanalysis was rejected as a capitalist school that justified irrational, aggressive behaviors. Soviet theories, as reflected in Jiyalovski's book on psychiatry, became an alternative (Munro 2000; Xia and Zhang 1987). The most prominent theory, Pavlov's theory of higher nervous activity, suggested that mental disorder results from the impairment of the nervous system's function by physiological disease, environmental pressure, or disruption of the excitation and inhibition mechanisms of the nervous system (Chin and Chin 1969; Gao 2015). Pavlovian treatments accordingly consisted of behavior conditioning and sleep therapy. TCM was based on an alternative theory about *yin* and *yang* as well as five elements, offering a variety of treatment methods including acupuncture, herbal therapy, moxibustion, and physical exercises (Cheng 1970). Political education gained momentum in periods

of heightened class struggle, and it required the patients' active engagement in studying Mao Zedong Thought. As will be discussed toward the end of this chapter, political education consisted of humanistic aspects but also became abused at times.

The 1958 Conference

One of the most notable professional events was the National Conference for the Prevention and Treatment of Mental Disorder, held by the Ministry of Health in 1958. This conference took place amid a mass campaign called the "Great Leap Forward" (GLF, 1958–1962), which involved the use of mass mobilization campaign to achieve rapid progress on many fronts, including health care. Meanwhile, China was undergoing the Anti-Rightist Campaign (1957–1959), a renewed wave of oppression of political dissidents. The conference presented a *Draft Classification of Mental Disorder* in emulation of the Soviet system. More importantly, it defined a direction for psychiatry that would prioritize political and ideological factors over biological factors in mental illness. The conference also called for the strengthening of TCM (Ho 1974). In short, this conference significantly enhanced psychiatry's Chinese-socialist characteristics (Ho 1974). Organizationally, inspired by the "mass line" policy of the GLF, psychiatry exhorted the creation of a greater collectivist spirit between the psychiatrist and the patient, as well as among patients – as manifest in the development of group therapy. The GLF's emphasis on the rapid expansion of psychiatric care also led to mass epidemiological mental health surveys and the extension of mental health care to the countryside (Ho 1974).

The Cultural Revolution

After the GLF and a Great Famine that took possibly 45 million lives, the period commencing in the early 1960s was characterized by social recovery under milder policies. Meanwhile, as the Sino-Soviet relationship faltered, Chinese psychiatrists started to free themselves from the domination of Pavlov's theory (Xia and Zhang 1987). Western writings once again appeared in Chinese textbooks, most notably *Clinical Psychiatry* by Mayer-Gross, Slater, and Roth (Parry-Jones 1986). This period of relative peacefulness did not last for long. In 1966, the Cultural Revolution plunged China into great chaos by replacing normal productive, educational, and social activities with class struggle. With regard to psychiatry, it further radicalized the proposal made by the 1958 conference, giving political education and TCM predominant roles in the treatment of mental illness (Xia and Zhang 1987). Due to the widespread anti-Western and anti-Soviet sentiments, scientific psychiatry became marginalized and sometimes even superfluous (Ho 1974; Kao 1974, 1979; Munro 2000). The publication of *Chinese Journal of Neurology and Psychiatry* was suspended. Numerous psychiatric professionals were labeled as "bourgeois

academic authorities," fired from positions, or sent down to the countryside (Munro 2000, p. 34). Many even committed suicide due to political persecution (Love 2016). Following directives on health care by Mao Zedong in 1965, previous village health workers were institutionalized to become part of the "barefoot doctor" program, where members of rural and remote communities received basic medical training that lasted between three and six months only. The program was integrated into national health policy in 1968. With limited expertise, the vast number of barefoot doctors staffed health clinics in factories and communes in remote areas of the country, delivering health care to dispersed residents (Koran 1972; Leung et al. 1978; Walls et al. 1975). The program was abolished in 1981, leaving rural and remote communities with less access to basic health care.

Epidemiology

General Characteristics

According to estimates made by the 1958 conference, 1–2 per thousand Chinese suffered psychiatric abnormalities; about 200,000 individuals required institutionalized treatment; from 1950 to 1958, over 73,150 individuals had been admitted to mental hospitals; and over 63,280 had been discharged with improvement or complete recovery (Ho 1974). The overall prevalence of mental disorders among the Chinese has been reported to be lower than that in other societies (Brown 1980; Lee and Kleinman 1997; T.-Y. Lin 1985; Phillips 1998), although the reported rates could have been underestimated due to social and cultural factors (Kleinman and Mechanic 1981). The morbidity rates with respect to major psychoses were roughly the same as those in Western societies (Kleinman and Mechanic 1981). In terms of age characteristics, there were very few children or elders being hospitalized (Kraft and Swift 1979; Lazure 1964), possibly because they were mostly taken care of at home (Lazure 1964; Parry-Jones 1986).

The most frequently recognized mental illness was schizophrenia (Leung et al. 1978). A second prominent disorder, neurasthenia, warrants particular attention because it bore particular Chinese characteristics. These two conditions will be discussed shortly. Hysteria and obsessive neurosis, psychoses associated with organic brain problems, psychopathic personality, and mental retardation were much less common (Koran 1972). Depressive illness and obsessive-compulsive neuroses were rare (T.-Y. Lin 1985).

One of the most notable phenomena was the very low prevalence of alcohol, drug addiction, and venereal diseases (Kao 1979; Leung et al. 1978; Ratnavale 1973; Xia and Zhang 1987). This has often been attributed to China's new political atmosphere, including legal actions, against the associated behaviors (Kao 1979; Phillips 1998). Drug addiction decreased from several million people to barely any (Walsh 1978; Xia and Zhang 1987). There were very few cases of psychosexual problems,

possibly due to the Chinese controlled attitudes toward sexuality (Yan 1985). Before 1949, the syphilis-induced mental disorder dementia paralytica accounted for 10–15% of psychiatric inpatients; by the end of the 1950s, the rate had dropped to less than 1% (Xia and Zhang 1987). According to one report, alcoholism accounted for only 0.75% of admissions (Walsh 1978). Although the low rate of alcoholism has been sometimes attributed to China's political climate, the fact that low rates were also found in Taiwan and Hong Kong invites alternative culturally based explanations (K.-M. Lin and Kleinman 1981; T.-Y. Lin 1985).

Schizophrenia

In various reports, from 50% to 83.7% of patients admitted to mental hospitals in China suffered from schizophrenia (Lazure 1964; Leung et al. 1978; Walls et al. 1975; Walsh 1978). The prevalence of schizophrenia was approximately 1.9 per thousand, which stood in the lower range of reported cases from other societies (K.-M. Lin and Kleinman 1981; T.-Y. Lin 1985). While the onset of the condition usually occurred during adolescence and young adulthood, the suffering population generally was aged between 20 and 50 years (Leung et al. 1978; K.-M. Lin and Kleinman 1981). The prevalence of schizophrenia was reported to be as low as approximately 1 per thousand, which was only one tenth of the estimated rates in the West (Taipale and Taipale 1973). In hospitals, patients were treated with chlorpromazine, insulin coma therapy, ETC, acupuncture, and herbs (T.-Y. Lin 1985; Walls et al. 1975). After an average length of hospitalization between 70 and 90 days (Walsh 1978), the relapse rate of schizophrenia was high (Xia 1985).

Neurasthenia

In China, neurasthenia, or "nervous exhaustion", manifested in insomnia, headache, pains, irritability, mental fatigue, poor concentration, and poor memory (Koran 1972; Yan 1985). Its occurrence was attributed to overwork, psychological trauma, and interpersonal conflicts, and its physiological mechanism was thought to involve the disturbance of higher cortical functions (Chin and Chin 1969; W.-J. Wang 2019). It was the second most frequent disorder in China, comprising as high as 16.4% of psychiatric hospitalization (C. Y. Wang and Tuan 1957) and 40–60% of general medicine outpatient visits (Chin and Chin 1969; W.-J. Wang 2019). The most susceptible population consisted of students, officials, and "brainworkers," especially those in their late adolescence and early adulthood (Chin and Chin 1969; W.-J. Wang 2019, p. 2). One report indicates that as high as 10–15% of students at Peking University and Peking Medical School suffered from neurasthenia (C. P. Li et al. 1958). The prevalence of neurasthenia was such as to lead to a national campaign to overcome neurasthenia in the late 1950s and the 1960s (W.-J. Wang 2019). The

pervasiveness of neurasthenia was not confined to clinical settings; it became part of everyday vocabulary for ordinary individuals to label themselves or others (Yan 1985).

According to Kleinman (1982, 1986), the fact that neurasthenia as a diagnostic category had fallen out of fashion in the West should not be read to be indicative of China being slow in medical modernization. The prominence of this nerve-based category in China can be partially attributed to Pavlov's emphasis on the neurological basis of mental function (W.-J. Wang 2019). Further, Kleinman proposed that neurasthenia should be viewed as a bioculturally patterned illness experience, a form of somatization contingent on culturally sanctioned idioms of distress and psychosocial coping. While Chinese individuals vigilantly avoid common mental illness labels because of the stigma attached, neurasthenia was an exception that was even claimed by Mao Zedong (Kleinman 1986). This exceptionalism was enforced by the popular TCM notion that weakness in vital essence naturally leads to impaired mental functions. There was a cultural consensus that neurasthenia patients deserved support from family and friends, should be released from work, and exonerated for academic and career failures. In China's generally rigid socialist system, neurasthenia was a condition that provided individuals with rare leverage in dealing with difficult social circumstances (Kleinman 1986; Kleinman and Mechanic 1981).

Institutionalized Treatments

Hospitalization

According to records, patients were largely admitted through the request of families and co-workers, who persuaded the patients into compliance (Ho 1974; Leung et al. 1978; Walls et al. 1975). Compulsory admission was relatively rare (Brown 1980; Parry-Jones 1986; Walsh 1978). The average length of hospitalization was 70–120 days (Ho 1974; Leung et al. 1978; Sidel 1972; Walls et al. 1975). However, it would be problematic to draw on admission records only, for that would miss individuals who did not register in the hospital system. The stigma attached to mental illness might have prevented individuals with mental illness from seeking help (Kleinman and Mechanic 1981). China's families, communes, and production units sometimes provided social support to individuals with mental malfunction and thus reduced the use of hospital services (Kleinman and Mechanic 1981). Meanwhile, it was difficult for people with mental illness to seek relief from work for hospitalization (Kleinman 1982). During the Cultural Revolution, the healthcare system was decentralized so that many patients received treatment at home under the care of barefoot doctors, which situation again would not be represented by hospital admission records. Once patients were discharged, they were usually

taken care of by families and the workplace, which offered strong support to facilitate recovery (Ho 1974; T.-Y. Lin 1985).

Western and Soviet Approaches

Western approaches applied in China generally consisted of psychopharmacology and physically or behaviorally based therapies. Common drugs included chlorpromazine, perphenazine, imipramine, lithium, hydroxyzine, and diazepam (Chin and Chin 1969; Ho 1974; Leung et al. 1978). Various tranquilizers were applied (Cerny 1965). Psychosurgery, especially prefrontal lobotomy, was applied between 1949 and 1955 but banned afterwards, because it was seen from the Soviet perspective to contradict the theory of "conditioned reflex" of the Pavlov school (Cerny 1965; Munro 2000). Soviet-imported ECT and insulin coma therapy were commonly used in China till the mid-1960s (Cerny 1965; Munro 2000). Under the Soviet influence, China widely applied artificial hibernation therapy, which involved the creation of a prolonged state of drug-induced deep sleep. A milder version of this treatment was known as sleep therapy (Cerny 1965; Chin and Chin 1969; Leung et al. 1978; Munro 2002).

Speedy Synthetic Therapy

One notable phenomenon was the infrequent use of psychotherapy for most of the 1950s. Psychotherapy was not widely practiced until the GLF, when it was integrated with other forms of treatment to result in what was called speedy synthetic therapy (Chin and Chin 1969; Ho 1974; Kao 1979; Taipale and Taipale 1973). Invented to treat neurasthenia, speedy synthenic therapy spread across the country following reports of remarkably high recovery rates (W.-J. Wang 2019). It was popularly claimed that the treatment took merely between two and three weeks to complete. This emphasis on efficiency was characteristic of the spirit of the GLF. Besides being "speedy," this technique was also "synthetic" as it combined psychotherapy, electric shock, psychiatric medication, herbal medicine, acupuncture, physical exercise, and group-based political study. In other words, it was an amalgamation of Western, Soviet, traditional Chinese, and political approaches (Kao 1979; Koran 1972; W.-J. Wang 2019). The following two sections will provide more details on TCM approaches and politically oriented therapies respectively.

Mental Health Through a Chinese Cultural Lens

Traditional Chinese Medical Approaches

Traditional Chinese medicine was guided by a holistic understanding of human-and-nature, as well as mind-and-body. In this theoretical system, *yin* and *yang* embrace two antonymous groups of phenomena that permeate the universe and the human body. *Yin* indicates earth, the right side, softness, weakness, rest, darkness, back, implicitness, cold, sinking, wetness, and the female; *yang* indicates heaven, the left side, firmness, movement, light, front, explicitness, heat, floating, dryness, and the male (Cheng 1970; Rin 1965). Health, including mental health, requires balance between *yin* and *yang*. Guided by the holistic view, TCM theory also understood five major emotions to correspond to five internal organs (which were seen to be both biological and metaphysical): happiness is associated with the heart, anger with the liver, worry with the lung, fear with the kidney, and overthinking with the spleen. Excess and incongruence of the emotions can affect the balanced functions of the internal organs, and vice versa. Thus, TCM considered both physiologically based therapy and emotion regulation to be important approaches to mental disorder.

Because TCM understood mind-body in a dynamic process of balance maintenance, it gave great emphasis to the prevention of illness. This focus on prevention was reflected in socialist China's mental health policies, which stemmed from a utopian ambition and economic concerns (Ho 1974; Leung et al. 1978). When it came to the treatment of mental illness, TCM offered several treatment approaches, such as acupuncture, herbal therapy, moxibustion, massage, and physical exercises (Cheng 1970). For example, the purpose of acupuncture was to remove stagnation and to facilitate the flow of *yin* and *yang* forces along the 12 meridians in the body (Cheng 1970). There were also modern innovations, such as that acupuncture was sometimes applied along with electric stimulation (Leung et al. 1978). TCM appeared to be particularly effective in relieving psychosomatic symptoms and minor neurotic disturbances in the early phases (Taipale and Taipale 1973).

Culture-Bound Syndromes

Similar to other societies, Chinese suffered mental disorders originating from interpersonal conflicts, poor parenting styles, achievement problems, and so forth (X. Li 1985; Yan 1985). Yet there were some culture-specific features. The manifestation of mental disorders in China often took the form of somatization, a process in which psychological disturbances are experienced and expressed through somatic symptoms (Kleinman 1979; K.-M. Lin et al. 1981; T.-Y. Lin 1985; Tseng 1975; Yan 1985). Chinese also displayed several culture-bound syndromes, namely, mental disorders affected by cultural characteristics, behavioral norms, and social

conditions in a particular environment (K.-M. Lin et al. 1981). One of the most popular Chinese illness concepts, *shen-kui*, or kidney deficiency, was believed to be caused by the loss of vital essence reserved in the kidney (Wen and Wang 1981). Its mental manifestation included weakness, fatigue, insomnia, anxiety, and hypochondriasis (K.-M. Lin et al. 1981). Chinese patients who suffered "frigophobia" displayed a profound fear of coldness. They not only covered themselves with layers of clothes, stayed indoors with windows shut, but also eagerly consumed symbolically "hot" foods and avoided "cold" ones (Chang et al. 1975). This syndrome stemmed from a belief that one is suffering from imbalance between hot and cold in their bodies in TCM terms, and it was often associated with obsessive-compulsive personality disorders and hypochondriasis (Chang et al. 1975). *Xie-bing* (evil illness) refers to a form of trance state that consists of clouding of consciousness, tremor, disorientation, and hallucination (Kleinman 1979; Yan 1985). It was understood that one experiencing a *xie-bing* attack is possessed by an ancestor or relative, who is attempting to communicate with the family through the body of the patient (T. Lin 1953; Yap 1960). If the other culture-bound syndromes were mostly based on TCM, *xie-bing* belonged to a separate category of Chinese beliefs about mental illness, one that stemmed from folklore and mythology (Cheng 1970). Further, given the cultural context of *xie-bing*, it remains controversial whether *xie-bing* should be seen as a mental illness (K.-M. Lin et al. 1981).

Koro is probably the best-known Chinese culture-bound syndrom, usually found in China as well as several Southeast Asian countries. Koro is called *suo-yang* in Chinese, which means "shrinking penis." It refers to a state of acute anxiety caused by the belief that one's penis is retracting into the abdomen and that it might lead to death (Kleinman 1979; Rin 1965). This syndrome is associated with the Chinese belief that nocturnal emissions and habitual masturbation cause the loss of masculine essence stored in the genital (Rin 1965; Yap 1965). At the personal level, it was frequently related to confusion and anxiety about masculinity, masturbation, and marriage (Rin 1965). Koro was usually found among young men with the following characteristics: poor education, dependent personality, the lack of confidence in one's virility, and conflict over the expression of sexual impulses (Yap 1965).

The Social and Political Characteristics of Psychiatry

Political Approach to Mental Illness

China's socialist worldview was guided by a doctrine of dialectical materialism (Ho 1974; Walsh 1978), which was initially meant to overcome the opposition between two philosophical extremes: mechanistic materialism that favors the deterministic power of the physical world and idealism that prioritizes the power of human consciousness (Gao 2019b, 2020, 2021). Yet in reality, various social movements in China usually leaned towards idealism by glorifying human agency (Schram 1969).

Thus, during 1958 and the Cultural Revolution, much faith was placed in the patient's capacity of recovery (Ho 1974; Lazure 1964; Walsh 1978). This optimistic view of human malleability overrode deterministic assumptions found in biomedical treatment approaches (Gao 2019a; Ho 1974; Sidel 1973). The biomedical model located mental illness in the body and not the patient's thoughts and attitudes, so that, in China's revolutionary ethos, it was seen to risk "treating the illness, not the person" (Ho 1974, p. 625). Thus, insulin therapy and electric shock as well as biologically based research were largely abandoned (Ho 1974; Xia and Zhang 1987). The alternative sociopolitical therapeutic approach required the patients to actively and consciously solve problems in their thoughts, so that it would "treat the disease as well as the person" (W.-J. Wang 2019, p. 6).

Meanwhile, Chinese psychiatry incorporated a version of humanism. Guided by this humanism, the 1958 conference and the Cultural Revolution deemed certain existing forms of treatment, such as physical restriction and shock therapy, to be inhuman and thus to be prohibited (Ho 1974; Leung et al. 1978; Walls et al. 1975). Set free from the previous passive role, patients were now required to actively engage in various activities to achieve recovery. Some of the activities were physical in nature, such as bed making, cooking, gardening, and maintaining the hygiene of the wards (Ho 1974). According to one report, patients worked 6 hours a day (Lazure 1964). A note should be added here that productive labor was not merely a means of mental recovery; there were economic benefits in it as well (Ho 1974; Pearson 1995). In China's nation building, the issue of mental health was not just a matter of personal well-being. More significantly, whether a person could fully function in contributing to socialist construction was of paramount importance. Thus, mental patients were encouraged to view their recovery as a responsibility to the whole society (Sidel 1973; Taipale and Taipale 1973). They must recognize that they belonged to something larger than themselves, the revolution (Sidel 1973). Thus, even suicide for personal reasons was considered to be a betrayal of the revolution (Taipale and Taipale 1973).

A most notable feature of this political model of treatment was its attention to consciousness: it considered the primary cause of mental illness to lie in problematic thoughts and attitudes inherited from the past feudal society of China or from Western capitalism (Pearson 1995; Walsh 1978). Correspondingly, the politically-based treatment required patients to work on their consciousness (Sidel 1973; Taipale and Taipale 1973). In order to transform their thoughts, the patients were required to study Mao Zedong's writings, such as "Where Do Correct Ideals Come From" and "Serve the People" (Sidel 1973). Regular group-based discussions were required to make such study effective (Brown 1980; Ratnavale 1973). Besides studying together, patients were required to perform mutual criticism and self-criticism so that undesirable thoughts could be identified and removed (Brown 1980; Ho 1974; Leung et al. 1978). Meanwhile, patients were also encouraged to treat each other with care and support (Ho 1974; Sidel 1973). Physicians and nurses played the role of group discussion supervisors; they also performed "heart-to-heart talks" with the patients, a form of rapport-based conversation unique to Chinese culture, to explain the illnesses and how to manage them (Sidel 1973; Walsh 1978).

Political Abuse of Psychiatry

Although the new ideologically-based treatment contained positive humanistic elements, at times of political radicalization, psychiatry was used as an abusive tool to discredit political dissents and their causes as crazy (Appelbaum 2001). Psychiatry's close connection with consciousness and ideology paved the way for its abuse. According to a survey conducted at the Shanghai Municipal Mental Health Center, in 1970 and 1971, political cases accounted for 72.9% of the total admissions (Munro 2000). According to Munro (2000, 2002), there were three forms of psychiatric abuse. The first involved the underdiagnosis of mental illness, when individuals with genuine mental illness were held legally responsible for their uncontrollable political offences. The second refers to the opposite phenomenon, the excessive diagnosis of mental illness, which was often applied to dissidents who became diagnosed because their "absence of instinct for self-preservation" in their nonconformist behaviors appeared to be puzzling in the eyes of government officials and psychiatric authorities (p. 26). A third type involved deliberate withdrawal of psychiatric provision from mentally ill prisoners (Munro 2002). The volatility of psychiatric abuse stemmed from China's unstable political situation. As Munro (2000) vividly illustrates, in the early 1960s, a group of individuals was sent to mental hospital for criticizing the policies of President Liu Shaoqi, and they suffered ECT and insulin therapy as punishment. In 1967, however, when Liu was attacked by Mao as China's "number one capitalist roader," these individuals were released from mental hospitals and even received honorary titles. The political abuse of psychiatry also originated from local social networks. In these cases, psychiatry was rendered a tool, sometimes used to discipline powerless individuals and other times to exonerate senior cadres who might otherwise be persecuted (Munro 2000).

China's political climate also directly affected the population's mental condition. The pressure for individuals to submerge their personal ambitions in favor of social conformity in the interests of the masses often led to emotional conflict and maladjustment (Leung et al. 1978). To individuals who suffered directly from class struggles, the stifling political atmosphere proved to be a source of mental disturbance (Lee and Kleinman 1997). For example, one patient acquired obsessive neurosis after having splashed ink on a newspaper portrait of Chairman Mao, driven by the fear that his mistake might lead to severe punishment (Yan 1985). The violence and repression of the Cultural Revolution led to various embodied mental issues, such as dizziness, exhaustion, and pain (Kleinman and Kleinman 1994). Many political dissidents developed mental disorder during imprisonment (Munro 2000). Some even acquired "prison psychosis," namely, they started believing that they had indeed committed towering crimes against the people such as conspiracy, espionage, and political subversion (Munro 2000).

Conclusion

This chapter reviews mental health and psychiatry in Maoist China between 1949 and 1976. This era is divided into three periods. From 1949 to 1959, China massively expanded its psychiatric provision and actively imported Soviet approaches to psychiatry. Besides all the apparent accomplishments, one should be reminded that the lack of funding and personnel in the psychiatric profession persisted (Phillips 1998). The political criticism of psychology as a bourgeois science also extended to psychiatry (Phillips 1998). The 1958 conference was a watershed event. Taking place amid the Great Leap Forward and the Anti-Rightist Campaign, this conference was an early instance of creating a Chinese socialist approach to psychiatry. Between 1960 and 1965, China experienced a period of relative stability and waning Soviet influence. The Cultural Revolution between 1966 and 1976 further radicalized the 1958 proposal; it sanctioned political indoctrination as a major psychiatric approach and led to the abuse of psychiatry. In each period, psychiatric practice was heavily influenced by China's socialist movement. For example, the nationwide concern with neurasthenia was largely due to the loss of productivity caused by the illness, and this situation was particularly undesirable in a time when high social function was valued (W.-J. Wang 2019).

Regarding mental health, this chapter reviews the general epidemiology as well as specific mental illnesses, including schizophrenia, neurasthenia, and several culture-bound syndroms. Regarding psychiatry, this chapter suggests that socialist China's psychiatric approaches were defined by an amalgamation of four systems: Western biomedical approaches, Soviet treatments centering around Pavlov's theory of higher nervous activity, traditional Chinese medicine, and a political approach that emphasized thought transformation. Despite reports of success, the effectiveness of these disparate treatment methods is hard to ascertain (T.-Y. Lin 1985; Sidel 1973).

It must be noted that the data this chapter draws on are not completely reliable (Kleinman and Mechanic 1981; T.-Y. Lin 1985; Pearson 1995). Statistics and reports produced in socialist China were subject to distortion under political pressure. The GLF, for instance, led to a staggering famine, while exaggerated and patently false reports of agricultural productivity continued to be produced (Dikötter 2010). While suicides during the Cultural Revolution were commonplace, they were hidden from foreign scholars visiting China and thus excluded from their reports (Taipale and Taipale 1973). Observations made by Western scholars visiting China were confined to institutions and events designated by Chinese officials (Kleinman and Mechanic 1981). Although humanistic treatment was often reported (Walls et al. 1975), Kleinman and Mechanic (1981) observed locked patients during a visit. While reports are mostly based on several institutions in Beijing and Shanghai, great variation existed at other locales, especially regions distant from the political centers (Allodi and Dukszta 1978; T.-Y. Lin 1985; Yip 2005).

After the death of Mao Zedong in 1976, China eventually exited the Cultural Revolution. Psychiatric training, research, and practice according to Western

scientific standards became revitalized. The Chinese Society of Neurology and Psychiatry and its journal were restored. International exchanges increased rapidly (Xia and Zhang 1987). However, to a certain degree, the political abuse of psychiatry remains alive today, as seen in the persecution of the religious group Falun Gong (Munro 2000, 2002) and in the cases of "manufactured mentally ill," in which individuals were subjected to unnecessary psychiatric treatment (H. Y.-J. Wu 2016).

References

Allodi, F., & Dukszta, J. (1978). Psychiatric services in China: Or, Mao versus Freud. *The Canadian Journal of Psychiatry, 23*(6), 361–371.

Appelbaum, P. S. (2001). Law & psychiatry: Abuses of law and psychiatry in China. *Psychiatric Services, 52*(10), 1297–1298.

Brown, L. B. (1980). A psychologist's perspective on psychiatry in China. *Australian & New Zealand Journal of Psychiatry, 14*(1), 21–35.

Cerny, J. (1965). Chinese psychiatry. *International Journal of Psychiatry, 1*, 229–247.

Chang, Y.-H., Rin, H., & Chen, C.-C. (1975). Frigophobia: A report of five cases. *Bulletin of Chinese Society of Neurology and Psychiatry, 1*(2), 9–13.

Cheng, J. C. C. (1970). Psychiatry in traditional Chinese medicine. *Canadian Psychiatric Association Journal, 15*(4), 399–401.

Chin, R., & Chin, A. S. (1969). *Psychological research in communist China, 1949–1966*. Cambridge, MA: The MIT Press.

Dikötter, F. (2010). *Mao's great famine: The history of China's most devastating catastrophe, 1958–1962*. New York: Walker & Co.

Gao, Z. (2015). Pavlovianism in China: Politics and differentiation across scientific disciplines in the Maoist era. *History of Science, 53*(1), 57–85.

Gao, Z. (2019a). Forging Marxist psychology in China's Cold War geopolitics, 1949–1965. *History of Psychology, 22*(4), 309–332.

Gao, Z. (2019b). Psychology. In H. Chiang (Ed.), *The making of the human sciences in China: Historical and conceptual foundations* (pp 283–302). Leiden: Brill.

Gao, Z. (2020). From empirical observation to social intervention: The Marxization of psychology in China, 1949–1958. In W. Pickren & T. Teo (Eds.) Special issue "Re-envisioning general psychology". *Review of General Psychology, 24*(1), 43–59

Gao, Z. (2021, forthcoming). From student-centered pedagogy to student labor: Chinese education's transnational entanglement with the Cold War. In M. Solovey & C. Daye (Eds.), *Cold war social and behavioral sciences: International and transnational entanglements*. New York: Palgrave Macmillan.

Ho, D. Y. (1974). Prevention and treatment of mental illness in the People's Republic of China. *American Journal of Orthopsychiatry, 44*(4), 620–636.

Kao, J. J. (1974). Psychiatry in the People's Republic of China: A prospectus. *The American Journal of Chinese Medicine, 2*(04), 441–444.

Kao, J. J. (1979). *Three millennia of Chinese psychiatry*. New York: Institute for Advanced Research in Asian Science and Medicine.

Kleinman, A. (1979). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. Berkeley: University of California Press.

Kleinman, A. (1982). Neurasthenia and depression: A study of somatization and culture in China. *Culture, Medicine and Psychiatry, 6*(2), 117–190.

Kleinman, A. (1986). *Social origins of distress and disease: Depression, neurasthenia, and pain in modern China*. London: Yale University Press.

Kleinman, A., & Kleinman, J. (1994). How bodies remember: Social memory and bodily experience of criticism, resistance, and delegitimation following China's cultural revolution. *New Literary History, 25*(3), 707–723.
Kleinman, A., & Mechanic, D. (1981). Mental illness and psychosocial aspects of medical problems in China. In A. Kleinman & T.-Y. Lin (Eds.), *Normal and abnormal behavior in Chinese culture* (pp. 331–356). Dordrecht: D. Reidel.
Koran, L. M. (1972). Psychiatry in mainland China: History and recent status. *American Journal of Psychiatry, 128*(8), 970–978.
Kraft, A. M., & Swift, S. S. (1979). Impressions of Chinese psychiatry December 1978. *Psychiatric Quarterly, 51*(2), 83–91.
Lazure, D. (1964). Politics and mental health in new China. *American Journal of Orthopsychiatry, 34*(5), 925.
Lee, S., & Kleinman, A. (1997). Mental illness and social change in China. *Harvard Review of Psychiatry, 5*(1), 43–46.
Leung, S. M., Miller, M. H., & Leung, S. W. (1978). Chinese approach to mental health service. *The Canadian Journal of Psychiatry, 23*(6), 354–360.
Li, X. (1985). The effect of family on the mental health of the Chinese people. In W.-S. Tseng & D. Y. H. Wu (Eds.), *Chinese culture and mental health* (pp. 85–93). New York: Academic Press.
Li, C. P., Li, T. S., et al. (1958). Accelerated treatment of neurasthenia. *Chinese Journal of Neurology and Psychiatry, 4*(5), 351–356.
Lin, T. (1953). A study of the incidence of mental disorder in Chinese and other cultures. *Psychiatry, 16*(4), 313–336.
Lin, T.-Y. (1985). Mental disorders and psychiatry in Chinese culture: Characteristic features and major issues. In W.-S. Wu & D. Y. H. Wu (Eds.), *Chinese culture and mental health* (pp. 369–393). New York: Academic Press.
Lin, K.-M., & Kleinman, A. (1981). Recent development of psychiatric epidemiology in China. *Culture, Medicine and Psychiatry, 5*(2), 135–143.
Lin, K.-M., Kleinman, A., & Lin, T.-Y. (1981). Overview of mental disorders in Chinese cultures: Review of epidemiological and clinical studies. In A. Kleinman & T.-Y. Lin (Eds.), *Normal and abnormal behavior in Chinese culture* (pp. 237–272). Dordrecht: D. Reidel.
Love, S. (2016, December 13). My grandparents survived the cultural revolution: Have I inherited their trauma? *The Independent*. Retrieved from https://www.independent.co.uk/news/world/asia/cultural-revolution-grandparents-trauma-dna-genes-a7465411.html.
Munro, R. (2000). Judicial psychiatry in China and its political abuses. *Columbia Journal of Asian Law, 14*, 1–128.
Munro, R. (2002). *Dangerous minds: Political psychiatry in China today and its origins in the Mao era*. New York: Human Rights Watch and Geneva Initiative on Psychiatry.
Parry-Jones, W. L. (1986). Psychiatry in the People's Republic of China. *The British Journal of Psychiatry, 148*(6), 632–641.
Pearson, V. (1995). *Mental health care in China: State policies, professional services and family responsibilities*. London: Gaskell.
Phillips, M. R. (1998). The transformation of China's mental health services. *The China Journal, 39*, 1–36.
Ratnavale, D. N. (1973). Psychiatry in Shanghai, China: Observations in 1973. *American Journal of Psychiatry, 130*(10), 1082–1087.
Rin, H. (1965). A study of the aetiology of Koro in respect to the Chinese concept of illness. *International Journal of Social Psychiatry, 11*(1), 7–13.
Schram, S. R. (1969). *The political thought of Mao Tse-tung*. New York: Praeger.
Sidel, R. (1972). Mental diseases and their treatment. In J. R. Quinn (Ed.), *Medicine and public health in the People's Republic of China* (pp. 289–305). Bethesda: National Institutes of Health.
Sidel, R. (1973). The role of revolutionary optimism in the treatment of mental illness in the People's Republic of China. *American Journal of Orthopsychiatry, 43*(5), 732–736.
Taipale, V., & Taipale, I. (1973). Chinese psychiatry: A visit to a Chinese mental hospital. *Archives of General Psychiatry, 29*(3), 313–316.

Tseng, W.-S. (1975). The nature of somatic complaints among psychiatric patients: The Chinese case. *Comprehensive Psychiatry, 16*(3), 237–245.

Walls, P. D., Walls, L. H., & Langsley, D. G. (1975). Psychiatric training and practice in the People's Republic of China. *The American Journal of Psychiatry, 132*(2), 121–128.

Walsh, N. (1978). Psychiatry in the People's Republic of China. *Psychiatric Annals, 8*(6), 42–63.

Wang, W.-J. (2019). Neurasthenia, psy sciences and the "great leap forward" in Maoist China. *History of Psychiatry, 30*(4), 443.

Wang, C. Y., & Tuan, S. C. (1957). Clinical statistic analysis of the hospitalized patients of the psychiatric hospital of Peking Medical School in four year period. *Chinese Journal of Neurology and Psychiatry, 3*(2), 162–170.

Wen, J.-K., & Wang, C.-L. (1981). Shen-k'uei syndrome: A culture-specific sexual neurosis in Taiwan. In A. Kleinman & T.-Y. Lin (Eds.), *Normal and abnormal behavior in Chinese culture* (pp. 357–369). Dordrecht: D. Reidel.

Wu, Z. (1959). The achievement in psychiatry in our country in the last decade. *Chinese Journal of Neurology and Psychiatry, 5*, 286–293.

Wu, H. Y.-J. (2016). The moral career of "outmates": Towards a history of manufactured mental disorders in post-socialist China. *Medical History, 60*(1), 87–104.

Xia, Z. (1985). The mental health delivery system in Shanghai. In W.-S. Tseng & D. Y. H. Wu (Eds.), *Chinese culture and mental health* (pp. 341–356). New York: Academic Press.

Xia, Z., & Zhang, M. (1987). History and present status of psychiatry in China. *International Journal of Mental Health, 16*(3), 22–29.

Yan, H. (1985). Some psychological problems manifested by neurotic patients: Shanghai examples. In W.-S. Tseng & D. Y. H. Wu (Eds.), *Chinese culture and mental health* (pp. 325–337). New York: Academic Press.

Yap, P. M. (1960). The possession syndrome: A comparison of Hong Kong and French findings. *Journal of Mental Science, 106*(442), 114–137.

Yap, P. M. (1965). Koro—A culture-bound depersonalization syndrome. *The British Journal of Psychiatry, 111*(470), 43–50.

Yip, K.-S. (2005). An historical review of the mental health services in the People's Republic of China. *International Journal of Social Psychiatry, 51*(2), 106–118.

Chapter 5
Psychiatry and Mental Health in Post-reform China

Hsuan-Ying Huang

Abstract Forty years of economic reform in China has made the once staunchly socialist country into an economic and military superpower. The same period also witnesses a drastic transformation of the mental health landscape. Based on relevant literature and my ethnographic research, this article offers an overview of the development of psychiatry and mental health services in post-reform China. It begins with the two decades between the launch of economic reform in the late 1970s and the inception of what later became the mental health reform at the turn of the century. This is a period in which the development of mental health services, despite the reorientation of psychiatry toward the West and the restoration of international exchange, remained slow and neglected by the state. Then I describe the two parallel developments that occurred during the first decade of the 2000s: the state-led reform of the public psychiatric system and the market-driven "psycho-boom" that developed outside the system. The former expanded the infrastructure serving and managing people with severe mental illness, and the latter catered to the urban middle class bothered by common mental disorders or piqued by the desire to know themselves better. The last section examines the content and implications of the Mental Health Law that came into effect in 2013, before ending with a brief discussion on recent initiatives and the challenges that the country is still facing in Xi Jinping's "new era."

Keywords Post-reform China · History of psychiatry · Mental health reform · Psycho-boom

This article delineates the development of psychiatry and mental health services in China's post-reform period, the four decades during which the country has recovered from the ruins of the Cultural Revolution, devised its development strategy of mixing marketization with political control, and turned into the second greatest

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economy in the world. Based on relevant literature and my ethnographic research, it is divided into four sections arranged in chronological order. The first section deals with the two decades between the launch of economic reform in the late 1970s and the inception of what later became the mental health reform at the turn of the century. This period witnessed the reorientation of psychiatry in China toward the West and the restoration of international exchange, yet the development of mental health services remained slow due to insufficient state commitment and funding. The second and the third sections both tackle the first decade of the 2000s, which laid the groundwork for the massive transformations in recent history. They respectively focus on state-led reform that targeted the system of public psychiatry and the "psycho-boom" that developed outside the system, driven by market forces. These two trends followed parallel courses: the former expanded the infrastructure serving and managing people with severe mental illness, while the latter catered to the urban middle class bothered by common mental disorders or piqued by the desire to know themselves better. The fourth section examines a landmark in China's mental health reform—the promulgation of the Mental Health Law in 2013. Besides assessing the implications of the law, I discuss a number of recent initiatives and end with the challenges that the country is facing in Xi Jinping's "new era."

From Rehabilitation to Crisis

After Deng Xiaoping came to power and initiated the "Reform and Opening" policy in 1978, Chinese psychiatry resumed its clinical and academic activities. The elite psychiatrists who had survived political persecution or rural exile during the Cultural Revolution returned to positions of leadership, and communication with the West began again. The World Health Organization (WHO) played a critical role in this so-called "joining tracks" (*jiegui*) process, assisting Chinese psychiatrists to catch up with postwar developments in the outside world (Lin 1985). During the 1980s, the WHO held a series of training courses in China, and the Institute of Mental Health (affiliated with the Beijing Medical University), the Shanghai Mental Health Center, and the Nanjing Brain Hospital became WHO collaborating centers. These eminent institutions, along with major training centers such as the psychiatry departments of the Hunan Medical University (formerly the Yale-in-China Medical College) in Changsha and the West China Medical University in Chengdu, formed the core of the discipline.

The most important achievements of the 1980s included an indigenous diagnostic system and the first national epidemiological study. The system, later known as the Chinese Classification of Mental Disorders (CCMD), was first published in 1979 and had notable differences from its Western counterparts like the ICD and DSM (Lee 1996). Operationalized criteria were not adopted until its second version (CCMD-II), which appeared in 1989. In 1982, a large-scale survey commonly known as the "twelve-region study" was conducted under the coordination of Shen Yucun, Director of the Institute of Mental Health. The study (Cooper et al. 1996) revealed a very low prevalence rate of mental disorders (3.3%) and a distinct

picture: neurasthenia, an obsolete diagnosis in its birthplace of the United States, was the most common (1.3%), while schizophrenia ranked second (0.47%) and was much more prevalent than anxiety disorders and mood disorders, including affective psychosis and depression.

This unusual profile—the high rate of neurasthenia and low rate of depression—led to Arthur Kleinman's classic study (Kleinman 1986) in Hunan. Kleinman argued that neurasthenia, a disease that typically manifested in somatic symptoms, functioned as a culturally and politically sanctioned conduit for people to express their suffering, much of which was incurred during the Cultural Revolution (see also Kleinman and Kleinman 1994). Yet in China the study was misunderstood as questioning psychiatrists' ability to recognize depression—this was true when seen from an American-centric perspective, as in those days in China the diagnostic label referred narrowly to melancholia. Despite the controversy, Chinese psychiatrists gradually accepted the Euro-American conception, and depression became a rather common diagnosis in the 1990s; concurrently, neurasthenia was on the wane (Lee 1999). The Chinese diagnostic system also moved closer to international standards in its subsequent editions, namely, CCMD-II-R (1995) and CCMD-III (2001).

At that time, Chinese psychiatry was mostly based in asylums and focused on major mental disorders, most commonly psychoses. Most of the diagnoses of neurasthenia—and later depression—were therefore not made in psychiatric settings. Mental institutions were staffed only with doctors and nurses; psychologists and social workers did not exist, as these two professions were revoked after the founding of the People's Republic. There were, however, some efforts being made to introduce a broader, interdisciplinary conception of mental health, and in 1985 the China Association of Mental Health was established. Psychiatrists took the lead in this organization, which also included psychologists and social scientists, forming an arena for developing various psychosocial approaches including psychosomatic medicine and psychotherapy. After some time, its influence began to rival that of the Chinese Association of Neurology and Psychiatry (an independent Chinese Psychiatric Association was formed after its split in 1994).

Although the small batch of elite institutions had made significant advances in international collaboration and research, the general condition of China's mental health system remained bleak during this period, despite some preliminary efforts by the state in the direction of policy planning. For example, the drafting of the Mental Health Law began in 1985 under the guidance of WHO experts. The second national meeting on mental health work was convened in Shanghai in 1986, and the following year a major policy directive, *Opinions on Strengthening Mental Health Work*, was issued by the three Ministries responsible for mental health: Health, Civic Affairs, and Public Security. Subsequently, the China Disabled Persons' Federation became the fourth official agency to get involved. In the early 1990s, an ambitious plan for building community-based services was proposed. These initiatives, however, proved no better than empty promises as the most essential problem—funding—was never solved (Pearson 2014). In fact, since the beginning of the economic reform, the state had withdrawn its investments on healthcare. Psychiatry, as a marginalized specialty, suffered the most, particularly because the government's

primary concern lay in the control of potential threats to the social order rather than the treatment and rehabilitation of mental illness.

Through the 1990s and into the 2000s, researchers from overseas began to make known the crisis in China's mental health system. Veronica Pearson (1995) and Michael Phillips (1998) painted a grim picture in their assessments: diminished funding, lack of personnel and training, crumbling facilities, and the pervasive stigmatization of mental illness. China was also discovered to have one of the highest suicide rates in the world, notwithstanding the low rate of depression, while its suicide demographics challenged established knowledge: rates were higher in rural areas and among the female population, with rural women being a particularly vulnerable group, among whom pesticide ingestion was the most common method (Phillips et al. 2002). These findings stimulated scholars to explore the cultural and moral meanings of suicide as well as its connections with continuing social problems and rapid social change (Ji et al. 2000; Lee and Kleinman 2003; Phillips et al. 1999).

Formation of the Public Mental Health Reform

The decade of the 2000s was the formative period for the large-scale mental health reform that has now entered its second decade (Li et al. 2014; Liu et al. 2011; Ma et al. 2009; Wong et al. 2014). Partly driven by the global mental health movement, at the turn of the century the Chinese state started to think seriously about how to improve its mental health system. In 1999, the WHO held a high-level conference in Beijing as part of its "Nations for Mental Health" campaign. At this historic conference, the Vice Minister of Health, Yin (2000), cited the World Bank and WHO's "Global Burden of Disease" study to indicate the gravity of China's mental health issues: mental disorders had become the most important cause of disease burden, yet the country had only about 13,000 psychiatrists and 110,000 psychiatric beds, figures respectively equivalent to and lower than the medians of lower-middle-income countries. In 2001, the third national meeting on mental health work was convened in Beijing. After that, two influential policy directives, the *National Mental Health Plan* (2002–2010) and the *Guiding Opinions on Further Strengthening Mental Health Work*, were issued in 2002 and 2004.

The *National Plan* and the *Proposal* guided the rebuilding of the mental health system during the 2000s. Both documents identified the system as being state-led with cross-sectional collaboration within the government and participation on the part of society. They put forward a sweeping range of goals including interventions for "key populations" (children, women, the elderly, and disaster survivors), treatment and rehabilitation of mental illness, personnel training, and capacity building, among other initiatives. The *Proposal* went further to stress the importance of community-based services and the responsibilities of local governments. On top of the four official agencies that were traditionally involved with mental health, three

Ministries—Education, Justice, and Finance—co-signed the document. This signaled the formation of a broader base of support within the state.

The reform arrived at the right time. After the 2003 SARS epidemic, the Chinese state was determined to undertake an overhaul of its public health system, which had suffered from years of underinvestment. In 2004, the "Management and Treatment of Severe Mental Illnesses" project, commonly known as the "686 project" (named after the initial funding of 6.86 million *yuan*), became the only noncommunicable disease program included in the larger reform—a highly symbolic act that marked the incorporation of mental health into public health (Liu et al. 2011). The project was led by the Institute of Mental Health (now affiliated with the Peking University), with the University of Melbourne and the Chinese University of Hong Kong assisting in personnel training. It began in 2005 with 60 demonstration sites that covered a population of 42.9 million. In each site, a network was formed that brought together medical personnel from specialized and community hospitals as well as nonmedical staff from local-level organizations in neighborhoods and villages. The exact measures varied from site to site, but in general the project managed to identify patients who were often hidden at home and have them assessed, registered, and properly treated.

According to the four-province study conducted between 2001 and 2005 (Phillips et al. 2009), only about 60% of patients with psychotic disorders ever sought psychiatric help, and in many cases treatment was far from regular. The "686 project" enhanced access to care, especially in rural areas and the western part of China where resources were scarce, and was scaled up after a 3-year trial; its coverage reached 30% of the country's population in 2011 (Ma 2012), and by 2014 it had expanded to most of the country, with the number of registered patients reaching 4.29 million. Media coverage of the project highlighted the unlocking of patients who were chained by their families at home—a moral act reminiscent of Philippe Pinel's freeing of the insane at Salpêtrière. As Good and Good (2012) noted, the program absorbed progressive ideals like rehabilitation and recovery and adopted a special strategy that suited local realities, sending multifunctional teams into communities rather than training primary care providers to treat mental problems (c.f. Liang et al. 2018). Apart from its humanitarian success, the project had from the beginning appealed to the state's long-term interest in social control by prioritizing patients presenting a risk of violence; the database that registered millions of patients could become part of the state's surveillance system.

There were other notable developments besides the "686 project." During the 2000s, six cities, all located in the affluent coastal regions, produced Mental Health Ordinances, although the impetus for legislation at the national level had decelerated. In 2006, the State Council established an inter-ministerial joint committee on mental health, which was composed of 17 ministries and commissions and served as the decision-making body at the top level. In 2008, another influential policy directive, *Guiding Compendium on Developing the National Mental Health Work System* (2008–2015), was issued. While reiterating the key points of previous policies, it asked governments at all levels to devise plans for strengthening mental health systems. Treatment for psychoses was still the primary concern, but the

document also called for psychiatric units, which were still not common, to be built in general hospitals. In the following years, the state invested heavily in renovating, expanding, and constructing psychiatric facilities. Between 2006 and 2010, the number of psychiatric beds saw a significant increase (from 123,000 to 228,000 or from 1.12 to 1.71 per population of 10,000), so did that of psychiatric facilities (Ma et al. 2012). The growth of psychiatric personnel was slower; this would be tackled strenuously in the following decade.

Psycho-Boom: A Parallel Development

The first decade of the twenty-first century witnessed the dawning of a prosperous age and a rapid expansion of the middle class in Chinese cities. Meanwhile, with public mental health reform underway, an equally vast and far-reaching development was unfolding outside the system of public psychiatry. The subject of this trend was Western-style psychotherapy, a treatment modality that had been repudiated in the Maoist era and then considered too luxurious to afford during the earlier post-reform period. This so-called psycho-boom (Huang 2014; Yang 2015; Zhang 2014) involved not only the surge of interest in psychotherapy training and practice but also the dissemination of related ideas and values into the broader culture. Mainly an urban phenomenon, it was most prominent in major cities like Beijing and Shanghai, where tens of thousands of people participated in various training programs and hundreds of private psychotherapy clinics suddenly emerged.

The psycho-boom was largely driven by market forces, although state policy also played a decisive role. In 2002, the Ministry of Labor and Social Security—historically not related to mental health—added "psychological counselor" to its National Vocational Qualification. The bar for certification was low: no prior background in psychology or medicine was needed, and the required training, even when taken part-time, was shorter than half a year. The certificates were issued by the state, but training programs were mostly offered by private agencies. These companies formed an industry that supplied all kinds of short-term training programs, and those featuring psychoanalysis were particularly well received (Chang et al. 2005; Huang 2015). A craze for training emerged in the following years, during which "the psychological" gained much salience. In 2004, the state-run China Central Television launched a daily program "Psychological Interviews" (*xinli fangtan*) that presented in-studio psychotherapy sessions. In 2006, the Communist Party incorporated the notion of "psychological harmony" into its ideology of "constructing a harmonious society." Concurrently, ideas associated with Western psychology became ubiquitous in popular culture as the middle class and the younger generation embraced an individualistic attitude.

The psycho-boom escalated after 2008, benefiting from the state's campaign to promote psychological interventions for the survivors of the Wenchuan earthquake. In 2011, the number of people who acquired the certification reached 300,000 (by then the Ministry of Human Resources and Social Security had replaced the Ministry

of Labor and Social Security). Since the certificate was not a license approved by the Ministry of Health, those certified could not enter the medical system. Remaining outside it, they could take advantage of the regulatory vacuum and practice privately. While the proportion of those who actually went into practice was low—10% at most—it might have been enough to outnumber the country's 20,000 psychiatrists circa 2010.

Towards the end of the decade, China's mental health landscape had become clearly bifurcated (Wang and Huang 2019). On one side was the system of public psychiatry focusing on psychoses, in which psychologists and social workers barely existed. Pharmacological treatment was the norm—in fact, psychiatrists in China were quite resistant to psychotherapy due to the socialist legacy and the dominance of biological psychiatry. On the other side was a new sector composed of private practitioners who claimed the specialty of talk therapy, served a wealthier clientele, and covered common mental disorders and other minor issues. Because of the institutional divide and the vastly different training and working experiences, these two sectors were disconnected from each other. Communication between them was rare, and referrals from one side to the other were complicated and, in many cases, not feasible.

The impacts of the psycho-boom went far beyond the new sector it created. The majority of those who received training never pursued practice; for them, training was more like a hobby or a meaningful social activity, a means to gain mental health knowledge or to make friends who shared an interest in psychology or the inner life. Some were psychologically distressed at the time and approached it as a form of self-help. In this regard, the training craze resembled popular healing movements such as the encounter groups, the human potential movement, and new age spiritualities in the West, or the "*qigong* fever" in earlier post-reform China (Huang 2014, 2018). As psychotherapy was associated with positive qualities like Western values, science, and urban lifestyles, it helped to reduce the stigma of mental illness, especially of common mental disorders—an issue with which psychiatry, with its emphasis on psychoses, continued to wrestle.

The Mental Health Law and Its Aftermath

The public mental health reforms culminated in the enactment of the Mental Health Law in May 2013. This was a hard-won milestone, as drafting the law dated back to 1985 and had encountered numerous difficulties (Xiang et al. 2012). It incorporated a number of reformist principles—including a broader conception of mental health that covered the treatment of mental illness and the promotion of psychological well-being, the ideal of community-based services, and the protection of patients' rights—and affirmed the state's responsibility for the provision of care (see Chen et al. 2012 for an English translation). During the early 2010s, as China transitioned from the Hu-Wen era into Xi Jinping's "new era," mental health issues received an unprecedented amount of attention, one reason for which was the release of the draft

law for public comment by the state in 2011. At the same time, the appalling results of the four-province study (Phillips et al. 2009)—173 million adults in China suffered from mental disorders (prevalence rate, 17.5%), and 158 million (92%) among them had never received any professional help—were frequently cited by the media, which fostered perceptions of a mental health crisis.

The final phase of legislation saw a public debate surrounding the so-called *bei jingshenbing* (literally "being mentally-illed") phenomenon. This neologism was coined around 2010 when cases of forced admission of self-proclaimed sane people appeared on the Internet, many of which were associated with the abuse of psychiatry by bureaucrats or family members (Wu 2016). In 2010, a Shenzhen-based NGO "Equity and Justice Initiative" published a report that accused Chinese psychiatry of widespread human rights infringements (Huang et al. 2010), which was widely read within the country's budding civil society. The NGO played a vocal role in the debate, advocating a more idealistic stance in legislation and, for instance, requiring a court order instead of a psychiatrist's decision to determine involuntary admission—a mechanism deemed capable of offsetting psychiatric abuse. Elite psychiatrists considered critiques of the draft law to some extent, making the legislation a compromise "between international standards and the Chinese reality" (Xie et al. 2011). Eventually, the law required that psychiatric treatment be voluntary in principle, although people with a severe mental disorder who were judged to be at risk of self-harm or harming others could be involuntarily admitted. When the risk only involved self-harm, legal guardians, who were almost always family members, could make the decision, an arrangement that reflected the enduring significance of family care for the mentally ill in China (Phillips et al. 2013; see also Ma 2014).

A similarly intense debate occurred within the psycho-boom. Since the law implied a strictly medical definition of psychotherapy, and given the upcoming state regulation, private practitioners—most of whom had entered the field through the system of certification for psychological counselors—panicked, while elite psychiatrists and psychologists grasped this opportunity to promote their new agenda of professionalization (Huang 2018). Ultimately, the law proved to have little effect on private practice, but the controversy did produce consensus on the turn to professionalization both within and beyond the medical system. Within psychiatry, the leaders of the still underdeveloped subfield of psychosomatic medicine began to promote psychotherapy as a core competence for psychiatrists and to advocate the need to bring other types of professionals, including psychologists and social workers, into the mental health system (Zhao 2014). Some of them further proposed to invigorate the humanistic spirit that had long been eclipsed by biological and material determinism in the history of Chinese psychiatry (Zhao et al. 2017).

In 2015, the state issued the *National Mental Health Plan (2015–2020)*, a key policy directive that would shape the post-Mental Health Law development. The *National Plan* set very specific goals: China would have 40,000 psychiatrists by 2020, and the number of psychiatrists per population of 100,000 would reach 3.8 and 2.8, respectively, in the eastern and western parts of the country—well above the average in upper-middle-income countries. Between 2010 and 2015, the number of psychiatrists increased from around 20,000 to over 30,000 (2.19 per population

of 100,000), while during the same period the number of psychiatric beds almost doubled from 228,000 to 433,000 (Shi et al. 2019). It was felt that the objective would most likely be achieved, partly because the state had encouraged doctors from other fields to transfer to psychiatry. In addition, the *National Plan* pledged to improve the community-based services system for major psychoses, which had been spearheaded by the "686 project." Specifically, it aimed to broaden the coverage of specialized care at the county/district level and to add rehabilitation to the existing services.

The *National Plan* also dwelled on common mental disorders and the training of a professional workforce (including psychotherapists and social workers). Besides depression and anxiety disorders, autism and dementia were highlighted. In 2014, the state launched a system of standardized residency training for all medical specialties. Training was divided into two steps: the first 3 years included a substantial amount of general medical training, while the following 2–4 years (2 in the case of psychiatry) were focused on the chosen specialty. Before this, psychiatric training—as well as other kinds of specialist training—had been chaotic in China; medical centers in major cities had a two-track system composed of graduate degree and residency programs, while in less developed areas training might not take place at all. The introduction of residency training for medical graduates would assure the competence of future psychiatrists.

Psychological well-being and psychosocial care constituted another focal point of the *National Plan*. After the Mental Health Law was implemented, the psychoboom continued to thrive in the cities: 1.3 million people had attained certification as psychological counselors by 2018, when the system was discontinued. The private practice scene was blossoming as young professionals and women flocked to therapy. The field attracted a fair amount of venture capital in the startup frenzy that emerged around 2015; digital platforms soon acquired profound influence over the market and the related professions (Huang 2017). Yet, at about the time market values seemed to have prevailed, in 2018 the state issued a highly publicized policy directive, *Guiding Opinions on Strengthening Psychological Health Services*. The document proposed to develop psychological services across a spectrum of sectors, including the formal mental health system and the private practice sector, as well as in the education, penitentiary, and social services systems. Recently, the state has begun to recruit demonstration site proposals for a new "social psychological services system." Little is known about this new system, but a large part of it seems to be about instilling psychological or therapeutic elements into community work, which accords with the rise of the therapeutic mode of governing envisioned by anthropologists Jie Yang (2015, 2018) and Li Zhang (2017).

Epilogue: Challenges and Prospects

In early 2019, the results of the China Mental Health Survey (Huang et al. 2019) were released. The overall prevalence rate of mental disorders is 16.6%, slightly lower than the four-province study but several times higher than the last national survey, the 12-region study conducted in the early 1980s. The study provides essential data for the future development of psychiatry and mental health services as the state continues to introduce new policies and to push the frontiers of mental health reform. After 15 years of reform, the once decrepit mental health system has seen significant improvement, making basic psychiatric care, which was a luxury for most of the history of modern China, available to ordinary people (Baum 2017). The state, with a strong political will and massive resources at its disposal, is the driving force behind the leapfrogging development that has distinguished China globally as a successful case in mental health development. However, the country is still facing many old and new challenges: the disparity in mental health resources between urban and rural areas and the eastern and western parts of the country is glaring. Psychiatry is far from a popular specialty for medical graduates; attracting young talent continues to be difficult. The introduction of psychologists and social workers into the system is at an early stage and needs to be amplified. While the quantity of personnel and facilities has increased, the quality of care and professionalization have not been addressed adequately. Last but not least, the NGOs and human rights groups that played a vital role in advocacy during the late Hu-Wen period are now suppressed owing to the Xi administration's tightening of political and social control. There is a long way to go before China can pride itself on a modern, high-quality, and accessible mental health system.

References

Baum, E. (2017). Chinese psychiatric welfare in historical perspective. In B. Carrillo, J. Hood, & P. Kadetz (Eds.), *Handbook of welfare in China* (pp. 64–78). London: Edward Elgar Publishing.

Chang, D. F., Tong, H., Shi, Q., & Zeng, Q. (2005). Letting a hundred flowers bloom: Counseling and psychotherapy in the People's Republic of China. *Journal of Mental Health Counseling, 27*(2), 104–116.

Chen, H. H., Phillips, M. R., Cheng, H., Chen, Q. Q., Chen, X. D., Fralick, D., et al. (2012). Mental health law of the People's Republic of China (English translation with annotations). *Shanghai Archives of Psychiatry, 24*(6), 305–321.

Cooper, J. E., Satorius, N., & Shen, Y.-t. (1996). *Mental disorders in China: Results of the National Epidemiological Survey in 12 areas*. London: Gaskell.

Good, B., & Good, M.-J. D. (2012). Significance of the 686 program for China and for global mental health. *Shanghai Archives of Psychiatry, 24*(3), 175–177.

Huang, H.-Y. (2014). The emergence of the psycho-boom in contemporary urban China. In H. Chiang (Ed.), *Psychiatry and Chinese history* (pp. 183–204). London: Pickering & Chatto.

Huang, H.-Y. (2015). From psychotherapy to psycho-boom: A historical overview of psychotherapy in China. *Psychoanalysis and Psychotherapy in China, 1*(1), 1–30.

Huang, H.-Y. (2017). Therapy made easy: E-commerce and infrastructure in China's psycho-boom. *China Perspectives*, (2017/4), 29–38.

Huang, H.-Y. (2018). Untamed Jianghu or emerging profession: Diagnosing the psycho-boom amid China's mental health legislation. *Culture, Medicine, and Psychiatry, 42*(2), 371–400.

Huang, Y., Wang, Y., Wang, H., Liu, Z., Yu, X., Yan, J., et al. (2019). Prevalence of mental disorders in China: A cross-sectional epidemiological study. *Lancet Psychiatry, 6*(3), 211–224.

Huang, X., Liu, X., & Liu, J. (2010). *The involuntary commitment system of China: A critical analysis*. Shenzhen: Equity and Justice Initiative.

Ji, J., Kleinman, A., & Becker, A. (2000). Suicide in contemporary China: A review of China's distinctive suicide demographics in their sociocultural context. *Harvard Review of Psychiatry, 9*(1), 1–12.

Kleinman, A. (1986). *Social origins of distress and disease: Depression, neurasthenia, and pain in modern China*. New Haven and London: Yale University Press.

Kleinman, A., & Kleinman, J. (1994). How bodies remember: Social memory and bodily experience of criticism, resistance, and delegitimization following China's cultural revolution. *New Literary History, 25*(3), 707–723.

Li, K., Sun, X., Zhang, Y., Shi, G., & Kolstad, A. (2014). Mental health Care in China: Review on the delivery and policy issues in 1949–2009 and the outlook for the next decade. *Acta Neuropsychiatrica, 26*(3), 134–145.

Liu, J., Ma, H., He, Y.-L., Xie, B., Xu, Y.-F., Tang, H.-Y., et al. (2011). Mental health system in China: History, recent service reform and future challenges. *World Psychiatry, 10*(3), 210–216.

Lee, S. (1996). Cultures in psychiatric nosology: The CCMD-2-R and international classification of mental disorders. *Culture, Medicine and Psychiatry, 20*(4), 421–472.

Lee, S. (1999). Diagnosis postponed: Shenjing Shuairuo and the transformation of psychiatry in post-Mao China. *Culture, Medicine, and Psychiatry, 23*(3), 349–380.

Lee, S., & Kleinman, A. (2003). Suicide as resistance in Chinese society. In E. Perry & M. Selden (Eds.), *Chinese society: Change, conflict, and resistance* (Second ed., pp. 289–311). New York: RoutledgeCurzon.

Liang, D., Mays, V. M., & Hwang, W.-C. (2018). Integrated mental health services in China: Challenges and planning for the future. *Health Policy and Planning, 33*(1), 107–122.

Lin, T.-Y. (1985). The shaping of Chinese psychiatry in the context of politics and public health. In T.-Y. Lin & L. Eisenberg (Eds.), *Mental health planning for one billion people: A Chinese perspective* (pp. 3–41). Vancouver: University of British Columbia Press.

Ma, H. (2012). Integration of hospital and community services – The "686" project – Is a crucial composition in the reform of China's mental health services. *Shanghai Archives of Psychiatry, 24*(3), 172–174.

Ma, H., Liu, J., & Yu, X. (2009). Interpreting the Most important mental health policies of the last decade. *China Mental Health Journal, 23*(12), 840–843. (In Chinese).

Ma, N., Yan, J., Ma, H., Yu, X., & Guo, Y. (2012). Allocation of mental health facilities and psychiatric beds in China. *China Mental Health Journal, 26*(12), 885–889. (In Chinese).

Ma, Z. (2014). Intimate life politics: Family duties and mental health legislation. *Thinking, 40*(3), 42–49. (In Chinese).

Pearson, V. (1995). *Mental health Care in China: State policies, professional services and family responsibilities*. London: Gaskell.

Pearson, V. (2014). The development of psychiatric services in China: Christianity, communism, and community. In B. Andrews & M. B. Bullock (Eds.), *Medical transitions in twentieth century China* (pp. 146–170). Bloomington & Indianapolis: Indiana University Press.

Phillips, M. R. (1998). The transformation of China's mental health services. *The China Journal, 39*, 1–36.

Phillips, M. R., Liu, H., & Zhang, Y. (1999). Suicide and social change in China. *Culture, Medicine and Psychiatry, 23*(1), 25–50.

Phillips, M. R., Li, X., & Zhang, Y. (2002). Suicide rates in China, 1995–1999. *Lancet, 359*(9309), 835–840.

Phillips, M. R., Zhang, J., Shi, Q., Song, Z., Ding, Z., Pang, S., et al. (2009). Prevalence, treatment, and associated disability of mental disorders in four provinces in China during 2001–05: An epidemiological survey. *The Lancet, 373*(9680), 13–19.

Phillips, M. R., Chen, H., Diesfeld, K., Xie, B., Cheng, H. G., Mellsop, G., & Liu, X. (2013). China's new mental health law: Reframing involuntary treatment. *American Journal of Psychiatry, 170*(6), 588–591.

Shi, C., Ma, N., Wang, L., Yi, L., Wang, X., Zhang, W., et al. (2019). Study on mental health resources in China. *Chinese Journal of Health Policy, 12*(2), 51–57. (In Chinese).

Wang, W.-J., & Huang, H.-Y. (2019). Mental health. In H. Chiang (Ed.), *The making of the human sciences in China: Historical and conceptual foundations* (pp. 460–488). Leiden and Boston: Brill.

Wong, D. F. K., Zhuang, X. Y., Pan, J.-Y., & He, X. S. (2014). A critical review of mental health and mental health-related policies in China: More actions required. *International Journal of Social Welfare, 23*(2), 195–204.

Wu, H. Y.-J. (2016). The moral career of 'outmates': Towards a history of manufactured mental disorders in post-socialist China. *Medical History, 60*(1), 87–104.

Xiang, Y.-T., Yu, X., Ungvari, B. S., Lee, E. H., & Chiu, H. F. (2012). China's National Mental Health Law: A 26-year work in progress. *The Lancet, 379*(9818), 780–782.

Xie, B., Tang, H.-Y., & Ma, H. (2011). The gap between international standards and the Chinese reality in the mental health legislation: Views from the Chinese Society of Psychiatry. *China Mental Health Journal, 25*(10), 721–724. (In Chinese).

Yang, J. (2015). *Unknotting the heart: Unemployment and therapeutic Governance in China*. Ithaca; London: IPR Press, an imprint of Cornell University Press.

Yang, J. (2018). *Mental health in China: Change, tradition, and therapeutic governance*. Cambridge, UK: Polity Press.

Yin, D. (2000). The current situation and problems of China's mental health and their solutions. *China Mental Health Journal, 14*(1), 4–5. (In Chinese).

Zhang, L. (2014). Bentuhua: Culturing psychotherapy in postsocialist China. *Culture, Medicine and Psychiatry, 38*(2), 283–305.

Zhang, L. (2017). The rise of therapeutic governing in postsocialist China. *Medical Anthropology, 36*(1), 6–18.

Zhao, X. (2014). Opportunities and challenges for promoting psychotherapy in contemporary China. *Shanghai Archives of Psychiatry, 26*(3), 157–159.

Zhao, X., Liu, L., Hu, C., Chen, F., & Sun, X. (2017). Necessity and feasibility of improving mental health Services in China: A systematic qualitative review. *International Journal of Health Planning and Management, 32*(3), 363–371.

Chapter 6
From Means to Goal: A History of Mental Health in Hong Kong from 1850 to 1960

Harry Yi-Jui Wu

Abstract The British ruled Hong Kong as a colony from 1842, when China ceded Hong Kong Island after the First Opium War. The colonial territory was expanded to include the Kowloon Peninsula and, in a further treaty in 1989, Britain leased the New Territories for 99 years. Its developmental trajectory was therefore very different to that of mainland China. This chapter examines the history of development of thinking about and responding to mental illness and the establishment of mental health services, between 1850 and 1960. In the early years, responses to mental disorder were based on the needs of the port city, a growing commercial center, and a matter for exercise of colonial authority, rather than concern for the needs of people with mental illness. Persons with mental illness were seen as disturbing the efficient operation of the port city, with police and the magistrates playing a key role in the disposition of the "insane." In the 1920s and 1930s, psychiatric and psychological sciences were actively introduced into Hong Kong. After World War II began, there was active modernization of the mental health system, with a focus on the well-being of persons with mental illness. Many of the leading psychiatrists studied in the UK. Psychiatric and psychological professional bodies proliferated, psychiatry was included in the medical curriculum, new treatments were introduced, hospital facilities improved, and a phase of collaboration among psychiatric/psychological professionals, social workers, and welfare policymakers established the foundations for today's comprehensive mental health system.

Keywords Hong Kong · History of psychiatry · Asylum · Colonialism · Free port · Deportation and repatriation · Judicial system

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The history of psychiatry in Hong Kong has been narrated repeatedly in historical or clinical accounts, most of which adopt the institutional approach that differentiates the history of mental health into phases of different asylums and hospitals (Lo 2003; Zhai and Gao 2017). However, the fact is that the agenda related to mental health started far earlier than the efforts of institutionalization. These efforts have, however, less to do with psychiatry. In 1854, an ordinance implemented in Hong Kong marked the significance of mental health to the port city. The methods for managing mentally ill individuals were formed as early as the commencement of commercial activities roughly about a decade after the opening of the treaty port. These methods reveal the spirit of mental health work in the city, now branded by the government as "Asia's World City," as a means to ensure the operation of the city instead of as a goal in itself. The ordinance was one of the many bills controlling the "outcasts" of the colony. It was not until the post-World War II period that the methods for addressing mental health were finally augmented with modernized psychiatric and psychological sciences, reworking itself to become a pursuit in the policy that served the dwellers' well-being.

If we put Hong Kong in the context of port governmentality and the economy of migration, mental health would mean something very different from what it meant in the colony. In the port city on the margin of the British and Chinese empires, all aspects of migration were linked to the worldwide chain of business, and services were commoditized (McKeown 2001). On the one hand, Hong Kong's colonial nature facilitated the formation of a local Chinese business elite group. They became allies of Britain that helped establish Hong Kong as a commercial center (Carroll 2005). On the other hand, it is sensible to say that anything meddling with the chain would be regarded as subjects to be cast away from the port-city.

On August 26, 1854, George Whittington Caine of the British Consular Service in Hong Kong published in the Government Gazette the Queen's confirmation of Ordinance No. 2 entitled "An Ordinance to Invest Her Majesty's Consuls in the Ports in China with Jurisdiction over the Persons and Property of Lunatics and Persons of Unsound Mind, as also with the Power inherent in the Office of Coroner" (The Hong Kong Government Gazette 1854). This ordinance ensured the daily functioning of Hong Kong and other treaty ports in China. In 1873, it was further regulated that insane individuals were not allowed to produce evidence at court (The Hong Kong Government Gazette 1873). During the second half of the nineteenth century, one could easily see individuals being declared insane in newspapers, meaning such problematic persons could no longer manage their own properties or on behalf of a company. During this time, insanity was used as a tactic to exploit someone's legal behavior mostly related to commercial activities, before it became something that could be diagnosed or treated.

Violent Sailors and Suicidal Chinese

In the second half of the nineteenth century, insanity was the culprit for the deviant behaviors that affected the soundness of the port. In Britain, large-scale asylums where the mad could be kept were already available in most counties. In its colony in East Asia, only one temporary asylum with a dozen beds was available to detain those who were charged with insanity because of violent or suicidal behaviors. It was built in 1875 for Europeans near the Hollywood Road Police Married Quarters. In around 1880, the temporary asylum was relocated to Hospital Road and became a wing of the Government Civil Hospital (Lo 2003). Those who were detained often came from the lower class in the society. The ways they ended up in temporary custody were largely similar. First, disturbing behaviors were observed by a watchman, an inspector, or a police officer. They would be brought to the police station, and then, without trial in court, the magistrate would decide whether to admit them to the asylum or send them back home. The high demand on the capacity of the magistrate reflected the judicial system in Hong Kong at the time, which tended to bypass court hearings or debate. Such an arrangement was for the convenience of maintaining social order. No psychiatric professionals testified to the behaviors or mental status of the charged. In most cases, medical opinions were only given as a formality. Because of the inadequate facilities to keep the insane, if no accommodation could be found at the Government Civil Hospital or Tung Wah Hospital, most of them ended up with a discharge after being remanded temporarily at the police station.

With the emergence of the asylum in Hong Kong, insanity was grouped mainly with suicide and other disturbing behaviors. However, it was the police force that dominated the deposition of "patients." For example, on 26 August 1877, a woman sitting on the Praya Central was found bleeding from the mouth. It was reported by Police Officer No. 541 that the self-mutilated woman was insane. She was brought to the Central Police Station and stayed there for 2 days before she was examined by the Colonial Surgeon (Hong Kong Daily Press 1877). In another example, in 1903, an Indian watchman out for a stroll saw a Chinese man jump into the harbor from the Praya at Wanchai. Taken to No. 2 Police Station, he said he was out of work and had had no "chow" for 2 days, which resulted in his suicidal behavior. By the magistrate's orders, he was placed under medical supervision, and the result of the detention was that he was not only declared to be a lunatic but also a leper. He was discharged immediately (Hong Kong Daily Press 1903).

Temporary Deposition of the Insane in Gaol and Tung Wah Hospital

In the mid-1870s, discussions began to envisage an asylum for the Chinese in Hong Kong similar to the proper amenities in England. These discussions in general discredited the backward Chinese ways of keeping the insane. In 1874, an opinion

piece in the Hong Kong Daily Press called for shifting attention from contagious diseases to insanity. The author, who used the pseudonym C, said "Contagious disease we are frightened of catching ourselves, and so we isolate it and supervise it, and build a lodge about it, and pass by on the other side; but as for hereditary disease we have nothing to do with it" (Hong Kong Daily Press 1874). Among these opinions was the view that Tung Wah Hospital was not an ideal institution to provide such custody. As C continued to note, "I am informed that some cells are being built at Tung Wa [sic] Hospital for the confinement of lunatics, but no one with any knowledge of the rational treatment of the insane" (Hong Kong Daily Press 1874). In a report written in 1893 Colonial Surgeon Phillip Ayres described his Tung Wah Hospital visit as follows: patients there were "confined in dark and dreary cells under Chinese native doctor's supervision and those who were violent were chained like wild beasts" (The Medical Department 1893).

In the late 1870s, several incidents highlighted conflicts between the Tung Wah Hospital's managing personnel and the magistrate, demonstrating their struggles concerning interpretative authority over lunatics. For example, in 1877, a boatman was charged with insanity and was sent to the Chinese Hospital before the scheduled court decision. However, the Acting Registrar General decided to allow the family to claim the patient and bring him home, resulting in the magistrate's discontent (Hong Kong Daily Press 1874). In 1878, another man was charged with being insane and a danger to the public. Instead of being sent to Tung Wah Hospital or due to the inadequate space, he was brought to stay in with the constable of the Government Civil Hospital to wait for the examination (The China Mail 1878). Apart from Tung Wah Hospital, some patients ended up in the Victoria Gaol if their cases were related to crime.

According to the Governor of Hong Kong, John Pope Hennessy, "it is perhaps unreasonable to suppose that [the current Lunatic Asylum] is intended to be used by Chinese as well as foreigners." Hennessy also reported that "I was astonished to see a man chained by a long chain to one of the inner gates and Mr. Tomlin cautioned me how I was to pass through the next little opening so as to avoid him." "He was chained because he was a lunatic and a violent one. There was another upstairs in one of the associated cells. He was a peaceable man, but a very talkative one, and he kept on talking the whole time." "There have been other cases of people confined in the prison as lunatics who never ought to have been inside its walls. Therefore, I propose to ask you for the sum of 5000 for a small lunatic asylum" (The China Mail 1878).

Reform of Tung Wah Hospital

It is worth noting that the outbreak of the bubonic plague in 1894 accelerated the reform of mental health services in Hong Kong, especially for the Chinese. With its failed handling of the treatment of plague patients during the plague epidemic, the question of whether to preserve or abolish Tung Wah Hospital was a heavily debated

issue. The horrible image of the lunatic cell was by chance revealed by journalists as well as in a report by John Mifford Atkinson, the Acting Colonial Surgeon. In the Hong Kong Telegraph, it was reported that in the "chamber of horrors" was "a stain on our boasted civilization." "The doors thrown wide open, a horrible sight presented itself to the spectator: lodged within thick hardwood boards, like ferocious wild animals in a menagerie" (Hong Kong Telegraph 1896). Immediately after the exposure through these articles in 1894, the colonial government redirected the power of government physicians and ordered the removal of mental patients from Tung Wah Hospital to the Government Civil Hospital. However, in Atkinson's 1896 report, he still indicated the continuing ill practice on mental healthcare despite government rules: "I found a man barricaded in one of the cells above the mortuary. It appears that this patient was admitted on the previous day, and as he seemed to be mad he was fastened up in his cell. This is contrary to all instructions" (Dr. Atkinson 1985).

Politics of Repatriation

Historians of psychiatry in China would not be unfamiliar with John G. Kerr's refuge for the insane in Canton. As a missionary project, it has been extensively written about in a number of accounts. However, its function went far beyond the honor of China's first psychiatric hospital and its charitable nature and the crossover between Eastern and Western psychiatric care (Szto 2014). On the one hand, it served as a doorway for missionaries to spread Christian tidings to all of China; on the other hand, it was a close and hidden corner convenient for the British colonial government to hide the city's outcasts. Before Hong Kong developed its full capacity to accommodate psychiatric patients, Kerr's refuge functioned as a temporary lodging for insane Chinese who were perhaps already used to never-ending removal.

In 1890, during the fifth Annual Meeting of the Medical Missionary Society, a proposal was adopted to look into the possibility of establishing an asylum for the insane in the Chinese Empire. The proposal was sent first to Chang Chih-tung, the Viceroy of the Two Guangs in the late Qing, but unfortunately fell on deaf ears. Kerr then insisted that the plan should be an international effort (The China Mail 1890). Opening its doors in 1892, the expansion of Kerr's refuge was related directly to the influx of inmates from Hong Kong, where the Chinese Lunatic Asylum coincidentally started to operate a year before (Li et al. 2017). In contrast to Tung Wah Hospital's "dungeon," it was "[a] large two-storey building, with wide verandahs and iron bars, looking out on a large lawn, and overlooking the grounds of the Civil Hospital. […] Each cell, with a heavy door and grating, was fitted with a comfortable bed, the large room being the dining room" (Whitehead 1896). In 1898, Kerr's refuge became China's first mental hospital, (Zhai and Gao 2017), while in Hong Kong, the first mental "hospital" was not established until 1906 after the implementation of the *Asylums Ordinance*. Victoria Hospital was a merger of the European and Chinese asylums, becoming part of the Government Hospital (Li et al. 2017).

With limited capacity to treat mental patients, Hong Kong's history of repatriation of patients is widely known: European patients in the Lunatic Asylum were repatriated to Britain; Chinese were instead repatriated "back" to Canton after John Kerr's refuge in Fong Tsuen was established. From 1894, the colonial government of Hong Kong began to negotiate a deal with Canton, hoping that the repatriation work among Hong Kong, Britain, and China could be connected seamlessly. Nonetheless, the asylum in Hong Kong and Kerr's refuge both suffered from the ceaseless problem of overcrowding and required further funds for expansion. Within the first decade after the opening of Kerr's refuge, about 1500 patients were admitted. Each year, around half of them "went away well," and the other half remained. In 1910, a large-scale call was made to establish more buildings, improve water quality, and renovate the interiors at the refuge (The China Mail 1910).

For Chinese, the map of repatriation routes was much larger than the distance between Hong Kong and Canton. In 1914, it was reported that 22 insane Chinese from the Oregon State Asylum for the Insane were brought from Seattle to Portland. From there, they were taken to Minnesota for deportation. The steamship sailed to Hong Kong. This deportation was the result of the negotiation between the Asylum Superintendent Senior with the Hong Kong colonial government that if the patient was expected to live for more than 10 years, they would be sent back to China (The Hong Kong Telegraph 1914). However, scarce documentation is available regarding their destiny after arriving in Hong Kong. In addition, not all residents in Hong Kong were convinced by these arrangements. For example, in 1910, responding to the fundraising campaign in Canton, an anonymous reader expressed discontent, asking "What has a lunatic asylum in Canton to do with us in Hong Kong?" (The Hong Kong Telegraph 1910). Such expressions foreshadowed the development of a self-contained and sustainable mental health structure in Hong Kong. The repatriation work stopped in 1941 during the wartime and was never resumed.

Criminal or Insane?

Before the full-fledged development of psychiatric institutions and a psychiatric profession in Hong Kong, insanity itself was a punishable social category. In those days, police stations or prisons were a legitimate space to remand insane individuals. In hindsight, some treatments appeared inhumane. For example, a prisoner who refused to speak and was suspected to be "psychological case" in the Victoria Gaol was treated with electricity and cold douche, making him shout and struggle (The Hong Kong Government Gazette 1979). With the formation of the psychiatric profession, differentiation between crime and insanity became possible, requiring different kinds of intervention. Such a developmental trajectory corroborates the thesis of this chapter that mental health works in Hong Kong had to be weaned gradually from their instrumentality over time.

In 1916, the land disputes between two village elders resulted in the counsel's suspicion concerning a murderer's mental status. An "insane" village elder was

accused of murdering his neighboring village's elder. The firm belief in "feng shui" caused the accused to kill those who invaded the land protected by the village deity. GN Orme of the Attorney General's Department questioned whether such beliefs could "create a feeling of depression and a feeling of irritability" (The China Mail 1916). The case was described by counsel as a Chinese parallel to Shakespeare's tragedy of Macbeth who committed an attack upon the Scottish King. However, in this context, the "Chinese regarded the ancestors of their family as a most sacred thought in their religious life and some of them might know that there was no curse more terrible to a Chinaman than the curse which suggested that this race or his family should be blotted out." In the end, after the chief justice reviewed the case, the jury returned a verdict of guilty with a recommendation of mercy on account of the village elder's age. Nevertheless, this incident revealed how, in early days, culture obscured the court's judgment on individuals' mental capacity, especially while the psychiatric profession still did not exist in Hong Kong.

In the 1920s and 1930s, criminal cases requiring psychiatric assessment proliferated, stimulating the development of forensic psychiatry. In 1930, the trial of Li Man-pun for the murder of five people at the Hung Tak Bank in the morning of May 24 attracted public attention on the role of psychiatric science in understanding the nature of aggression (The China Mail 1930a). Li, who had worked at the bank for 7 years, was alleged to have chopped five young people to death before wounding his own throat. He was treated at the Government Civil Hospital for 18 days before being taken to court. During the trial, despite the absence of psychiatric professionals, witnesses had to be called to clarify the person's mental capacity. In the records, he was never seen by people as having any "fits of depression." No one had seen him muttering or mumbling to himself. He was never called "San Kin Man (crazy man)" (The China Mail 1930b). The jury in the end found Li guilty.

It was only in the late 1950s when psychiatry began to play a critical role in assessing criminal cases. Both Pow-Meng Yap and Cho-Man Chung were psychiatrists commonly called to the bar to testify to the mental status of the accused (The China Mail 1956, The China Mail 1960b, The China Mail 1961). With the increasing need to detain criminals who were also mentally unstable, Hong Kong's government started to plan a special hospital for the treatment of the criminally insane (The China Mail 1960a). By 1960, the total psychiatric beds in Hong Kong were only 200 out of 6500 beds for all kinds of diseases. The Medical Department hoped to establish day hospitals and outpatient clinics first in Hong Kong and then in Kowloon. However, the most important development was Castle Peak Hospital in the New Territories which had the capacity to accommodate 1000 patients. At a Ladies' Day Luncheon at Rotary Club, Pow-Meng Yap explained to the media, "The lunatic often serves the function of a scapegoat for society. In the middle ages, they were burnt as witches. Today, they are regarded by some as possessed either by Satan or by a vengeful and evil ghost, and they may still be exorcised." "If by some turn of events, public attitudes change, then opportunities will soon be found for useful voluntary effort in the prevention and rehabilitation of mental disease" (The China Mail 1961).

Psychiatric Knowledge and Its Practicality

In Hong Kong, the development of mental health support, such as institutions, soon outgrew knowledge-based content. One of the reasons was the insignificant scale of institutionalization. Unlike asylums in Britain or state-sponsored hospitals in France, where the accumulation of cases became convenient for psychiatrists to observe, classify, and explain lunacy, the inadequate number of patients and, most importantly, trained psychiatrists resulted in no significant theories being formed in Hong Kong. However, a call for modern institutions that could accommodate insane individuals as patients arose.

In addition, despite Hong Kong being on the nexus of international trade, the city was unfortunately regarded as a "pitfall" among the global trend of mental hygiene movement, especially during the interwar period. In 1923, for example, it was reported that only two psychiatrists were working for a population in excess of three million and the suicide rate was 24.1/1000 persons (Kaplan 1959). Instead, the international mental hygiene movement had a greater impact in Canton. Not lagging behind the trend in the Anglo-American context, from 1919, Kerr's refuge held the annual Mental Hygiene Campaigns on Chinese New Year holidays, during which the hospital demonstrated the best methods for treating mental patients to Chinese crowds. In those days, while patients were still confined in wards, the door was open to visitors. Various forms of entertainment were also provided to better educate the public with knowledge of mental illnesses and raise funds to improve the hospital's facilities (Hong Kong Daily Press 1924).

In the 1920s and 1930s, knowledge related to psychiatric and psychological sciences was introduced actively to Hong Kong through periodicals, such as *The Caduceus*, the official journal of Hong Kong Medical Society. It was also during this period that the term "lunatic asylum" was substituted by "mental hospital" in official reports (Lo 2003). These reports emphasized the relevance of emerging theories with medicine. For example, M. O. Pfister introduced theories of psychopathology, psychotherapy, and hypnotism (Pfister 1927; Pfister 1929). Lindsey Ride, a professor of physiology, commented in 1935 on the analogical relationship between racial psychological differences, morphological characteristics, and inheritable genetic traits (Rider 1935). Quite extraordinarily, Sigmund Freud's dream interpretation and the concept of the unconscious were introduced by the British psychiatrist Alexander Cannon (1896–1963), who worked for the Government Medical Department of the University of Hong Kong and later became famous for his enthusiasm for alternative treatments learned while working in "China" (Cannon 1927). To what extent these theories were applied in actual clinical practice, however, requires further clarification.

After World War II, a new page of psychiatric science in Hong Kong was seen. The aforementioned Pow-Meng Yap, who was appointed as the government psychiatric specialist and superintendent of the Mental Hospital in High Street, took a great leap to modernize mental health services in Hong Kong. Born in Malaysia, Yap first read psychology before graduating from medicine at Cambridge. He was

trained to become a psychiatrist at Maudsley Hospital in London. He took the opportunity to renovate the facilities in the hospital and introduce new treatments, including the first-generation antipsychotics that proved effective in treating psychosis; electroconvulsive therapy, which was cost-effective; and several therapies no longer in use these days, such as insulin coma, lobotomy, and malaria therapy (Lo 2003). He also became the first Professor of Psychiatry at the University of Hong Kong. All of these events occurred before the abovementioned Castle Peak Hospital was established. Following Yap's footsteps, most psychiatrists in the early postwar period received training at Maudsley (Li et al. 2017).

Conclusion

In Hong Kong, the discourses related to mental health were developed for more than half a century before there were psychiatrists or psychiatric institutions. Unlike other colonies of either European or East Asian empires, theories and practices of colonial psychiatry were not well developed. As a free port, movement itself was a self-perpetuating source of profit and an interest to be defended (McKeown 2001). Thus, mental health was primarily a means for the colonial authority to maintain normal functioning of the port, especially in the matters of business. Many of the interventions were passive, sometimes merely practical management after crises. Movement itself, such as the matter of repatriation, became a legitimate mega plan that safeguarded the operation of the port.

After the 1960s, despite remaining a colony, Hong Kong gradually became a residential "city." The concept of Hong Kong citizens also emerged in contrast to their original identity as overseas Chinese. Mental health became an important factor that determined the well-being of residents in the port city. Psychiatric and psychological professional bodies and associations also proliferated. After the establishment of the Castle Peak Hospital, the infrastructure for psychiatric and psychological professions in Hong Kong became more complete. Mental health since then entered the phase of collaboration among psychiatric/psychological professionals, social workers, and welfare policymakers, requiring further analysis in a separate account. Mental health had also grown into a common pursuit for the various stakeholders in the still legendary international port.

References

Cannon, A. (1927). Mental mechanisms, dreams and their interpretation. *The Caduceus, 6*, 333–356.

Carroll, J. (2005). *Edge of Empires: Chinese Elites and British Colonials in Hong Kong*. Cambridge: Harvard University Press.

Dr. Atkinson, A. C. S. (1985). *In a letter dated 20th August 1895*. p. 1162.

Hong Kong Daily Press. (1874). *The treatment of the insane*. 13 November.

Hong Kong Daily Press. (1877). *Police court*. 26 August.
Hong Kong Daily Press. (1903). *A leper and insane*. 25 June.
Hong Kong Daily Press. (1924). *The John G Kerr Hospital for the Insane: Financial assistance urgently needed*. 18 January.
Hong Kong Telegraph. (1896). *The treatment of lunatics in of the*…. 13 June.
Kaplan, M. (1959). Rise in neuroses in Asia reported: Cultural conflicts with the west. *New York Times*. New York: 83.
Li, S. W., et al. (2017). *Oral history of psychiatry in Hong Kong after World War II*. Hong Kong: Joint Publishing (H.K.) Co. Ltd.
Lo, W. H. (2003). A century (1885–1985) of development of psychiatric services in Hong Kong – with special reference to personal experience. *Hong Kong J. Psychiatry, 13*(4), 21–29.
McKeown, A. (2001). *Chinese migrant networks and cultural change: Peru, Chicago, and Hawaii 1900–1936*. Chicago: Chicago University Press.
Pfister, M. O. (1927). The nervous and psychical element in disease. *The Caduceus, 6*, 60–72.
Pfister, M. O. (1929). Hypnotism and psychotherapy in medical practice. *The Caduceus, 8*, 12–29.
Rider, L. (1935). Human genetics and its relation to medical problems (Continued). *The Caduceus, 14*(3), 181–204.
Szto, P. (2014). *Psychiatric space and design antecedents: The John G. Kerr Refuge for the Insane. Psychiatry and Chinese History H. Chiang* (pp. 71–91). London: Pickering & Chatto.
The China Mail. (1878). *An unfortunate chinaman*. 13 September.
The China Mail. (1890). *An asylum for the insane*. 21 February.
The China Mail. (1910). *The John G. Kerr refuge for the insane*. 14 May.
The China Mail. (1916). *Murder trial, was accused insane at the time?*. 21 September.
The China Mail. (1930a). *Bank murder trial.* 18 July.
The China Mail. (1930b). *Li Man Pun. Murder without a motive? Ghastly Affairs in Chinese Bank*. 16 July.
The China Mail. (1956). *Accused medically insane, but knew what he was doing*. 5 January.
The China Mail. (1960a). *New hospital for insane criminals*. 7 April.
The China Mail. (1960b). *Woman cut son's throat found insane*. 19 July.
The China Mail. (1961). *Man Who Attacked Wife Found Insane*. 25 April.
The Hong Kong Government Gazette. (1854). No. 49, 26 August.
The Hong Kong Government Gazette. (1873). *Chapter VIII, evidence at the hearing*. No. 150, 27 September.
The Hong Kong Government Gazette. (1979). *Victoria gaol*. No. 404, 9 July.
The Hong Kong Telegraph. (1910). *Refuge for the insane: To the editor of the "Hong Kong Telegraph"*. 23 May.
The Hong Kong Telegraph. (1914). *Insane Chinese: Sent back to China from Oregon*. 5 February.
The Medical Department. (1893). *Annual report of the medical department*. Hong Kong.
Whitehead, T. H. (1896). *Report on the Tung Wah Hospital* by The Honourable T. H. Whitehead, SP.
Zhai, H., & Gao, Y. (2017). Early psychiatric services in Hong Kong from 1841 to 1947. *Mental Health in Family Medicine, 13*, 435–438.

Chapter 7
From the Kerr Asylum to the Affiliated Brain Hospital of Guangzhou Medical University

Jie Li and Mao-Sheng Ran

Abstract With the influence of Western culture in the nineteenth century, lunatic asylums were established in many Asian countries, including China. This trend gradually opened the door to the development of mental health services. This chapter introduces and reviews the development of the first lunatic asylum in China across four periods: rise, stagnant development, rapid development, and co-development. The history of the hospital reflects the orientation and trends in development of mental health services in China.

The first period (1898–1950s) was the establishment and rise of psychiatric hospitals. John Kerr, a missionary from the United States, built the first Chinese lunatic asylum by the Pearl River at Fong Tsuen in Canton, China, in order to provide care and relief for people with mental disorders. He was not only a pioneer of Chinese medical care but also initiated the development of mental health services. However, due to the unstable environment, including wars and civil strife, the services of the hospital fell into a decline. After the People's Republic of China was founded in 1949, mental health care began to grow.

The second period (1960s–1970s) was a time of stagnation in the development of psychiatric hospitals. From 1966 to 1976, the Cultural Revolution resulted in enormous social turmoil and even recession of Chinese society, including in the field of mental health care.

The third period was the rapid development of psychiatric hospitals (1980s–1990s). Spring finally arrived, and everything was coming back to new life. At the same time as the rebuilding of psychiatric hospitals domestic and international academic cooperation was extended, promoting the development of mental health care.

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The fourth period (since 2000) is the co-development of the hospital and the community. With the growth of the Chinese economy and the transformation of society, the construction of mental health institutions in China has greatly accelerated. The Affiliated Brain Hospital of Guangzhou Medical University has become an influential academic mental health institute in China. Now, the hospital is focusing on a balanced cooperation between hospital and community mental health care and has changed from a specialized psychiatric hospital to a comprehensive brain hospital as well as community primary care sites in order to serve more persons with severe mental disorders. In order to deliver the best ethical-scientific services and to reduce stigma and discrimination, the hospital initially set up the Policy, Training, Services, Assessment (PTSA) model and a continuing anti-stigma campaign in China.

Keywords Lunatic asylum · History · Psychiatric institute · Community · Human rights · Mental health services · Stigma

Introduction

With the evolution of society and culture in the nineteenth century, the need for systematic provision of psychiatric services and protection of human rights led to the establishment of asylums for people with mental disorders in many places around the world (Dinos 2015). These asylums provided basic living security and care for people with mental disorders. The establishment and development of modern Chinese psychiatry was influenced by both Western medicine and the colonial influence of the Western powers in China. During the nineteenth century, Western psychiatrists and Christian missionaries established many asylums for refugees and for people with mental disorders in Asia. Among them was Dr. John Glasgow Kerr (1824–1901), a Presbyterian medical missionary, who founded the first lunatic asylum in Canton (now Guangzhou city) in 1898.

After more than a hundred years, this hospital has become a grade-A tertiary psychiatric hospital. The development of this hospital has gone through four periods. The progress of the hospital can be seen as a microcosm of the development of mental health services in mainland China.

The First Period: The Rise of Psychiatric Hospital (1898–1950s)

John Kerr was born on November 30, 1824, in Duncansville, Ohio, USA. In 1840, he entered Denison University at the age of 16. In 1847, he graduated from Jefferson Medical College in Philadelphia, which prepared him to take up medical practice in a small town of southern Ohio over the following 7 years. One day, he went to a

lecture given by a Chinese who stressed the need for Western medicine in China where there were massive sufferings among the people. He was deeply moved by what he heard and determined to go to China as a missionary doctor. In accordance with his determination, in 1853, he was assigned by the Presbyterian Board with the mission of spreading the gospel of Jesus Christ and healing people who were suffering from diseases in China (Cadbury and Jones 1935).

After Kerr came to Canton, which eventually played an important role in the history of Chinese psychiatry in southern China, he took charge of the Canton Hospital from Dr. Peter Parker as the superintendent. The Canton hospital was the first missionary hospital in China. As time passed the Canton Hospital gradually extended its scope of work from being a specialized Ophthalmic Infirmary to becoming a polyclinic with both internal medicine and surgery.

Dr. Kerr practiced medicine in China for more than 40 years. During those decades, he devoted himself to many different medical and related fields, including performing surgery, translating medical textbooks from English to Chinese, editing the *Chinese Medical Missionary Journal* and two newspapers in Canton, managing Lingnan University, and training local medical practitioners. Kerr's extraordinary commitment and productivity were documented by Dr. Seldon, who became superintendent of the Canton Hospital following Kerr (Seldon 1935). The extraordinary range of Kerr's activities is summarized in the following Table 7.1.

As an inspiring missionary and preeminent surgeon, Dr. Kerr extended the domain of his medical services in China to include concern for people with mental disorders. From an historical perspective, asylums were often jumbled institutions that provided shelter and support to the people who were mentally ill and to the poor and the homeless. Gradually there was partition of the functions and responsibilities of asylums. Lunatic asylums became specialized care institutions for the insane. General hospice institutions assumed responsibility for the poor and homeless. Soon after Kerr arrived in China, he saw the tragedy of the mentally ill. He witnessed many people with mental disorders being chained in their homes, with no human rights. Many were abandoned by their families and became homeless. He also witnessed those who suicided due to helpless despair. What he saw, heard, and felt motivated him to build a refuge in Canton to provide care and relief for people with mental disorders.

Table 7.1 Dr. Kerr's activities in Canton

Outpatients treated	740,324
Inpatients treated	39,441
Total surgical operations performed	48,098
Surgical operations performed for vesical calculus	1284
Translation of medical works (volumes)	34
Number of towns and villages from which Kerr's patients came	4000
Medical practitioners completing 3 years of instruction	
Instruction under Dr. Kerr	150
Partially instructed students	50

After more than 20 years of hardships and perseverance, Dr. Kerr eventually built the first Chinese lunatic asylum by the Pearl River at Fong Tsuen (芳村) in Canton. "February 20th, 1898, a party, consisting of Dr. Kerr, a man carrying on his back an insane patient, followed by the wife of the doctor, stood at the door of one of these buildings. A key was inserted in the door. It opened, and for the first time in the history of China a mind-diseased patient was to receive special hospital care" (Cadbury and Jones 1935). This male patient had been chained to a stone for 3 years before being brought to the refuge. On the same day, the asylum treated another female patient who had been chained in a straw hut. Although the male patient was not able to recover, the female patient made a miraculous recovery and later returned to her hometown. This refuge for the insane was called Canton Huiai Yi Dian Yuan (广州市惠爱医癫院). The name indicates the fraternity from Christianity (Li 2010), as Dr. Kerr said, "Love the patients as brethren for Christ's sake" (Cadbury and Jones 1935). Since then the mentally ill in China have gradually been liberated from the mists and shackles of witchcraft spells of thousands of years.

After Kerr died, on August 10, 1901, Dr. Charles C. Selden took charge of the hospital as its superintendent. The refuge for the insane in Canton remained a private institution until 1904, while American asylums of the time were operated either as both private-for-profit or public welfare institutions (Porter 2002). In 1927, the Canton national government took over the management of the asylum and renamed it John Kerr's Hospital in honor of his great contribution.

Between 1898 and 1927, the hospital expanded from 30 beds to more than 500 beds and admitted 6599 individuals with mental disorders (4428 male and 2171 female). Sheltering growing numbers of patients required a variety of treatment and management methods, depending on the needs of patients with various disorders. The hospital used physical restraints when this was considered necessary and also used the medicines available at that time, including sulfonal, methylsulfonal (trional), and mist tribromide, to treat patients with violent behaviors. For patients with pathological excitement, frequent showering treatment was used. For convalescent patients or patients with minor symptoms, music therapy and labor therapy were employed. Following the establishment of John Kerr's refuge, similar hospitals were established in other places in China, including Peking (1906), Suzhou (1923), and Shanghai (1935).

In the 1930s, in addition to the treatments mentioned above, insulin coma therapy became another widely used treatment in the hospital for mental disorder. Following the outbreak of the war of resistance against Japanese aggression in 1937, Canton was seized by the Japanese in the following year. The hospital was entrusted to the Catholic church of Canton by the national government. During this time, the hospital was trapped in a financial predicament, with the loss of many medical practitioners. Consequently, patients in the hospital were exposed to a tragic situation until 1946. The national government again took charge of the hospital for 3 years, which brought the hospital another short period of progress. During that period, electroconvulsive therapy was introduced, in line with treatment methods used in American psychiatric hospitals at that time.

Despite the important roles the hospital and Canton had played in the history of psychiatry in China, the first generation of outstanding Chinese psychiatrists was

trained in other cities, including Shanghai, Beijing, Nanjing, Changsha, and Chengdu. This group of psychiatrists included Zonghua Su (Shanghai), Zhenyi Xia (Shanghai), Yulin Wei (Beijing), Zhenyi Wu (Beijing), Xueshi Chen (Beijing), Yuli Chen (Nanjing), Guotai Tao (Nanjing), Minyou Ling (Changsha), and Changyong Liu (Chengdu) (Xu 1995). Most of these first-generation psychiatrists were trained by American psychiatrists in China or in the United States.

On October 1, 1949, the People's Republic of China was founded. At that time, it was estimated that there were around 1100 psychiatric beds nationwide with about 60 neuropsychiatrists working in these institutions. However, psychiatric beds were mainly concentrated in big cities such as Beijing, Shanghai, and Guangzhou. This distribution of psychiatric beds highlighted that the planning of beds was not based on the medical needs of the regions but on the characteristics of city stability and safety.

After 1950, the relatively stable domestic environment provided opportunities for the hospital to forge ahead. In 1958, along with several other important psychiatric hospitals that represented the nucleus of mental health services in China, the hospital attended the first national conference on mental health – the National Conference on the Prevention and Treatment of Mental Disorders (Ho 1974; Xia and Zhang 1987) – organized by the Ministry of Health in Nanjing. The outline of policy for future work was proposed by the conference as "Adhering to prevention, empowering local management, prioritizing hospitalization and promoting unrestrained treatment." This outline played a certain role in promoting the development of mental health services in China.

To keep pace with other psychiatric hospitals in the country, the Kerr hospital was renamed, becoming the Guangzhou Psychiatric Hospital. It promoted the view that patients with mental illness should receive comprehensive medical services instead of simple nursing and accommodation provided by asylums. In the mid-1950s, the hospital used chlorpromazine, which was synthesized only in 1951 and first became available in France in 1952, to provide high-quality medication for persons with schizophrenia. In the early 1960s, Chinese pharmaceutical factories gradually began to produce many psychotropic, such as chlorpromazine, perphenazine, imipramine, and chlorodiazepoxide. However, as in many other fields, all aspects of medical development, including psychiatry, were all seriously interrupted by the growing political struggle within China.

The Second Period: Stagnant Development of the Psychiatric Hospital (1960s–1970s)

The civilization and development of a society is full of up and downs, times of great hardship, and difficulties. For China, that time was the decade of the "Cultural Revolution," from 1966 to 1976. The turmoil resulted in a serious recession of Chinese society. While Western medicine was inveighed against by the government and the public, traditional Chinese medicine was promoted as a panacea. Mental

illness was believed to be the consequence of faulty political thinking during the period of revolution (Ho 1974). A person with mental illness might be considered as essentially selfish and severely in conflict with society (Young and Chang 1983). Ironically, these were views on mental illness found in ancient Western societies thousands of years ago, when people believed that people with mental illness were possessed by evil spirits. However, thousands of years later, this history repeated itself in China. Under this ideology, some psychiatric hospitals were forced to close, while many others were left open but obliged to discard standardized treatments, such as chlorpromazine therapy, insulin coma, and electroconvulsive therapies. Instead, "a silver needle (acupuncture), a handful of herbs, and a copy of Tse-tung Mao's quotations" were regarded as new standards of treatment for people with mental disorders. Very many people with mental disorders received no effective treatment. Many of these people had a tragic life. A retrospective analysis of suicide among inpatients with schizophrenia in Guangzhou Psychiatric Hospital from 1956 to 2005 showed that the rate of suicide was 133.1/100,000 admissions (Li et al. 2008). The highest suicide rate was during the period of the Cultural Revolution (1966–1976) (252.1/100,000), followed by 1956–1965 (188.2/100,000), 1976–1985 (134.0/100,000), 1986–1995 (128.2/100,000), and 1996–2005 (13.3/100,000) (Fig. 7.1) (Li et al. 1992).

The hospital was renamed as the tenth People's Hospital of Guangzhou in 1969 and was under the semi-militarized management of the local government, becoming similar to what was described by Goffman as a "total institution" (Weinstein 1994). Due to the stereotype of psychiatric hospitals, and the strong prejudice and discrimination against people with mental illness, the hospital was called "Suo Lao Yuan" or "Suo Shi" by the locals, which means place for foolish persons.

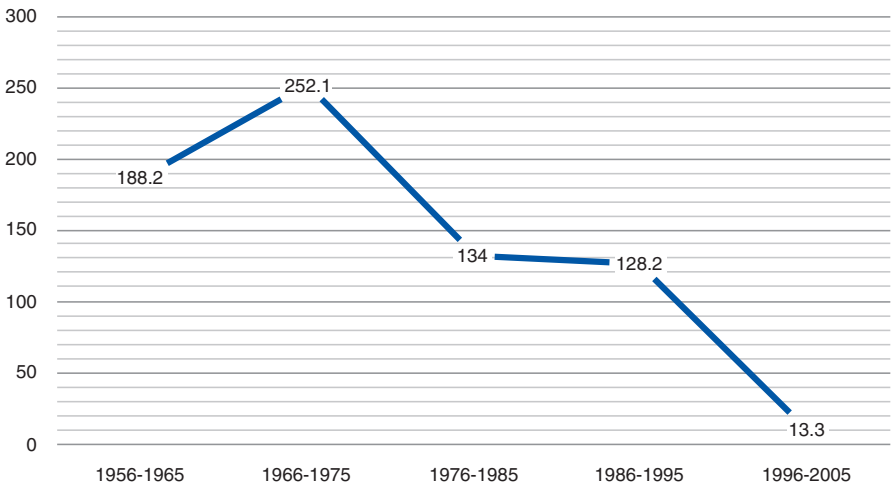

Fig. 7.1 Inpatient suicides per 100,000 admissions

The Third Period: The Rapid Development of the Psychiatric Hospital (1980s–1990s)

At the end of the 1970s, the 10-year "Cultural Revolution" came to an end. Spring finally arrived, and everything was coming back to new life. The hospital started a general survey of mental disorders in several districts of Guangzhou to get the whole picture of persons with mental disorders. Through many similar investigations, a department of prevention and illness control was established. This department then built up a network system for community mental health in Guangzhou. In the same period, the hospital's name was again changed to the original Guangzhou Psychiatric Hospital.

In this era, everything restarted from scratch. Dr. Kanming Mo, a well-known psychiatrist in China who was president of the hospital, led the focus of working away from "class struggle" to the reconstruction of medical discipline. For example, two research institutes of mental health and substance abuse in the hospital were founded successively in 1980 and 1992. A range of reforms together promoted the development of mental health care in Guangdong. At the same time, with the geographical and historical advantages of Guangdong, the hospital, a pioneer in the period of Reform and Opening Up, the first stage of which was from 1979 through the early 1980s, had been engaging in international academic communication and cooperation. For instance, some well-known psychiatrists and other mental health staff from more than ten countries, including the United States, United Kingdom, France, and Germany, visited the hospital. Particularly, the team of Dr. Mo and Professor Wenshing Tseng from University of Hawaii developed a close cooperation to conduct a sociocultural study of the epidemics of Koro in Guangdong, China (Tseng et al. 1988). The academic impact of the hospital in a global context began to grow.

All these innovations and efforts paid off. One of the most significant markers was that in 1998 the hospital was ranked as a third-grade class-A level specialized psychiatric hospital in Guangdong, which acknowledged that the hospital was the best psychiatric hospital in Guangdong province. The hospital continually expanded its service capacity and service coverage. In 1918, the hospital treated 249 patients and 8947 patients in 2018.

The Fourth Period: The Co-development of the Hospital and the Community (Since the 2000s Onward)

Since the beginning of the twenty-first century, with the growth of economy and the transformation of society, the construction of mental health institutions in China has been greatly accelerated. For example, the National Mental Health Plan (2002–2010) (Ministries of Health Public Security Civil Affairs and CDPF 2002) was proclaimed

by the Ministry of Health in 2002. As part of the reform, the hospital had been transformed from a basic psychiatric institution to an integrated hospital of psychiatry, neurology, and neurosurgery. Therefore, the hospital was given another name, the Guangzhou Brain Hospital, while the original name was also kept.

Given the stigma of mental illness on the one hand and, on the other hand, the wish of staying at this beautiful place near the Pearl River, the Guangzhou Psychiatric Hospital restored its previous name as Guangzhou Huiai Hospital (广州市惠爱医院) in 2014. Reviewing the ever-changing name, the awareness of stigma had in the early history of the hospital resulted in the removal of the character "dian" in its name (from "Guangzhou Hui Ai Yi Dian Yuan" to "Guangzhou Hui Ai Yi Yuan"), because "dian" is similar to the character "kuang" which means insane in ancient Chinese.

In 2018, the hospital had 1800 beds, mainly psychiatric, neurological, and intensive care unit beds. More than 1200 staff members work in 20 medical departments. The hospital is also among five standardized training sites for psychiatric residents in mainland China and ranked in the top 10 psychiatric hospitals in the country by the ranking system of Fudan University.

With economic development and the development of all forms of infrastructure, the cultural confidence of China has been strengthened. In this regard it is worth mentioning that the hospital has been facilitating the revitalization of Chinese medicine on a scientific basis. The use of Chinese herbs and acupuncture as treatment alternatives for persons with mental disorders is being investigated. However, some scholars in the hospital believe that traditional Chinese medicine integrates both science and art, which makes scientific evidence not easy to find. How to scientifically examine the efficacy of traditional Chinese medicine remains a major challenge.

It is a global trend in public mental health to emphasize a balanced cooperation between hospital and community mental health care (Thornicroft et al. 2016). Mental health services have been encouraged to move from specialized psychiatric hospitals to comprehensive hospitals as well as community primary care sites in order to serve more persons with severe mental disorders.

Historically, the hospital built a prevention and control section in 1964. This section was renamed the department of community psychiatry in 2006 and is focusing on public mental health. Receiving acknowledgement and support from the local government, the hospital was given the title of Guangzhou Mental Health Center in 2015. In addition to the clinical routine services that the hospital provides, extra responsibilities in community mental health services were expected along with the new title awarded. These include (1) regulating the management and treatment of persons with severe mental disorders in communities; (2) providing training and supervision to community mental health staff and assessment of their competence; (3) carrying out community educational activities in different forms, such as science popularization, general lectures, counseling services, etc.; (4) providing interventions for persons with mental disorders in communities; and (5) providing scientific evidence for mental health policy-making and the allocation of mental health resources.

In order to achieve these goals, the center set up the PTSA model which emphasizes prioritizing Policy, Training essential skills, delivering effective Services, and Assessment of training and services (Li et al. 2014b, 2015). In addition, a philosophy called "COACH" was proposed. These letters stand for Co-development among special hospitals, psychiatric departments in general hospitals, and community mental health centers; Accessible and decentralized services; Comprehensive services in community mental health; and Harmonious life of people with mental illness in society.

In order to promote the construction of community and public mental health and establish an evidence base for mental health services delivery (Collins and Saxena 2016), Dr. Jie Li, the leader of the department of community psychiatry, and his team have facilitated a series of anti-stigma research projects in Guangzhou since 2013 under the supervision of Dr. Graham Thornicroft from King's College London (Li et al. 2014a, 2014b, 2017, 2018, 2019). At the same time, in 2017, Dr. Li and his team launched the first anti-stigma campaign of mental health in Guangzhou, China. Dr. Li and colleagues were invited to join the International Study of Discrimination and Stigma Outcomes (INDIGO) Research Network to undertake research related to stigma and discrimination in low- and middle-income countries (LIMICs) (Thornicroft et al. 2019).

Just as the belief in humanity and human rights was held by Dr. Kerr, more than a hundred years ago, the hospital has been sustaining its core values in the new era by advancing the medical technology and environment and by empathizing and responding to the suffering of persons with mental disorders and their families and promoting social justice in China (Patel 2015). Apart from ordinary clinical work and community mental health services, in order to further promote scientific research and education, the hospital was renamed as the Affiliated Brain Hospital of Guangzhou Medical University in January 2020. After more than a hundred years, during which time the hospital's name has changed several times, we believe that the hospital's mission should include high-quality scientific research and education and the elimination of stigma and discrimination.

Conclusion

As a clergyman, surgeon, physician, and medical educator, Dr. Kerr inaugurated mental health services in China. To date, the Affiliated Brain Hospital of Guangzhou Medical University remains committed to its primary aspirations and keeps its mission firmly in mind. After more than 120 years of development, from a basic lunatic asylum to a comprehensive neuropsychiatric hospital, the hospital has played and continues to play an indispensable role in the medical field of Southern China. Constant efforts are made to pursue a dynamic balance between hospital and the community services. The origins and development of the Affiliated Brain Hospital of Guangzhou Medical University are a microcosm of the development of mental health services in China.

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References

Cadbury, W. W., & Jones, M. H. (1935). *At the point of a Lancet: One hundred years of the Canton Hospital*. Shanghai: Kelly and Walsh, Limited.

Collins, P. Y., & Saxena, S. (2016). Action on mental health needs global cooperation. *Nature, 532*(7597), 25–27. https://doi.org/10.1038/532025a.

Dinos, S. (2015). Public psychiatry and public health mental systems. In J. D. Wright (Ed.), *International encyclopedia of the social & behavioral sciences* (Vol. 19, 2nd ed., pp. 586–590). Elsevier.

Ho, D. Y. (1974). Prevention and treatment of mental illness in the People's Republic of China. *The American Journal of Orthopsychiatry, 44*(4), 620–636. https://doi.org/10.1111/j.1939-0025.1974.tb00917.x.

Li, J. (2010). The first psychiatric hospital in China. *The British Journal of Psychiatry, 197*(6), 440–440. https://doi.org/10.1192/bjp.197.6.440.

Li, J., Fan, Y., Zhong, H. Q., Duan, X. L., Chen, W., Evans-Lacko, S., & Thornicroft, G. (2019). Effectiveness of an anti-stigma training on improving attitudes and decreasing discrimination towards people with mental disorders among care assistant workers in Guangzhou, China. *International Journal of Mental Health Systems, 13*, 1. https://doi.org/10.1186/s13033-018-0259-2.

Li, J., Huang, Y. G., Ran, M. S., Fan, Y., Chen, W., Evans-Lacko, S., & Thornicroft, G. (2018). Community-based comprehensive intervention for people with schizophrenia in Guangzhou, China: Effects on clinical symptoms, social functioning, internalized stigma and discrimination. *Asian Journal of Psychiatry, 34*, 21–30.

Li, J., Guo, Y. B., Huang, Y. G., Liu, J. W., Chen, W., Zhang, X. Y., Evans-Lacko, S., & Thornicroft, G. (2017). Stigma and discrimination experienced by people with schizophrenia living in the community in Guangzhou, China. *Psychiatry Research, 255*, 225–231. https://doi.org/10.1016/j.psychres.2017.05.040.

Li, J., Li, J., Huang, Y. G., & Thornicroft, G. (2014a). Mental health training program for community mental health staff in Guangzhou, China: Effects on knowledge of mental illness and stigma. *International Journal of Mental Health Systems, 8*(1), 49. https://doi.org/10.1186/1752-4458-8-49.

Li, J., Li, J., Thornicroft, G., & Huang, Y. G. (2014b). Levels of stigma among community mental health staff in Guangzhou, China. *BMC Psychiatry, 14*, 231. https://doi.org/10.1186/s12888-014-0231-x.

Li, J., Li, J., Thornicroft, G., Yang, H., Chen, W., & Huang, Y. G. (2015). Training community mental health staff in Guangzhou, China: Evaluation of the effect of a new training model. *BMC Psychiatry, 15*, 263. https://doi.org/10.1186/s12888-015-0660-1.

Li, J., Su, J. H., Guo, Y. B. Zhao, Z. H., Lu, H. X., Hao, Y. T., & Ran, M. S. (2008). A case-control study of suicide among psychiatric inpatients in the Guangzhou Psychiatric Hospital. *Chinese Mental Health Journal, 22*(1), 8–10.

Ministries of Health Public Security Civil Affairs and CDPF. (2002). *National Mental Health Plan (2002–2010)*. Beijing: Government of the People's Republic of China.

Patel, V. (2015). Addressing social injustice: A key public mental health strategy. *World Psychiatry, 14*(1), 43–44. https://doi.org/10.1002/wps.20179.

Porter, R. (2002). *Madness: A brief history*. Oxford: Oxford University Press.
Seldon, C. C. (1935). The life of John G. Kerr: Forty-three years superintendent of the Canton Hospital. *Chinese Medizinhistorisches Journal, 49*, 366–376.
Thornicroft, G., Bakolis, I., Evans-Lacko, S., Gronholm, P. C., Henderson, C., Kohrt, B. A., et al. (2019). Key lessons learned from the INDIGO global network on mental health related stigma and discrimination. *World Psychiatry, 18*(2), 229–230. https://doi.org/10.1002/wps.20628.
Thornicroft, G., Deb, T., & Henderson, C. (2016). Community mental health care worldwide: Current status and further developments. *World Psychiatry, 15*(3), 276–286. https://doi.org/10.1002/wps.20349.
Tseng, W. S., Mo, K. M., Hsu, J., Li, L. S., Ou, L. W., Chen, G. Q., & Jiang, D. W. (1988). A socio-cultural study of Koro epidemics in Guangdong, China. *The American Journal of Psychiatry, 145*(12), 1538–1543. https://doi.org/10.1176/ajp.145.12.1538.
Weinstein, R. M. (1994). Goffman's asylums and the total institution model of mental hospitals. *Psychiatry, 57*(4), 348–367. https://doi.org/10.1080/00332747.1994.11024699.
Xia, Z., & Zhang, M. (1987). History and present status of psychiatry in China. *International Journal of Mental Health, 16*(3), 22–29.
Xu, T. Y. (1995). History of modern psychiatry in China. *China Joural of Neuropsychiatry, 28*(3), 168–176.
Young, D., & Chang, M. Y. (1983). Psychiatry in the People's Republic of China. *Comprehensive Psychiatry, 24*(5), 431–438. https://doi.org/10.1016/0010-440x(83)90034-2.

Chapter 8
China's Mental Health Law

Stephen Minas

Abstract The adoption and entry into force of the Mental Health Law (MHL) of the People's Republic of China is a very recent development in the governance of mental health in the mainland of the People's Republic of China. Prior to 2012, when the Standing Committee of the National People's Congress adopted the MHL, China lacked a national legal framework for mental healthcare, and the rights and interests of patients with mental disorders, as well as the duties of various actors for their care, were not comprehensively addressed through national law. The creation of the MHL is therefore an important milestone for the governance of mental healthcare in the world's most populous country. However, it will be seen that there remain significant controversies over the Law's content, as well as major difficulties of implementation. This chapter provides an introduction to the MHL and identifies key ongoing issues related to its implementation. It gives an overview of the decades-long process of the development of the Law, commenting on the purposes which animated this legislative effort and the responses to the Law's adoption. It focuses on a discussion of the content of the MHL, highlighting key provisions and debate concerning their drafting, interpretation and implementation. Particular attention is given to the MHL's normative approach in favour of community-based care, patient consent and rehabilitation and to the crucial material on involuntary hospitalisation. The chapter summarises studies and commentaries on the MHL's implementation since its entry into force in 2013 and concludes that the Law's adoption can be seen as a key step, rather than an endpoint, for the reform of mental healthcare in China.

Keywords Mental health law · Health law · Health governance · Involuntary admission · Human rights law · Chinese law · Chinese legislation

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Introduction

The adoption of China's first national Mental Health Law (MHL) in 2012 (Chen et al. 2012) was a significant development in the legal regulation of mental healthcare in the world's most populous country. The decades-long deliberation over the Law's content, the breadth of its provisions and its potential to improve the treatment and safeguard the human rights of mentally ill patients have all garnered well-merited international attention. The Law's adoption has been less an endpoint and more the beginning of an arduous new journey of implementation, with much debate over the Law's merits and the interpretation of its sometimes vague terms. This chapter aims to present the MHL's key features and provisions and to foreground important and ongoing debates concerning its implementation and possible reform, detailed discussion of which are beyond the present scope.

The remainder of the chapter is structured as follows. Section two provides an overview of the MHL's journey from initial drafting in the 1980s to adoption in 2012 and amendment in 2018 (Standing Committee of the National People's Congress 2018). Section three details the content of the Law and highlights analysis and debate of key provisions. Section four focuses on implementation of the MHL and identifies ongoing challenges. Section five concludes.

Development of the Law

The long and winding road to the adoption of the MHL began in the 1980s. As early as 1985, when the Ministry of Health tasked the Sichuan and Hunan Provincial Health Departments with drafting the Law (Shao et al. 2015), Wu Jiasheng called for legislation to be 'formulated soon' and observed that 'the most outstanding problem is the compulsory custodial treatment…[T]here are no clear guidelines to define the boundary, operational procedures, treatment means, period of detention for compulsory custodial treatment. There are also no clear guidelines regarding rights of the mental patients' (cited in Pearson 1992, 409–10). The Law's gestation proceeded from multiple academic drafts in the 1980s and 1990s to further development by the Ministry of Health from 1999 onwards (Phillips et al. 2013) (p. 588). The 2002 adoption of China's first Mental Health Plan was an important milestone.

Prior to the adoption of the MHL, although various laws addressed various rights of mentally ill persons (Liu 1998), China lacked national regulation of important mental health matters such as involuntary admission, resulting in significant disparity in local experiences (Charlton and Xiang 2014). There is a well-documented history of the abuse of 'judicial psychiatry' in China, with various political oppositionists, eccentrics, petitioners and other 'troublesome' characters declared mentally ill and locked away (Munro 2000). An example of this practice comes from a 1990 encyclopaedia of police work, which listed the categories of 'maniac' to be taken into custody (including 'political maniacs' who 'express opinions on

important domestic and international affairs'), and advised: 'The taking of mentally ill people into custody is especially important during major public festivals and when foreign guests arrive for visits, and it should be appropriately reinforced at such times' (Cited in Munro 2000). By the time of the MHL, 'human rights violations' connected with involuntary admission had been reported in Chinese and international media for 'decades' (Xiang et al. 2012). The assertions by Munro (Munro 2000; Munro 2002) and others (Birley 2004; van Voren 2010; van Voren 2016) of political abuse of psychiatry in China have not gone unchallenged (Lee and Kleinman 2002) and have generated a spirited debate (Bonnie 2002).

It is therefore unsurprising that much of the debate over the planned law concerned the key issue of involuntary hospitalisation. A 2002 survey across 17 cities found that only 18.5 per cent of mental health patients had been voluntarily hospitalised (Ma et al. 2019). Prior to the MHL's entrance into force, Xiang and colleagues reported:

> In the absence of any national guidelines on compulsory psychiatric admission and discharge, the current daily practice in China is that individuals who are suspected of having mental disorders are often compulsorily admitted to psychiatric hospitals with the consent form signed only by family members. Usually only the person who signed the consent form for the admission is then allowed to apply for the patient's discharge from hospital. This common practice does not respect the human rights of patients with mental illness. (Xiang et al. 2012)

Indeed, also in 2012 it was claimed that 'China's involuntary commitment system is a black hole into which citizens can be "disappeared" for an indefinite period of time based on the existence or mere allegation of a psychosocial disability by family members, employers, police or other state authorities' (Chinese Human Rights Defenders 2012, cited in Charlton and Xiang 2014). Related to involuntary hospitalisation is the broad licence for forced constraining of patients, which China's health minister in 2011 acknowledged as 'one of the biggest problems facing the mental health system' (Charlton and Xiang 2014).

The MHL was adopted by the Standing Committee of the National People's Congress in 2012 and entered into force in 2013. Even prior to the Law's adoption, it has been claimed that its 'influence could already be perceived in practice throughout China over the last decades because its successive drafts (or sections of them) were *de facto* implemented by mental health authorities in diverse Chinese provinces' (Bertolote 2013, 63). The adoption of the MHL has been described as the culmination of a 'positive trajectory' of increasing recognition of the importance of mental health to overall public health in China (Phillips 2013). It has also been recognised as a 'milestone' for the ' "Global Mental Health" movement' (Hussey and Mannan 2015). Moreover, Charlton and Xiang have described the MHL as an attempt by China to fulfil its obligations under the Convention on the Rights of Persons with Disabilities (ratified by China in 2008) and therefore as 'an important example of the domestic incorporation of international norms and law into a state legal system' (Charlton and Xiang 2014). In 2018, the Standing Committee of the National People's Congress amended the MHL. The amendments introduced 'medical insurance' into Articles 8 and 68, replacing other sources of support (Standing Committee of the National People's Congress 2018).

The Content of the Law

The MHL is divided into seven chapters: I. General Provisions; II. Psychological Health Promotion and Mental Disorder Prevention; III. Diagnosis and Treatment of Mental Disorders; IV. Rehabilitation of Mental Disorders; V. Safeguards; VI. Legal Liability; and VII. Supplementary Provisions. The broad, 'omnibus' format of the MHL has been contrasted to the 'more incremental approach' of countries which have opted to address different aspects of mental healthcare in standalone laws (Diesfeld and Mellsop 2012). The content of the MHL addresses four of the six cross-cutting principles of the World Health Organization's Comprehensive Mental Health Action Plan 2013–2020: 'universal health coverage, human rights, evidence-based practice, and a multisectoral approach' (while a life-course approach and empowerment of patients in the planning of services are not addressed) (Phillips 2013). The Law has however been faulted for neglecting to specifically address a variety of 'vulnerable groups', such as the aged, ethnic minorities and displaced persons (Hussey and Mannan 2015).

The final chapter defines key terms. 'Mental disorders' refer to 'disorder or abnormity of mental activities such as perception, emotion and thinking due to a variety of reasons, resulting in obvious psychological pains or dysfunction of social adaptation of the patients' (Article 83). 'Severe mental disorders' are 'mental disorders with severe symptoms, resulting in the patients' severe dysfunction of social adaptation, inability to completely understand their own health status or objective reality, or inability to handle their own affairs' (Article 83). 'Guardians of patients with mental disorders' are persons who may serve as guardians according to the General Principles of Civil Law (Article 83) (National People's Congress 1987). Article 17 of these General Principles provides that guardians for mentally ill persons may include spouses, parents, adult children, other 'near relatives', other 'closely connected' relatives or friends and, if no such people are available, the mentally ill person's work unit, neighbourhood or village committee or the local civil affairs department.

General Provisions

Chapter 1 sets out a number of general principles. The first of these is that 'mental health work shall implement the prevention-oriented guideline, and adhere to the principle of combination of prevention, treatment and rehabilitation' (Article 3). The focus on prevention in the MHL has been favourably contrasted with the mental health laws of many other countries (Phillips 2013). 'Prevention' is the second-most frequently mentioned 'core concept' in the Law, after 'family resource' (Hussey and Mannan 2015). Article 4 declares that the 'personality, dignity, and personal and property safety of the patients with mental disorders are inviolable' and that the 'lawful rights and interests of the patients with mental disorders in terms of

education, employment, medical treatment, obtainment of material assistance from the state and society and other lawful rights and interests shall be protected by law'.

'[R]elevant entities and individuals' are obliged to maintain patient confidentiality 'unless the disclosure of such information is necessary for the entities and individuals to perform their duties according to law' (Article 4). Article 5 provides that the 'whole society shall respect, understand and care for the patients with mental disorders', while '[n]o organizations or individuals may discriminate against, insult, or maltreat the patients with mental disorders, or illegally restrict their personal freedom'. The same article prohibits news reports and artistic content 'discriminating against or insulting the patients with mental disorders'.

The first chapter also allocates responsibilities to different levels of government and to other institutions and persons. The State Council's health administrative department 'shall take charge of the mental health work throughout the country', while health administrative departments of governments at county level and above perform the same role within their regions (Article 8). Departments of justice, civil affairs, public security, education and medical insurance are also made responsible for mental health work 'within the scope of their respective duties' (Article 8). More generally, the responsibilities of governments at county level and above include service systems for the 'prevention, treatment and rehabilitation of mental disorders' and supervision of mental health work, while governments at township and sub-district levels 'shall, in accordance with the local actual conditions, organize the activities of preventing the occurrence of mental disorders, promoting the rehabilitation of the patients with mental disorders and other activities' (Article 7). The state must also support the training of mental health professionals, protect their legal rights and support mental health research (Article 11). The China Disabled Persons' Federation (previously led by Deng Pufang, son of former paramount leader Deng Xiaoping) is empowered to 'mobilize social forces to carry out mental health work', while village and resident committees are to 'assist the local people's governments in carrying out mental health work' (Article 10). Article 9 provides that the 'guardians of patients with mental disorders shall fulfill the duties of guardianship and protect the lawful rights and interests of the patients with mental disorders'. The same article prohibits family violence against and 'abandonment' of patients. Nevertheless, scholars have faulted other provisions of the Law for 'assum[ing] that guardians will act in the patient's best interests' (Guo and Feeney 2018).

Psychological Health Promotion and Mental Disorder Prevention

Chapter 2 allocates responsibilities to a broad range of actors for mental health promotion and disorder prevention. Governments at county level and above have a general responsibility to 'strengthen the psychological health promotion and mental

disorder prevention' (Article 13). The State Council's health administrative department is made responsible for monitoring mental health incidence and must, together with relevant bodies, establish a 'mental health information sharing mechanism to realize information interconnection, interflow, exchange and sharing' (Article 24).

Employers must 'pay attention to the psychological health of employees' and 'conduct targeted psychological health education' (Article 15). Schools are given responsibility for educating students on mental health and providing psychological assistance to students following traumatic events, while teachers must learn about mental health (Article 16). Prisons, detention houses and drug rehabilitation centres (Article 18), various government departments (Article 19), village and resident committees (Article 20) and the news media (Article 22) are all allocated responsibilities for mental health promotion and prevention within their areas.

Medical staff must 'provide psychological health guidance for patients, and upon finding that a patient may suffer from mental disorders, advise him or her to go to a medical institution complying with the provisions of this Law for treatment' (Article 17). Psychological counsellors must 'not engage in psychotherapy or the diagnosis or treatment of mental disorders' and must advise a person being counselled who may suffer from mental disorders to 'go to a medical institution in compliance with the provisions of this Law for treatment' (Article 23).

'Family members' are also assigned broad responsibilities: 'if they find any of the family members may suffer from mental disorders, they shall help him or her to see a doctor in a timely manner, take care of his or her daily life, and perform well in nursing and management' (Article 21).

Diagnosis and Treatment of Mental Disorders

Chapter 3 provides for the rights of patients' mental disorder diagnosis and treatment, establishing rules for involuntary hospitalisation and allocates related responsibilities to various actors. Article 26 provides that the 'diagnosis and treatment of mental disorders shall follow the principles of protecting the lawful rights and interests of patients and respecting the personality of patients, and ensure that the patients can obtain good mental health services under existing conditions'. Moreover, '[n]o medical examination may be conducted on a person against his or her own will to determine whether he or she suffers from mental disorders unless it is otherwise prescribed by law' (Article 27).

Patients may be 'sent' to a medical institution for diagnosis by a 'close relative' or, in the case of 'vagrants and beggars with suspect mental disorders', by local authorities. In the case of someone who has 'committed any act of harming himself or herself or endangering the safety of others, or has the potential to commit the said act', close relatives, employers or the 'local public security organ' 'shall immediately take measures to stop him or her and send him or her to a medical institution for the diagnosis of mental disorders' (Article 28).

Concerning hospitalisation, Article 30 provides that 'hospitalization of patients suspected of mental disorders shall observe the principle of free will'. However, paragraph 2 of the same article states:

> If the diagnostic conclusion or the assessment of the state of illness shows that the patient suffers from severe mental disorders and falls under any of the following circumstances, he or she shall be hospitalized: (1) having committed any act of harming himself or herself or having the potential to harm himself or herself; or (2) having committed any act of endangering the safety of others or having the potential to endanger the safety of others.

In the case of a patient with severe mental disorder in the category of Article 30.2(1), where the patient's guardian withholds consent to hospitalisation, the mental institution 'shall not hospitalize the patient' and the guardian will be required to 'take good care and management of the patient living at home' (Article 31). This allocation of a 'proxy decision' regarding hospitalisation to the guardian has been criticised as 'conflat[ing] having a mental disorder with lacking capacity to consent' (Ding 2014). In the case of a patient falling within Article 30.2(2), a patient or guardian objecting to hospitalising may request a second diagnosis (Article 32). If the second diagnosis confirms the original, the guardian 'shall agree' to hospitalisation and, moreover, '[i]f the guardian hinders the hospitalization of the patient or the patient gets away from hospitalization without permission, the public security organ may assist the medical institution in taking measures to hospitalize the patient' (Article 35). The requirements for second diagnosis and authentication (Articles 32–33) fall short of 'judicial review for involuntary admissions' (Diesfeld and Mellsop 2012).

The 'risk-based criteria' for involuntary hospitalisation in Article 30 were trialled in various subnational jurisdictions before incorporation into national law (Ma et al. 2019). There has been debate over the precise meaning (and most accurate translation) of the Article 30 criteria. The arguably 'vague definition' of risk criteria is the 'result of a compromise between the civil liberties approach, which highlights the importance of individual freedom and autonomy, and the application of substituted decision-making, which emphasizes the need for treatment as a sufficient prerequisite for involuntary admission' (Ma and Shao 2019). It has been reported that 'successive drafts of the law swung between rigorously protecting patients' rights and interests to rigorously ensuring the safety of community members' (Xie 2013). Vague as the criteria may be, they are a clear improvement on a 2011 draft which included 'imminent or current behavior that endangers public security and disturbs public order' as grounds for involuntary admission. This criterion 'met with fierce criticism from the legal, ethical, and psychiatric community' and was therefore expunged from the finalised Law (Hu 2014).

Article 44 governs the requirements for discharge of different categories of patients. A voluntarily hospitalised patient may ask to leave the hospital at any time, and the hospital must consent. In the case of a patient hospitalised 'having committed any act of harming himself or herself or having the potential to harm himself or herself', the patient's guardian may require discharge at any time and the hospital must consent. In the case of a patient hospitalised 'having committed any act of

endangering the safety of others or having the potential to endanger the safety of others', the medical institution must 'immediately inform' the patient or guardian if it deems that the patient may be discharged. However, the Law does not address what should happen in the 'common situation in which the legal guardians are unwilling to accept the discharge of the patient' (Shao and Xie 2013).

This scenario was tested in the widely reported case of Xu Wei, a Shanghai man who was involuntarily admitted by his father and remained in hospital for 15 years until his eventual discharge in 2017. Although Xu's condition was reportedly mild, during his stay in hospital his father died and his brother, who became guardian, refused to accept Xu's discharge. Following the adoption of the MHL, Xu sued both his brother and the hospital under Article 82 (discussed below) but was unsuccessful. Finally, the Ministry of Justice certified Xu to have 'full civil capacity' and the hospital consented to his release (Zheng 2017). This story has been celebrated as the 'first case' under the MHL, but, as Cohen and Chi have observed, Xu's was an unusual case: 'If he had not demonstrated the same zeal to challenge his incarceration that he had shown in petitioning against other injustices, which is what originally got him into trouble, he would still be confined' (Cohen and Chi 2018).

In addition to governing hospitalisation and discharge, the chapter provides for a variety of protections of patient rights while in the care of a medical institution. Institutions must inform patients and their guardians of 'patients' rights during the process of diagnosis or treatment' (Article 37) and of 'treatment plans, methods and purposes and possible consequences' (Article 39). Article 40 prohibits the use of 'protective medical measures such as constraint and isolation to punish the patients with mental disorders'. Where a hospital constrains or isolates a dangerous or disruptive patient 'under the condition of no other alternative measures', the guardian must be informed (Article 40). Medicines cannot be used for purposes other than diagnosis and treatment, and institutions 'shall not compel patients with mental disorders to engage in production and labor' (Article 41). Surgeries cannot be performed on patients hospitalised under Article 30.2 (Article 42).

The health administrative departments of governments at county level and above are given responsibility to 'inspect' medical institutions for compliance with MHL in the areas of personnel, facilities and equipment compliance, diagnostic standards and treatment specifications, hospitalisation procedures and protection of patient rights and interests (Article 50). Interestingly, the MHL provides that when conducting such an inspection, health administrative departments 'shall hear the opinions of the patients with mental disorders and their guardians'.

In the case of patients who are not hospitalised, Article 49 provides that their guardians 'shall properly take care of the patients…, urge them to take medicines on time according to prescription, and accept follow-up visits or treatment', while village and resident committees, employers and 'other entities' must provide assistance upon request of the guardians. Whether such assistance materialises may prove crucial to whether the status quo of involuntary admission by family members of patients with severe disorders persists. Phillips and colleagues have warned that '[c]hanging that long-standing practice to a largely voluntary admission system will increase the burden on families' (Phillips et al. 2013).

Rehabilitation of Mental Disorders

The MHL places an emphasis on rehabilitation within the community. Article 54 provides: 'Community rehabilitation institutions shall provide places and conditions for the patients with mental disorders who are in need of rehabilitation, and provide rehabilitation training for the patients on self-care ability, social adaptability and other aspects.' Medical institutions are to provide 'essential drug maintenance treatment' for patients with severe disorders living at home and provide support for community rehabilitation institutions (Article 55). 'Community health service institutions' are responsible for supporting patients living at home, and governments are obliged to provide guidance and training for these institutions and other local bodies involved in rehabilitation (Article 55). Village and resident committees are assigned various roles, including to 'provide assistance for the families of patients with mental disorders living in hardship' (Article 56). Employers are required to assign appropriate work to patients, 'ensure equal treatment for the patients as other employees' and arrange training to 'improve their employability' (Article 58). Guardians of patients 'shall help the patients conduct rehabilitation training' and may receive 'guidance' from community rehabilitation institutions, village clinic and other local bodies (Article 59). While welcoming the MHL's focus on rehabilitation, Li and colleagues have warned that 'it will take a long time to train up enough manpower' to achieve in practice what the Law prescribes (Li et al. 2014). Similarly, Shao and Xie noted that 'it will take time to integrate mental health services into the current general medical services and to train the mental health manpower needed to provide these services' (Shao and Xie 2013).

Safeguards

Chapter 5 attempts to establish a range of 'safeguards' for the MHL, in essence by tasking a broad range of actors to contribute to an enabling environment for the implementation of the Law. There is a significant emphasis on education and training, with medical colleges and institutes (Article 64), medical institutions (Article 66), 'normal universities' (i.e. teacher-training colleges) and colleges (Article 67) all assigned roles in the teaching, research or awareness of mental health. The chapter also allocates responsibilities to different levels of government, supplementing the material in Chap. 1. Noteworthy is the responsibility of county governments to 'establish community rehabilitation institutions' (Article 61). Governments at all levels are required to increase funding for mental health work (Article 62). Patients with several mental disorders are entitled to 'free basic public health services' (Article 68).

Chapter 5 also establishes protections for mental health staff. Article 71 provides: 'The personality and personal safety of the mental health staff shall be inviolable, and the mental health staff shall be protected by law while performing their duties in accordance with law. The whole society shall respect the mental health staff.' The same article calls for increased salaries for mental health staff.

Legal Liability

Chapter 6 provides for the enforcement of the MHL by establishing legal liability for situations in which hospitals and various other actors breach their MHL obligations. Officials of government departments which fail to perform their MHL duties face criticism, disciplinary actions and, in serious cases, demotion or dismissal (Article 72). There are penalties for medical institutions which engage in mental health diagnosis or treatment without authorisation (Article 73) and for psychological counsellors and psychotherapists engaging in mental health diagnosis (Article 76).

Medical institutions and their staff face sanctions for the following acts or omissions: refusing to diagnose patients sent for diagnosis, or failing to inspect and assess hospitalised patients in a timely manner (Article 74), imposing constraints or isolation in violation of the MHL, forcing a patient to work, performing surgery or 'experimental clinical treatment' in violation of the Law, refusing a patient communication or visitors or 'diagnosing a patient without mental disorders as a patient with mental disorders' (Article 75). The Article 75 violations can result in suspension from practice from 6 months to 1 year and, in serious cases, dismissal and revocation of practicing certificates. Further, any 'entity or individual' who violates the patient privacy requirements of Article 4.3 and so causes damage to a patient will be liable for compensation and potentially disciplinary action (Article 77).

Legal liability is not limited to government departments and hospitals. Article 78 makes liable to compensation anybody who causes damage to another citizen by 'deliberately sending a patient without mental disorders as a patient with mental disorders to a medical institution for treatment'; as a guardian, abandoning a patient or otherwise failing to fulfil the duty of guardianship; 'discriminating against, insulting or maltreating a patient with mental disorders, or infringing upon the personality or personal safety of a patient with mental disorders'; 'illegally restricting the personal freedom of a patient with mental disorders'; or otherwise infringing upon patients' lawful rights and interests (Article 78). A guardian who refuses to consent to hospitalisation contrary to diagnostic conclusion, resulting in personal or property damages to others, bears civil liability (Article 79). Anybody found 'picking quarrels and provoking trouble', or otherwise obstructing the work of medical institutions, etc., is subject to 'public security administration punishment' (Article 80). Finally, patients and their guardians and close relatives may bring a lawsuit against any 'administrative organ, medical institution or any other relevant entity or individual' which they deem has 'infringed upon the lawful rights and interests of the patient in violation of this Law' (Article 82).

Implementation Issues

Following the adoption of the MHL, many scholars and practitioners have highlighted significant challenges to implementation. These include insufficient training, services and drugs in rural areas, as well as the broader problem of a 'very low rate of care-seeking for psychological problems' (Phillips 2013).

A variety of studies have attempted to measure the Law's impact. A 2015 questionnaire-based study examined Shanghai-based psychiatrists' attitude to informed consent following adoption of the MHL. The study found that disclosure of diagnosis and treatment (as required by Article 39) was 'much higher than that reported previously in China' (Huang et al. 2019). Moreover, the authors noted: 'There was an association between training related to the NMHL and attitudes toward the IC [informed consent] process. The odds of holding a positive attitude toward the IC process was higher in psychiatrists trained in using the NMHL than in those not trained' (Huang et al. 2019).

The impact of the MHL on rates of involuntary admission has been unclear. A study of involuntary admission in Shanghai from 2013 to 2017 found that outcomes were similar to previous experiences with mental health law reforms in Western countries: 'The IA [involuntary admission] rate declined rapidly under the influence of the new regulation; however, it rose gradually [again] due to a lack of supporting measures following the law, such as detailed operational procedures on IA and sufficient community-based services' (Ma et al. 2019). A separate study found a 'significant decrease' in the physical restraint of admitted patients following adoption of the MHL (An et al. 2016).

The narrowed criteria for involuntary admission also represents a challenge for medical practitioners, in that the 'danger criterion' of Article 30 is a 'brand new concept for most psychiatrists' and one which occasions 'conflict between two basic bioethical principles: respect for autonomy and beneficence'. One doctor who spoke to Hu put the quandary in stark terms: 'When they leave the hospital, they can't be treated properly and their conditions worsen, and they will very likely leave home, hurt themselves, commit suicide or hurt others. It would be too late then... Should we watch such patients die with their autonomy respected?' (Hu 2014). Some doctors have argued that the MHL 'over-emphasizes patient's self-sufficiency and, thus, neglects traditional Chinese culture' (the debate is summarised by Xiang et al. (2012)). It has also been suggested that fewer involuntary admissions could result in 'increased numbers of homeless mentally ill and some of these individuals may enter the correctional system' (Xie 2013).

A study published in 2018 found that only 45.3% of involuntarily admitted patients 'met the MHL-defined risk criteria', which 'suggests that some patients' civil rights might have been violated' (Huang et al. 2019, 3–4). This finding has been challenged by other scholars, who nevertheless observed that 'the author's [sic] concerns that some mental illness patients' civil rights might have been violated in China are not alarmist. There is no clear definition of 'current risk' in the criterion for involuntary admission, which may open a loophole for abuse of this clause' (Ma and Shao 2019).

Conclusion

The MHL is a key instrument for the governance of mental healthcare in China, although its ultimate impact remains to be seen. This chapter has illustrated that the MHL, described as a '26-year work in progress' in 2012 (Xiang et al. 2012), continues to be a focus of debate within psychiatric and medico-legal circles. The Law has been both hailed for its 'innovative facets' (Bertolote 2013) and criticised for imprecision and for tilting the balance too far in the direction of patient autonomy. Successful implementation in each province and municipality is likely to depend on matters such as competent planning and management and the provision of adequate resources.

For advocates of quality mental healthcare and the human rights of patients, the Law has nevertheless provided a valuable signal, by entrenching the purposes of 'developing the cause of mental health, regulating mental health services, and protecting the lawful rights and interests of patients with mental disorders' in national legislation (Article 1). It has codified important norms concerning community-based care, patient consent and rehabilitation, providing a national standard against which to measure local efforts. One further potential impact of the MHL, beyond the scope of this chapter, is the extent to which it influences mental health law in other countries, particularly in the global South. As China steps up its role in South-South cooperation and as forums such as the BRICS address legal topics (Neuwirth et al. 2017), China's approach to mental health regulation might well influence developments abroad, even as it continues to be debated at home.

References

An, F.-R., Sha, S., Zhang, Q.-E., Ungvari, G. S., Ng, C. H., Chiu, H. F. K., Wu, P.-P., Jin, X., Zhou, J.-S., Tang, Y.-L., & Xiang, Y.-T. (2016). Physical restraint for psychiatric patients and its associations with clinical characteristics and the National Mental Health Law in China. *Psychiatry Research, 241*, 154–158.

Bertolote, J. M. (2013). Rehabilitation in the mental health law of the peoples republic of China. *Shanghai Archives of Psychiatry, 25*(1), 63–64.

Birley, J. (2004). Political abuse of psychiatry. *Psychiatry, 3*(3), 22–25.

Bonnie, R. J. (2002). Political abuse of psychiatry in the Soviet Union and in China: Complexities and controversies. *The Journal of the American Academy of Psychiatry and the Law, 30*(1), 136–144.

Charlton, G., & Xiang, G. (2014). Human rights, procedural protections and the social construction of mental illness: Involuntary civil commitment under China's new mental health law. *Australian Journal of Asian Law, 15*(1), 1–19.

Chen, H., Phillips, M., Cheng, H., Chen, Q., Chen, X., Fralick, D., Zhang, Y., Liu, M., Huang, J., & Bueber, M. (2012). Mental health law of the People's Republic of China: Translated and annotated version of China's new mental health law. *Shanghai Archives of Psychiatry, 24*(6), 305–321.

Cohen, J., & Y. Chi. (2018). *It's too easy to wind up in a Chinese psychiatric hospital, and far too hard to get out*. China File, from https://www.chinafile.com/reporting-opinion/viewpoint/its-too-easy-wind-chinese-psychiatric-hospital-and-far-too-hard-get-out

Diesfeld, K., & Mellsop, G. (2012). Mental health law of the People's Republic of China: Inviting dialogue. *Shanghai Archives of Psychiatry, 24*(6), 360–361.
Ding, C. (2014). Involuntary detention and treatment of the mentally ill: China's 2012 mental health law. *International Journal of Law and Psychiatry, 37*(6), 581–588.
Guo, Z., & Feeney, F. (2018). The new Chinese mental health laws. *Washington University Global Studies Law Review, 2*, 411.
Hu, L.-Y. (2014). Reconsidering the danger criterion in China's mental health law: From an ethical perspective. *Asian Bioethics Review, 6*(2), 187.
Huang, J., Shao, Y., Ma, H., Yang, W., & Li, H. (2019). Changing of Chinese psychiatrists' attitudes toward consent process to treatment and its association with the China's National Mental Health Law. *The International Journal of Psychiatry in Medicine, 54*, 11–21.
Hussey, M. M., & Mannan, H. (2015). China's mental health law: Analysis of Core concepts of human rights and inclusion of vulnerable groups. *India, Shree Ramana Maharishi Academy for the Blind, 117*.
Lee, S., & Kleinman, A. (2002). Psychiatry in its political and professional contexts: A response to Robin Munro. *The Journal of the American Academy of Psychiatry and the Law, 30*(1), 120–125.
Li, D., Tsui, M. C., & Yuan, G. Z. (2014). China's new mental health law needs to tackle manpower imbalance of professionals in schizophrenia psychosocial rehabilitation. *The International Journal of Social Psychiatry, 60*(4), 410–411.
Liu, X. (1998). Preparation and draft of mental health law in China. *Psychiatry and Clinical Neurosciences, 52*(Suppl), S250–S251.
Ma, H., & Shao, Y. (2019). Commentary: The Implementation of China's Mental Health Law-Defined Risk Criteria for Involuntary Admission: A National Cross-Sectional Study of Involuntarily Hospitalized Patients. *Frontiers in Psychiatry, 10*, 121.
Ma, H. J., Xie, B., Shao, Y., Huang, J. J., & Xiao, Z. P. (2019). Changing patterns and influencing factors of involuntary admissions following the implementation of China's mental health law: A 4-year longitudinal investigation. *Scientific Reports, 9*(1), 15252.
Munro, R. (2000). Judicial psychiatry in China and its political abuses. *Columbia Journal of Asian Law, 14*(1), 1–128.
Munro, R. J. (2002). Political psychiatry in post-Mao China and its origins in the cultural revolution. *The Journal of the American Academy of Psychiatry and the Law, 30*(1), 97–106. discussion 195-106.
National People's Congress. (1987). *General Principles of the Civil Law of the People's Republic of China* (Revised) (English Translation), 中华人民共和国民法通则 [已被修订] (1986; in force 1987). (http://www.npc.gov.cn/englishnpc/lawsoftheprc/202001/c983fc8d3782438fa775a9d67d6e82d8.shtml). Beijing, The Government of the People's Republic of China.
Neuwirth, R., Svetlicinii, A., & Halis, D. D. C. (Eds.). (2017). *The BRICS-Lawyers' guide to global cooperation*. Cambridge University Press.
Pearson, V. (1992). Law, rights, and psychiatry in the People's Republic of China. *International Journal of Law and Psychiatry, 15*(4), 409–423.
Phillips, M. R. (2013). Can China's new mental health law substantially reduce the burden of illness attributable to mental disorders? *The Lancet, 381*(9882), 1964–1966.
Phillips, M. R., Chen, H., Diesfeld, K., Xie, B., Cheng, H. G., Mellsop, G., & Liu, X. (2013). China's New Mental Health Law: Reframing Involuntary Treatment. *American Journal of Psychiatry, 170*, 588–591.
Shao, Y., Wang, J., & Xie, B. (2015). The first mental health law of China. *Asian Journal of Psychiatry, 13*, 72–74.
Shao, Y., & Xie, B. (2013). Operationalizing the involuntary treatment regulations of China's new mental health law. *Shanghai Archives of Psychiatry, 25*(6), 384–386.
Standing Committee of the National People's Congress. (2018). *Decision of the Standing Committee of the National People's Congress to Amend Six Laws Including the Frontier Health and Quarantine Law of the People's Republic of China* (including the Law on Import and

Export Commodity Inspection, the National Defense Education Law, the Mental Health Law, the Counterterrorism Law and the National Intelligence Law), 全国人民代表大会常务委员会关于修改《中华人民共和国国境卫生检疫法》等六部法律的决定(含:进出口商品检验法、国防教育法、精神卫生法、反恐怖主义法、国家情报法) [现行有效],. Beijing, The Government of the People's Republic of China.

van Voren, R. (2010). Political abuse of psychiatry–an historical overview. *Schizophrenia Bulletin, 36*(1), 33–35.

van Voren, R. (2016). Ending political abuse of psychiatry: Where we are at and what needs to be done. *BJPsych Bulletin, 40*(1), 30–33.

Xiang, Y., Li, L., Ungvari, G. S., & Chiu, H. F. (2012). The proposed national mental health law in China: A landmark document for the protection of psychiatric patients' civil rights. *Shanghai Archives of Psychiatry, 24*(1), 48–49.

Xiang, Y.-T., Yu, X., Ungvari, G. S., Lee, E. H. M., & Chiu, H. F. K. (2012). China's National Mental Health Law: A 26-year work in progress. *The Lancet, 379*(9818), 780–782.

Xie, B. (2013). Detailed operational regulations are needed to implement the mental health law. *Shanghai Archives of Psychiatry, 25*(1), 60–62.

Zheng, S. (2017). *'Justice came late': Chinese psychiatric patient wins long battle for freedom in landmark case*. South China Morning Post https://www.scmp.com/news/china/society/article/2105935/justice-came-late-chinese-psychiatric-patient-wins-long-battle

Chapter 9
The National Mental Health Work Plan 2015–2020

Harry Minas

Abstract Development of the contemporary mental health system in China has been a work in progress since the late nineteenth century. Until the late 1970s, this has been in a context of conflict, and social and economic disruption. Despite such a difficult environment for attention to an already neglected field, progress was made, both during the Republican period and during the first three decades after the foundation of the People's Republic. The same period saw a major transition from largely traditional approaches to mental disorders to Western conceptions of mental illness and medical and other interventions and the institutional arrangements for the delivery of such interventions. It was not until the economic and social reforms that commenced in the late 1970s and early 1980s that mental health began to receive sustained government attention and investment, for the first time in a context of political stability, spectacular economic growth, growing international engagement and rapidly expanding internal capacity in all fields. In a very short historical time span, only four decades, a great deal has been achieved in population health and in mental health. The National Mental Health Work Plan 2015–2020 (NMHWP) is the latest government mental health policy and implementation plan. This chapter examines the historical background of the NMHWP, its structure and contents and the extent to which the NMHWP is aligned with international conceptions of comprehensive mental health systems.

From the mid-nineteenth century until the late 1970s, there was almost constant political, social and economic turmoil in China. Foreign interference in, and control of, major coastal cities; the Opium Wars of 1839–1842 and 1856–1860; the Taiping Rebellion (1850–1864), which resulted in the death of 20 million; the Boxer Rebellion in 1900 that sought to drive out all foreigners from China; and the nationalist democratic revolt in 1911–1912 that brought about the collapse of the Qing dynasty, which had ruled since 1644. From the early 1920s, the long conflict for

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control of China between the Nationalists under Chiang Kai-shek and Communists under Mao Zedong, briefly interrupted when a united front was formed to fight the Japanese, ended with the proclamation of the People's Republic of China on 1 October 1949. In 1950 China invaded and annexed Tibet, which had declared independence in 1912, and, in the same year, was drawn into the Korean War. The 1950s were further marked by the catastrophe of the Great Leap Forward and the 1960s and 1970s by the tremendous upheaval of the Cultural Revolution (Chap. 4, Gao).

Given this political, economic and social context, it is not surprising that psychiatric services development was not a political priority. And yet there was some development of capacity to respond to the needs of persons with mental disorders, both before and after the establishment of the People's Republic, consisting predominantly of building of psychiatric hospitals. The precursors to China's mental hospitals were established in the late nineteenth century in Guangzhou (Chap. 7, Li and Ran) and Hong Kong (Chap. 6, Wu). During the Republican period, "Western psychiatry" was more firmly established as a discipline in China (Chap. 3, Wang). In 1950 there were 9 mental hospitals, with 1142 beds, and 100 psychiatrists in all of China. By 1978 these numbers had grown to 219, 42,195 and 3128, respectively (Li et al. 2014) (Fig. 9.1).

The economic and social reforms initiated in the late 1970s and early 1980s, and rebuilding of educational and health institutions, ushered in a period of "opening up" to new ways of organising the Chinese economy and society and to growing international exchange and engagement. The period from the 1980s has been characterised by political stability, remarkable economic growth, increasing global engagement and vastly increased internal economic, scientific and educational capacity, creating the conditions for sustained attention to mental health system development. Along with developments in general health services and public health programs and health insurance systems, there was acceleration in the building of psychiatric facilities and in the training of psychiatrists. In 2009 there were 637

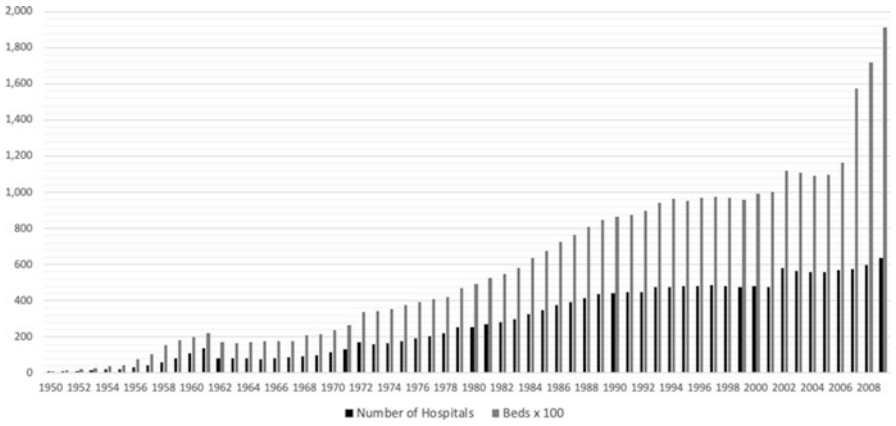

Fig. 9.1 Number of psychiatric hospitals and beds in China 1950–2009. (Source: Health statistics by the Center for Health Information and Statistics, Ministry of Health, cited in Li et al. 2014)

psychiatric hospitals and psychiatric departments in general hospitals, with 191,200 beds and 19,751 psychiatrists (Li et al. 2014) (Fig. 9.1).

As in other countries, the level of government attention to mental health and illness in China has grown, particularly since the 1980s, as has the recognition that mental health is both a vitally important health issue and important for economic and social development. The Second National Mental Health Plan (NMHWP) (the Plan) (Xiong and Phillips 2016) builds on more than a century of transformation in thinking about mental health and illness and efforts to develop effective treatment and care services for persons with mental disorders.

This chapter is organised in three sections: (1) an outline of some of the key historical developments in mental health in China; (2) the structure and content of NMHWP; and (3) an examination of NMHWP from a health systems perspective (World Health Organization 2009, 2010, 2013).

Mental Health System Development in China 1949–2015

Table 9.1 is a selection of important steps forward since the establishment of the People's Republic. Most are discussed in some detail in previous chapters. I will comment on only a few.

The First National Conference on Mental Health Care, a most important step in the development of the Chinese mental health system, was held in Nanjing in 1958, the same year that marked the beginning of the Great Leap Forward. The Cultural Revolution, which commenced in 1966 and ended with the death of Mao Zedong in September 1976, was not as deadly as the Great Leap Forward, but it destroyed education systems, schools and universities were closed, and the lives of many educators and researchers were severely disrupted. Psychiatric hospitals were closed, training of psychiatrists ceased and professionals of all kinds were humiliated, assaulted and sent into the countryside. Mental disorders were deemed not to exist as health problems but were understood as aberrant political thinking requiring political re-education (Chap. 4, Gao).

The early years of economic reforms initiated by Deng Xiaoping in the late 1970s and early 1980s resulted in the collapse of the successful Cooperative Medical Schemes and community health programs which had done so much to improve population health, particularly in rural communities, when they could no longer be economically sustained by provincial and local governments. But the opening up of China and the rapidly accelerating engagement with the rest of the world, in all fields, formed the basis for a resurgent, increasingly prosperous and confident China.

The publication in 1979 of the Chinese Classification of Mental Disorders (CCMD) was an expression of the prevailing desire of the time to assert distinctively Chinese conceptions of mental health and illness and of treatment and care. In subsequent editions CCMD has been increasingly aligned with successive editions of both the World Health Organization (WHO) International Classification of Diseases (ICD) and the American Psychiatric Association's Diagnostic and

Table 9.1 Some points on the road to the National Mental Health Work Plan 1949–2015

Year(s)	Development
1949	Establishment of the People's Republic of China
1951	Founding of the Chinese Society of Neuro-Psychiatry, later (1994) the Chinese Society of Psychiatry
1958	First National Conference on Mental Health Care held in Nanjing
1960s	Community mental health service models initiated
1979	Chinese Classification of Mental Disorders (CCMD)
1986	Second National Conference on Mental Health Services at Shanghai. Forensic psychiatry conference in Chengdu
1998	Beginning of expansion of the Chinese tertiary education system and establishment of comprehensive universities
1999	National mental health workshop convened by 10 Chinese Ministries and the WHO (Liu et al. 2011)
2002	The National Mental Health Project of China: 2002–2010 (The First National Mental Health Work Plan) (Wong et al. 2013)
2004	The Proposal on Further Strengthening Mental Health Work (2004) (Liu et al. 2011; Wong et al. 2013)
2004	Central Government Support for the Local Management and Treatment of Severe Mental Illnesses Project (the "686 Project") (Ma 2012)
2004	Continuous Improvement in Mental Healthcare Guide 2004 (Wang 2017)
2006	Ningbo Provincial Mental Health Law passed (Wong et al. 2013)
2007	Beijing, Hangzhou, and Wuxi Provincial Mental Health Laws passed (Wong et al. 2013)
2008	Guidelines for The Development of National Mental Health Care System (2008–2015) (Ministry of Health, 2008) (Wong et al. 2013)
2009	Opinions of the Communist Party of China Central Committee and the State Council on Deepening the Health Care System Reform (CPC Central Committee 2009)
2010	The political measures to promote the development of the mental health sector that arose from the 12th Five-Year Plan (2010–2015)
2010	Construction and Development Plan for the Mental Health Preventative Care System, which supported substantial construction of psychiatric hospitals
2012	The attention given to mental health in the 12th Five-Year Plan for Economic and Social Development (2011–2015) Planning commenced for the China Mental Health Survey (Huang et al. 2019)
2012	National Mental Health law passed, coming into effect in 2013 (Chen et al. 2012; Phillips et al. 2013)
2015	The Second National Mental Health Plan: 2016–2020 (Dong and Phillips 2008; Xiong and Phillips 2016)

Statistical Manual of Mental Disorders (DSM). Although all three classifications continue to be used in China, ICD is used for national statistics and international reporting, e.g. to WHO, DSM is most commonly used in psychiatric research and CCMD is widely used in clinical practice (Xiong and Phillips 2016). The increasing alignment of successive revisions of CCMD with ICD and DSM is an indication of the internationalisation of psychiatric thinking and practice in China.

Among the most important developments was the 1998 decision to greatly expand the Chinese tertiary education system and the development of

comprehensive universities. This change, together with the vast numbers of Chinese international students in the world's leading universities, has enabled an explosion of scientific research and technical and industrial innovation which has seen China emerge as a leading centre for cutting-edge science, including in the field of mental health (Zhang et al. 2017).

A seminar convened by ten Chinese Ministries and WHO in Beijing in 1999 produced an important declaration that more closely aligned Chinese government and WHO thinking on mental health system development in China. It included involvement of all levels of government, strengthened leadership and support for mental health, improved inter-sectoral collaboration and committed to establishing a mental health strategy and action plan, and to enacting a national mental health law (Liu et al. 2011). Discussion concerning the need for, and content of, such a law had commenced more than a decade earlier, and its enactment in 2012 was preceded by several local mental health laws and ordinances, in Shanghai (2001), Ningbo (2006), Beijing, Hangzhou and Wuxi (2007).

The first national mental health plan, The National Mental Health Project of China, 2002–2010, was a joint project of the Chinese Ministry of Health, Ministry of Civil Affairs and Ministry of Public Security and the Disabled Persons Federation. It stated that China must raise awareness of society's mental health needs and reduce the treatment gap. The project noted that "community care will take over… from the traditional hospital care in the 21st century" (cited in (Kelly 2014)), anticipating the direction taken by the National Mental Health Work Plan.

The Proposal on Further Strengthening Mental Health Work was approved in 2004 by the Ministries of Health, Education, Public Security, Civil Affairs, Justice and Finance and the China Disabled Persons Federation. In the same year, the most ambitious program of mental health service development for persons with psychotic disorders, the "686 Project" (Liu et al. 2011; Good and Good 2012; Ma 2012), was initially financially supported by the Ministry of Finance and subsequently grew quickly into a truly national mental health service and education program. The program started with 60 demonstration sites in 30 provinces in 2005, covering a population of 43 million and including extensive training programs. As noted in the NMHWP by the end of 2014, "4.3 million patients with severe mental disorders had been registered, among whom 73.2% had received follow-up visits and recommendation about rehabilitation from primary healthcare facilities" (Xiong and Phillips 2016). By 2018 the project had registered and was treating and managing 5.89 million (Fang et al. 2019).

Throughout this period of development, WHO has provided crucially important advisory and technical support. This has been important specifically in relation to the Plan. Following the publication of the WHO Mental Health Action Plan in 2013, the Regional Committee for the WHO Western Pacific Region, which includes China, approved the implementation of the Global Action Plan for the region. The WHO Mental Health Action Plan 2013–2020 and the Western Pacific Regional Implementation Plan – both endorsed by the Government of China – and the National Mental Health Work Plan "were formulated using similar principles and values" (Wang 2017).

Structure and Content of the National Mental Health Work Plan

The Mental Health Work Plan emerged from and is an elaboration of the mental health-related commitments made in the 12th Five-Year Plan. Multiple ministries and other government organs and related organisations, at national and subnational levels, were engaged in the framing of the National Mental Health Work Plan and have responsibility for its implementation, conveying the clear message that mental health is an all-of-government responsibility. As well as outlining significant past successes, it is forthright in identifying gaps and deficiencies in mental health system capabilities and performance. The NMHWP outlines strategies to build on past successes and to expand capacity and to improve the quality and reach of programs and services. Clearly stated objectives and numerical targets enable rigorous evaluation of the extent to which implementation has been achieved and of the impact of the proposed developments. The structure of the Plan is summarised in Table 9.2.

The opening paragraph of the Plan acknowledges the fact that population mental health and effective treatment and care for persons with mental disorders are not the sole responsibility of the health sector and that they are centrally important for social and economic development. The message that mental health is a whole-of-government and all-government-levels responsibility is most clearly expressed by the fact that the NMHWP is released under the authority of ten state organs, "executive agencies under the State Council of the People's Republic of China" (Xiong and Phillips 2016), each of which has departments and offices at lower administrative levels (Xiong and Phillips 2016). The NMHWP has depth as well as breadth of reach, an essential requirement for full implementation. In addition to responding directly to population mental health concerns, reform of the mental health system is seen as an important contribution to broader health and administrative reform, to strengthening the rule of law and to ensuring "a safe China". One of the two primary objectives of the NMHWP is to fully implement the National Mental Health Law (Chap. 8, Minas), which contains among its provisions strong protections of the civil rights of persons with mental disorder.

While the NMHWP has its origins in the commitments made in the 12th Five-Year Plan, it should be noted that it was developed at the same time as the 13th Five-Year Plan for Economic and Social Development of China (2016–2020) (Central Committee of the Communist Party of China 2016). The NMHWP and the 13th Five-Year Plan may be seen as working in concert. Chapter 4 in the 13th Five-Year Plan articulates the development philosophy, organised around five domains:

1. Innovation: the primary driving force for development
2. Coordination: an integral quality of sustained and healthy development
3. Green: both a necessary condition for ensuring lasting development and an important way in which people can work to pursue a better life
4. Opening up: vital for China's prosperity and development
5. Sharing: the essence of Chinese-style socialism

Table 9.2 Structure of the Second National Mental Health Work Plan

A. Background
B. General requirements
1. Ideological guidance
2. Overall target
3. Specific targets (by 2020)
C. Strategies and measures
1. Comprehensively advance the treatment and aid for individuals with severe mental disorders
Reinforce the patient surveillance system
Implement service management for patients
Implement medical aid policies
Improve rehabilitation services
2. Gradually develop preventive care for common mental disorders
3. Actively work on promoting psychological well-being
4. Make efforts to upgrade mental health service capacity
Strengthen the capacities of facilities
Strengthen the workforce
5. Gradually improve mental health information systems
6. Expand the effort to increase publicity and education about mental health
D. Enforcement
1. Strengthen governmental leadership
2. Assign responsibilities to relevant departments
3. Ensure financial input
4. Strengthen scientific research
E. Supervision and evaluation

The Five-Year Plan has set the task of ensuring, through a range of economic and related reforms, that it will be possible "*…to satisfy the people's ever-growing, constantly upgrading, and increasingly individualized material, cultural, ecological, and environmental needs*". The Action Plan for a Healthy China, part of the 13th Five-Year Plan, lists mental healthcare and mental illnesses among the "key and weak" areas requiring development support.

The 13th Five-Year Plan includes initiatives to improve accessibility and affordability of healthcare services and to increase both urban and rural health insurance coverage. Among important 13th Five-Year Plan initiatives that will support general and mental healthcare are the intended reforms in (1) the household registration system (hukou) which has in the past created hurdles to healthcare access and access to financial protection, education and other benefits, particularly for internal migrants; (2) health insurance and social security arrangements; (3) opening the healthcare system to greater participation by private service providers and a strong commitment to improving educational opportunities, particularly for poor and rural citizens (Staff Research Report 2017).

Background

The *Background* section of the NMHWP begins with a brief summary of past attention to, and achievements in, mental health, many of which are listed in Table 9.2.

> Substantial achievements include the gradual establishment of a coordinating network for mental health work among government leaders and departments at all levels of the government and the basic creation of a national mental health preventive care system and service network. By the end of 2014, 4.3 million patients with severe mental disorders had been registered, among whom 73.2% had received follow-up visits and recommendation about rehabilitation from primary healthcare facilities.

More importantly, the *Background* acknowledges both the increasing demands on, and the significant deficiencies in, the mental health system, observing that common mental disorders are increasing, and recognising that "mental health work in China still faces great challenges". The NMHWP identifies key gaps and deficiencies requiring specific attention. Some of the problems mentioned are the inadequate number and maldistribution of psychiatric facilities, beds and psychiatrists; the absence of a community-based rehabilitation capability; difficulties in some regions in identification and follow-up of patients; difficulties, particularly for poor people and some who require compulsory treatment, in access to effective treatment and support; limited community awareness and knowledge concerning mental health and illness; and social stigma and consequent reluctance of some people to seek treatment and care.

> Overall, the current capacity and quality of our country's mental health services lag far behind the community's demands for health care and the national needs for economic construction and social administration.

General Requirements

The *General Requirements* section of the NMHWP sets out ideological guidance for implementation, and the overall target and specific targets to be achieved by 2020.

The *ideological guidance* affirms the primacy of the Central Committee of the Chinese Communist Party (CPC) and the State Council in implementing the National Mental Health Law and the National Mental Health Work Plan.

> In order to optimize service systems, prioritize the treatment and management of patients, and safeguard social harmony, the work plan must integrate all types of resources, improve work procedures, make efforts to upgrade the capacity and quality of services, perfect the system for providing treatment and aid to patients, protect the legal rights of patients, safeguard the physical and mental well-being of the public, and promote the comprehensive development of the mental health sector.

Effective governance and leadership are universally acknowledged to be among the most critical determinants of success in reform and development of health

systems, including mental health systems. The model of governance and leadership expressed in the Plan is one of strong and unambiguous central control and leadership, with specified responsibilities at lower levels. At the same time, space is created for engagement and cooperation with non-state agencies and organisations, civil society organisations and the private sector. While the Plan is clear and explicit about the areas of responsibility for implementation of multiple state and non-state departments and agencies, the role of non-state players, crucially including patients and their families, in implementation of the Plan and in continuing policy development is a less prominent feature of the NMHWP.

A study of health system governance practices in relation to implementation of rural health insurance (Yuan et al. 2017) concluded that strong government commitment to health reform and clarity of policy goals within a hierarchical administrative system, central government prioritisation of health within national development policies, and increasing use of evidence and the ability of local government to adopt policy measures in the context of local conditions were all important contributors to successful reform (Yuan et al. 2017). The study also found, however, that poor collaboration between government departments continued to be a major challenge, a deficiency not unique to China.

Strong central control has been variously interpreted as necessary for effective decision-making and implementation (Yuan et al. 2017) or as political dominance of mental health services (Yip 2004). The existence of strong central control, or political dominance, has in the past been seen as a source of political abuse of psychiatry and the denial of human rights of persons with mental illness (Munro 2000; Birley 2002; Yip 2004). However, the 2013 Mental Health Law and the NMHWP contain strong civil rights protections, consistent with China's international human rights obligations – particularly the provisions of UN Convention on the Rights of Persons with Disabilities (CRPD) (United Nations 2007) which China ratified in 2008 – and sufficiently strong to raise concern among some observers within China that the protections in relation to involuntary admission may have gone too far.

"Policy experimentation under hierarchy" has been referred to as China's unique policy instrument in formulating and implementing health policies. "As a tool of governance, policy experimentation under hierarchy helps policymakers identify more feasible and adaptive pathways to master the complex institutional changes while avoiding systematic breakdown. Moreover, it is a smart approach to overwhelm the bureaucratic inertia and minimise the political opposition at the same time" (Li and Fu 2017).

The *overall target* of the Plan is "a universal integrated service system of prevention, treatment, and rehabilitation that guarantees treatment and support for persons with mental illness, substantially reduces the number of serious cases of 'incidents or troubles', improves the population's understanding of mental health, creates a social milieu of understanding, acceptance, and caring for individuals with mental illnesses, promotes psychological wellbeing and enhances the harmonious development of the society. The management network is to be led by government and cooperatively administered by government departments, community organisations, employers and families" (Xiong and Phillips 2016).

This is a bold, ambitious mental health system development target. It is also an overall target that is closely aligned with the WHO guidance on mental health system development as articulated in the WHO's Mental Health Action Plan 2013–2020 (World Health Organization 2013), with the UN Convention on the Rights of Persons with Disabilities (United Nations 2007) and with the general direction of mental health system development that is occurring in most countries globally.

As well as developing a more comprehensive and capable mental health promotion, treatment and rehabilitation system, the overall target includes substantial reduction in "the number of serious cases of 'incidents and troubles' caused by persons with mental illnesses". This is related to the view that mental health is an essential component of creating "a safe China", as noted in the opening paragraph of the NMHWP. The focus on incidents and troubles "caused by persons with mental disorders" in both the National Mental Health Law and the NMHWP unfortunately suggests that persons with mental disorder constitute a threat to social harmony and stability, a serious matter in China. Such an implied message can potentially undermine efforts to reduce stigma and discrimination and undermine the stated intent of creating "a social milieu of understanding, acceptance, and caring for individuals with mental illnesses".

> Yet the desire for control, and the order and stability control is believed to bring, is very strong. China's experience this century has largely been one of chaos: the overthrowing of the Qing dynasty and the declaration of the Republic; the descent into warlordism following that, compounded by the internecine warfare between the Nationalists and the Communists; the Japanese invasion; the Great Leap Forward in 1958 leading to a disastrous famine; to be followed by the terror of the Cultural Revolution (1966-76). The… continuing concern for order and stability permeate through mental health policies and practice and inevitably have an impact on the lives of people with a mental illness. (Pearson 1996)

Specific targets – e.g. percent of rural townships and urban districts that have mental health teams, the target number of psychiatrists per 100,00 population, and percent of patients with severe mental disorder who are receiving treatment and follow-up – are outlined in seven domains. The priority areas for action are:

1. Improved management and coordination mechanisms;
2. Strengthened administrative systems for mental health service agencies, with encouragement of participation by "non-public forces" (non-government and private agencies)
3. Reduced shortages of mental health professionals;
4. Treatment and support for persons with severe mental illness, substantial reduction in "incidents and troubles" caused by persons with such illness and prompt compulsory treatment of persons who cause "incidents and troubles";
5. Enhanced capacity to prevent and treat common mental disorders, including improved public knowledge and willingness to seek treatment;
6. Establishment of a community-based rehabilitation system through collaboration between specialised mental health facilities, community rehabilitation centres, social organisations and families; and
7. Improved social milieu for mental health work, including public education, and improved public awareness about psychological well-being.

The specificity of these targets is important in enabling rigorous evaluation of the implementation of the Plan, in informing necessary adjustments and course corrections during the implementation of the Plan, and in formulating the next mental health work plan.

Strategies and Measures

In order to implement service management for patients, local authorities are encouraged to follow the principle of "treat as many as possible of those who need treatment, manage as many as possible of those who need to be managed, and admit as many as possible of those who need to be admitted", and to implement a service model based on "treating severe illnesses in hospitals and managing rehabilitation in communities". Management mechanisms should lead to compulsory hospital admission and treatment for persons with mental illness who cause "incidents or troubles".

Implementing medical aid policies requires successful linking of multiple insurance systems to improve healthcare security for persons with mental illness. People with mental illness living in poverty, and populations affected by natural disasters and other emergencies, are a particular focus to ensure access to healthcare and social and economic support.

To improve rehabilitation services, local communities are encouraged to "promote a comprehensive, community-based, open model of rehabilitation for individuals with mental illnesses and mental disabilities that effectively links medical rehabilitation and social rehabilitation and that strengthens the technical support provided from specialized mental health institutions to community-based rehabilitation facilities". For poor patients the social aid systems should be adjusted to ensure access to treatment and to provide adequate social and financial support. Governments can purchase services from "non-public resources" to provide community-based rehabilitation and to re-integrate persons with mental illness into society.

The development of community-based rehabilitation programs and services is a high, and welcome, priority in the NMHWP. Although social rehabilitation is mentioned, it does not appear to fully encompass the contemporary community-based rehabilitation programs (Thomas and IDDC CBR Task Group) that explicitly seek to give effect to the principles of the UN Convention on the Rights of Persons with Disabilities (United Nations 2006). The core of these principles is the autonomy and legal agency of persons with mental disorders. Inconsistencies are likely to emerge between these principles and various other aspects of the NMHWP, such as the reliance on registration and surveillance and hospital admission and treatment for persons with mental illness who cause "incidents or troubles".

The NMHWP identifies mental health promotion and illness prevention as being essential to an effective mental health system. The targets for improved public awareness of, and knowledge about, mental health and illness, reduction of stigma and discrimination and creation of a more welcoming and inclusive social

environment are important in this regard. This is a significant shift from an institution-based and treatment-focused mental health system to one that spans the whole spectrum from positive mental health promotion, illness prevention, treatment, care and rehabilitation.

The NMHWP states that preventative efforts require "rational, scientific, and standardized diagnosis and treatment services that are based on established classification systems of mental disorders and on standardized practice guidelines", and that Traditional Chinese Medicine (TCM) "…professionals should be encouraged to participate in the preventive care". Preventative programs should also include programs that support psychological well-being, a most important part of which will be community education. Multiple government agencies and other organisations are expected to contribute to this society-wide effort to "develop mental health promotion strategies which include educational activities about psychological well-being targeted for specific groups including students, rural women, left-behind children, occupational subgroups, individuals who are incarcerated, and the elderly". This focus on mental health promotion and illness prevention is a relatively recent priority in the Chinese mental health system. Building the capacity to realise the relevant objectives will require sustained, long-term effort.

While some of these activities and programs will have primary prevention as a goal, the main focus of the NMHWP largely remains on secondary prevention. Little attention is given to important social determinants, such as domestic violence, child abuse, unsafe workplaces, insecure employment and migrant labour, and other factors that are known to substantially increase risk of mental disorder. Nor does the NMHWP devote much attention to the important links between general health problems – particularly non-communicable diseases such as cardiovascular disease and diabetes – and mental disorders or propose initiatives that would better integrate specialist mental health services and general health services.

The Plan's clearest focus is on upgrading mental health service capacity, improving the accessibility and quality of treatment services and moving towards a greater community focus, including building the capacity of primary care to recognise and treat mental disorders and to establish community-based rehabilitation facilities and capabilities. These are areas where the links between planning, investment, implementation and outcomes are most clear and direct. They are also areas of reform and development that are most amenable to quantification, monitoring and evaluation.

A central concern in the NMHWP is the need to substantially increase the number, quality and distribution of the mental health workforce, without which mental health service capacity cannot be improved. Part of this effort is directed at reducing the decades-long reliance on doctors and nurses, in recognition of the important contribution that can be made by other mental health disciplines. There is an intention to clarify the meaning of the term psychiatrist, since the majority of doctors working in the public mental health system and referred to as psychiatrists are not fully trained. There are multiple initiatives in various parts of the country to encourage and enable doctors to fully train as psychiatric specialists.

There is a clear commitment to strengthening of mental health information systems and research. An important objective of this strategic direction is to reinforce

the patient surveillance system. The 2012 National Mental Health Law stipulates the establishment of a mental health surveillance network (article 24), and that information from the surveillance system should guide the development of mental health work plans. Multiple government departments and agencies at all levels, including village and neighbourhood committees, and healthcare facilities and primary healthcare facilities are required to strengthen their cooperation to "identify, register, and report the illness episodes of individuals with severe mental illnesses", for the information to be collated in the National Informatics Management System for Severe Mental Illnesses.

The development of a sophisticated mental health information/surveillance system commenced in 2004 with the establishment of the National Continuing Management and Intervention Programme for Psychoses (the "686 Programme") "as a response to the Chinese government's concern on social harmony and stability" (Zhou and Xiao 2015). This program included registration of persons diagnosed with schizophrenia, bipolar disorder, delusional disorder or schizoaffective disorder. In 2011, at which time the 686 Programme had expanded to cover a population of 330 million in both urban and regional areas, the National System of Basic Information Collection and Analysis for Psychoses was implemented nationally and operated by the Centre for Disease Control and Prevention. As well as demographic and clinical data, information is collected on financial status, whether the patient has created "incidents and troubles" and an assessment of the risk of violence (Zhou and Xiao 2015).

Improved information is vitally important for policy and program development and for the continuing evaluation of mental health system performance. An overview of information systems collecting mental health data can be found in Zhou and Xiao (2015). The extent of identification, reporting and registration of persons with severe mental illness, the intended integration of mental health, general health and census databases, and the intended wide sharing of this information across multiple state and service agencies are likely to raise significant privacy and related concerns. Already there are concerns in many parts of the world about the growing reach into personal lives of multiple forms of "surveillance", both by states and by private companies that collect enormous amounts of personal data. An issue of particular concern relates to whether the wide range of personal and mental health data gathered by the mental health surveillance systems in China, and the sharing of these data across multiple systems, will result in the use of the data for purposes other than treatment and care of the patient and for policy and program planning. There is a measure of protection against such uses in the NMHWP in the statement that a "mental health surveillance system that includes basic information on mentally ill individuals and on mental health work should be established in accordance with relevant laws". However, the experience in other countries with surveillance as part of anti-terrorism laws suggests that surveillance measures introduced by governments, within existing laws, continually expand and are difficult to reverse.

Enforcement

The section on Enforcement consists of four domains of activity: (1) strengthen governmental leadership; (2) assign responsibilities to relevant departments; (3) ensure financial input; and (4) strengthen scientific research.

The first, *strengthen leadership*, is essentially concerned with the need for local authorities to build their capacity for "mental health work" and to commit to full implementation of the National Mental Health Law and the National Mental Health Work Plan. The second, *assign responsibilities*, is a listing of the wide range of national and lower-level government departments and non-government agencies that have responsibilities for implementation of various elements of the NMHWP.

The third component, *ensure financial input*, is arguably among the most important of the elements that will determine the extent and quality of implementation. The English language text of the Plan is almost 6000 words in length. Only 153 words are devoted to "ensure financial input", and much of the responsibility for finding, managing and reporting on the use of funds for mental health programs and services is allocated to local authorities. Beyond this there is the suggestion that "a diversified fund raising mechanism should be established; mechanisms for boosting non-profit investment and financing in mental health should be actively explored, and non-public [for-profit] investment in the provision of mental health services and community-based rehabilitation services should be encouraged". There is no statement about whether, how or to what extent the national government will financially support the implementation of the Plan. It is possible that this information may be contained in the implementation strategy that is noted in the brief final section of the NMHWP on Supervision and Evaluation. Given the scale of the ambition of the NMHWP, it would seem clear that provincial and local governments will not have the financial resources that are required to fully implement the NMHWP unless they receive substantial financial support from the national government.

The final component of the Enforcement section, *strengthen scientific research*, emphasises the need for mental health research and the fact that policymaking and planning should be based on evidence. This section provides a brief outline of a research agenda, specifying particular priority research areas. This is likely to be a useful guide to universities, other research institutions and research funders in identifying high-priority mental health research questions. The section also continues to reinforce the importance of international research engagement.

Supervision and Evaluation

Local authorities are encouraged to "evaluate the progress, quality, and effectiveness of the plan implementation", and implementation of the NMHP, and outcomes of implementation, are identified as criteria for evaluation of the performance of lower levels of government. The final evaluation of implementation outcomes is intended to be completed in 2020.

Does the Plan Address All Relevant Aspects of Mental Health Systems?

A health system is conceived as "all the organizations, institutions, resources and people whose primary purpose is to improve health… [including] efforts to influence determinants of health as well as more direct health-improvement activities" (World Health Organization 2009, 2010). A comprehensive mental health system consists of facilities, resources (human, physical and financial) and programs that deliver mental health promotion, illness prevention and treatment and rehabilitation. Underpinning the development and operations of a mental health system is a web of cooperative relationships between government departments and agencies (including health, education, employment, housing, justice), different levels of government from national to local, non-government and private sector organisations and agencies, the general population and, crucially, current and potential providers and users of mental health system programs and services. The political, economic and cultural context determines the extent to which such programs and services are funded, developed and managed through state/public or private for profit and not-for-profit organisations.

The building blocks of health and mental health systems (World Health Organization 2009, 2010) include (1) leadership and governance; (2) financing and payment arrangements; (3) human resources; (4) mental health facilities, equipment and supplies; (5) a full array of service delivery programs, including promotion, prevention, treatment and care and rehabilitation; and (6) health information systems and research. The operation of these components of the mental health system should produce equitable access to programs and services; adequate coverage for disparate populations and types of mental health problems and disorders; and high-quality programs and services that are effective and affordable, and which service users judge to be responsive to their needs and preferences. Programs and services must protect the safety of service users, service providers and the general community. A well-functioning mental health service system will make efficient use of limited resources, result in improved individual service user and population mental health, provide social and financial risk protection for persons with mental illness and their families, and be responsive to the diverse needs of population subgroups, e.g. rural and urban populations, different age groups, cultural and ethnic minorities, and the poor and homeless. The objective of mental health system reform and development is to improve health system performance.

It is clear from global experience, and from what is known about the social determinants of mental health and illness, that Ministries of Health cannot do all that needs to be done in order to protect and improve population mental health and to respond effectively to the multiple needs of persons with mental disorder. Sustained and deep cooperation with other sectors is essential. These include the education systems responsible for producing the mental health workforce and for educating children and the general public about mental health; the social systems responsible for financial protection; sectors that ensure availability of employment and housing

that are so crucial for good mental health; and justice and security systems that are responsible for public safety and the safety of persons with severe mental disorders. It is also essential to emphasise that the mental health system is embedded within a broader general health system that may or may not be sufficiently aware of the importance of mental health for good general health and of the frequent and sometimes severe mental health consequences of general health problems.

The leadership and governance arrangements, referred to as "policy experimentation under hierarchy" (Li and Fu 2017), if applied in a sufficiently flexible and creative manner, can be consistent with a complex systems approach to mental health system reform and development (Minas 2005, 2014). Given the diversity of sociocultural and economic circumstances across China, and the current inequities across the regions, considerable flexibility and creativity will be required for successful implementation.

There is an explicit recognition that there is currently insufficient investment in the mental health system and that this needs to be increased; that financing, that is, raising funds for mental health, needs to be diversified; and that the role of non-public or private-for-profit providers should be explored. Although there are numerical targets for most of the objectives included in the Plan, there is none for funding, although substantially increased funding will be an essential precondition for success in achieving the NMHWP targets.

The section on strengthening the workforce proposes a series of strategies to deal with the current shortage, quality and maldistribution of mental health professionals (Hu et al. 2017). Several of these strategies are being implemented in order to improve psychiatry training (Jing et al. 2018; Li et al. 2020), mental health skills in primary care (Wong et al. 2017), training to protect human rights of patients (Huang et al. 2018; Ye et al. 2018), training of community mental health staff to reduce stigma (Li et al. 2015, 2019) and training of primary care doctors in mental health (Searle et al. 2019). There is an intention to clarify and promote the roles of psychologists, psychotherapists and social workers in the mental health system. The NMHWP states that "Bringing Traditional Chinese Medicine (TCM) into full play, the capacity of psychiatry-like clinical departments in TCM facilities should be strengthened" and TCM clinicians should be trained "in the prevention and treatment of mental illnesses". However, there is no clarity about how the dominant allopathic (and mental) health system and TCM clinicians might work collaboratively.

Strategies to improve capabilities and clarify the roles of both specialist facilities and primary mental health services are outlined in the section *Strengthen the capacities of facilities*. The NMHWP proposes to broaden mental health service delivery by encouraging participation by for-profit specialised mental health facilities and community rehabilitation centres and government purchasing of services from private providers. This, together with the strategies on diversifying financing, broadening of the mental health workforce, and other aspects of the NMHWP will create a more pluralistic mental health system more capable of responding to diverse needs in the population.

The NMHWP is clear about existing service deficiencies and gaps and about the need for improved quality of, and more equitable access to, specialist and primary care mental health services, and promotion of population mental well-being. The provisions of the NMHWP, including the general and specific objectives, promote wider coverage, improved quality of services and safety of both service users and staff working in mental health services. The goals are improved health, by providing mental health promotion, treatment and rehabilitation programs and services, and equity, by identifying and focusing on the needs of a number of particularly vulnerable groups that require particular attention.

In articulating the desired mental health service delivery model, the NMHWP promotes a decisive move towards community-based mental health prevention and treatment services and the much needed and poorly developed capacity for community-based rehabilitation. There is recognition in the NMHWP that capable and effective community-based treatment, rehabilitation and care cannot be achieved with the current over-reliance on doctors (specialist and generalist) and nurses and that there is an urgent need to strengthen and to more systematically engage in the mental health system the disciplines of psychology and social work. Given the strong commitment to development of community-based rehabilitation, it is surprising that the discipline of occupational therapy is not mentioned.

The NMHWP is specific about the need for evidence-based policy and practice, emphasising the need for "rational, scientific, and standardized diagnosis and treatment services that are based on established classification systems of mental disorders and on standardized practice guidelines" and by providing both support and a broad set of priorities for mental health research. The NMHWP expresses strong support for improving mental health information systems in general, requiring identification, reporting and registration of persons with severe mental illness, the expansion of a national database of such persons and wide sharing of information from the database, as well as integration of these data with the residents' electronic health records, electronic medical records, and census databases.

Conclusions

The National Mental Health Work Plan 2015–2020 is comprehensive in scope and ambitious in intent, and addresses, to varying extents, all elements – the building blocks – of the mental health system in China. Full implementation would radically transform the scope, reach, capabilities and orientation of the Chinese mental health system. The mental health system envisaged by the NMHWP is closely aligned with global directions in mental health system development and reform, particularly as articulated by the mental health policy and service development guidance articulated by the WHO (World Health Organization 2009, 2010, 2013; Wang 2017). The NMHWP and the National Mental Health Law have gone a long way, but not all the way, to meeting the provisions of the UN Convention on the Rights of Persons with Disabilities (United Nations 2006). There is still some way to go in recognising the

centrality and the extent of agency of the person with a mental disorder in decision-making about her/his own life and the importance of engaging persons with mental disorder and their families in the processes of policymaking, service design and delivery, and service evaluation.

Comprehensive evaluation of the implementation of the NMHWP Plan will be critically important in sustaining and accelerating mental health system development in China. While the implementation challenges are many, there is a commitment by the government to create national, provincial and local mental health systems that are effective, affordable, equitable and attuned to local needs and circumstances. Whether the strength of this commitment can be sustained in the context of the anticipated slowing of economic growth in China in coming years remains to be seen. What will follow the National Mental Health Work Plan after 2020 will no doubt depend on the outcomes of evaluation of the implementation of the Plan and is as yet unknown.

However, there may be some indications. This and previous mental health plans and reform efforts have been, as they should be, a component of broader social, economic and general health reforms and plans, particularly the Five-Year Plans. In this regard it is likely that the most important development and the clearest guide to future mental health reforms is the Healthy China 2030 Plan (HC2030) (Li 2020). The next national mental health plan will need to fully conform with the goals, strategies and implementation plans of HC2030. This is not a constraint but an opportunity to fully integrate mental health with general health and possibly to achieve, in China, the levels of government attention and resourcing for mental health that have been lacking in every country. Mental health promotion and illness prevention, and development of high-quality, accessible mental health services, feature as key priorities in HC2030 (Li 2020).

References

Birley, J. (2002). Political abuse of psychiatry in the Soviet Union and China: A rough guide for bystanders. *The Journal of the American Academy of Psychiatry and the Law, 30*(1), 145–147.

Central Committee of the Communist Party of China. (2016). *13th five year plan for economic and social development of China (2016-2020)*. Beijing: Central Compilation & Translation Press.

Chen, H., Phillips, M., Cheng, H., Chen, Q., Chen, X., Fralick, D., Zhang, Y., Liu, M., Huang, J., & Bueber, M. (2012). Mental Health Law of the People's Republic of China (English translation with annotations): Translated and annotated version of China's new Mental Health Law. *Shanghai Archives of Psychiatry, 24*(6), 305–321.

CPC Central Committee. (2009). Opinions of the CPC Central Committee and the State Council on Deepening the Health Care System Reform. from http://www.china.org.cn/government/scio-press-conferences/2009-04/09/content_17575378.htm.

Dong, Z., & Phillips, M. R. (2008). Evolution of China's health-care system. *The Lancet, 372*(9651), 1715–1716.

Fang, M., Hall, B. J., Lin, Y., & Hu, S. X. (2019). Structural changes to enhance Mental Health Services in China: Experience and challenges. *Asian Journal of Psychiatry, 43*, 177–178.

Good, B. J., & Good, M. J. (2012). Significance of the 686 Program for China and for global mental health. *Shanghai Archives of Psychiatry, 24*(3), 175–177.

Hu, X., Rohrbaugh, R., Deng, Q., He, Q., Munger, K. F., & Liu, Z. (2017). Expanding the mental health workforce in China: Narrowing the Mental Health Service gap. *Psychiatric Services, 68*(10), 987–989.

Huang, J., Shao, Y., Ma, H., Yang, W., & Li, H. (2018). Changing of Chinese psychiatrists' attitudes toward consent process to treatment and its association with the China's National Mental Health Law. *International Journal of Psychiatry in Medicine*. https://doi.org/10.1177/0091217418791436.

Huang, Y., Wang, Y., Wang, H., Liu, Z., Yu, X., Yan, J., Yu, Y., Kou, C., Xu, X., Lu, J., Wang, Z., He, S., Xu, Y., He, Y., Li, T., Guo, W., Tian, H., Xu, G., Xu, X., Ma, Y., Wang, L., Wang, L., Yan, Y., Wang, B., Xiao, S., Zhou, L., Li, L., Tan, L., Zhang, T., Ma, C., Li, Q., Ding, H., Geng, H., Jia, F., Shi, J., Wang, S., Zhang, N., Du, X., Du, X., & Wu, Y. (2019). Prevalence of mental disorders in China: A cross-sectional epidemiological study. *The Lancet Psychiatry, 6*(3), 211–224.

Jing, L., Chang, W. C., Rohrbaugh, R., Ouyang, X., Chen, E., Liu, Z., & Hu, X. (2018). The psychiatry major: A curricular innovation to improve undergraduate psychiatry education in China. *Academic Psychiatry, 42*(3), 376–381.

Kelly, T. A. (2014). Transforming China's Mental Health System: Principles and recommendations. *International Journal of Mental Health, 36*(2), 50–64.

Li, B. (Ed.). (2020). *Tutorial for outline of the healthy China 2030 plan: National Health Commission of the People's Republic of China*. Singapore: Springer Nature and People's Medical Publishing House.

Li, L., & Fu, H. (2017). China's health care system reform: Progress and prospects. *The International Journal of Health Planning and Management, 32*(3), 240–253.

Li, K., Sun, X., Zhang, Y., & Kolstad, A. (2014). Mental health care in China: Review on the delivery and policy issues in 1949-2009 and the outlook for the next decade. *Acta Neuropsychiatrica, 26*(3), 134–145.

Li, J., Li, J., Thornicroft, G., Yang, H., Chen, W., & Huang, Y. (2015). Training community mental health staff in Guangzhou, China: Evaluation of the effect of a new training model. *BMC Psychiatry, 15*, 263.

Li, J., Fan, Y., Zhong, H. Q., Duan, X. L., Chen, W., Evans-Lacko, S., & Thornicroft, G. (2019). Effectiveness of an anti-stigma training on improving attitudes and decreasing discrimination towards people with mental disorders among care assistant workers in Guangzhou, China. *International Journal of Mental Health System, 13*, 1.

Li, W., Ng, R. M. K., & Li, L. (2020). Psychiatric education in greater China. *International Review of Psychiatry, 32*(2), 167–171.

Liu, J., Ma, H., He, Y. L., Xie, B., Xu, Y. F., Tang, H. Y., Li, M., Hao, W., Wang, X. D., Zhang, M. Y., Ng, C. H., Goding, M., Fraser, J., Herrman, H., Chiu, H. F., Chan, S. S., Chiu, E., & Yu, X. (2011). Mental health system in China: History, recent service reform and future challenges. *World Psychiatry, 10*(3), 210–216.

Ma, H. (2012). Integration of hospital and community services-the '686 Project'-is a crucial component in the reform of China's mental health services. *Shanghai Archives of Psychiatry, 24*(3), 172–174.

Minas, H. (2005). Leadership for change in complex systems. *Australasian Psychiatry, 13*(1), 33–39.

Minas, H. (2014). Human security, complexity and mental health system development. In V. Patel, H. Minas, A. Cohen, & M. Prince (Eds.), *Global mental health: Principles and practice*. New York: Oxford University Press.

Munro, R. (2000). Judicial psychiatry in China and its political abuses. *Columbia Journal of Asian Law, 14*(1), 1–128.

Pearson, V. (1996). The Chinese equation in mental health policy and practice: Order plus control equal stability. *International Journal of Law and Psychiatry, 19*(3-4), 437–458.

Phillips, M. R., Hanhui, C., Diesfeld, K., Bin, X. I. E., Cheng, H. G., Mellsop, G., & Xiehe, L. I. U. (2013). China's New Mental Health Law: Reframing involuntary treatment. *American Journal of Psychiatry, 170*(6), 588.

Searle, K., Blashki, G., Kakuma, R., Yang, H., Zhao, Y., & Minas, H. (2019). Current needs for the improved management of depressive disorder in community healthcare centres, Shenzhen, China: A view from primary care medical leaders. *International Journal of Mental Health System, 13*, 47.

Staff Research Report. (2017). *The 13th five year plan*. US-China Economic and Security Review Commission: Washington, DC.

Thomas, M., & IDDC CBR Task Group. *Community based rehabilitation and the convention on the rights of persons with disabilities*. Brussels: International Disability and Development Consortium.

United Nations. (2006). *Convention on the rights of persons with disabilities*. New York: United Nations.

United Nations. (2007). Convention on the Rights of Persons with Disabilities (CRPD). From https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html.

Wang, X. (2017). Objectives of China and the global mental health work plan. *Shanghai Archives of Psychiatry, 29*(2), 111–112.

Wong, D., Zhuang, X., Pan, J.-Y., & He, X. (2013). A critical review of mental health and mental health-related policies in China: More actions required. *International Journal of Social Welfare, 23*, 195–204.

Wong, W. C. W., Zhu, S., Ong, J. J., Peng, M., Lam, C. L. K., Kidd, M. R., Roland, M., & Jiang, S. (2017). Primary care workforce and continuous medical education in China: Lessons to learn from a nationwide cross-sectional survey. *BMJ Open, 7*(7), e015145.

World Health Organization. (2009). *Improving health systems and services for mental health*. Geneva: World Health Organization.

World Health Organization. (2010). *Monitoring the building blocks of health systems: A handbook of indicators and their measurement strategies*. Geneva: World Health Organization.

World Health Organization. (2013). *Mental health action plan 2013-2020*. Geneva: World Health Organization.

Xiong, W., & Phillips, M. R. (2016). Translated and annotated version of the 2015-2020 National Mental Health Work Plan of the People's Republic of China. *Shanghai Archives of Psychiatry, 28*(1), 4–17.

Ye, J., Xiao, A., Yu, L., Guo, J., Lei, H., Wei, H., & Luo, W. (2018). Staff training reduces the use of physical restraint in Mental Health Service, evidence-based reflection for China. *Archives of Psychiatric Nursing, 32*(3), 488–494.

Yip, K.-s. (2004). Political dominance of Mental Health Services in the People's Republic of China. *Administration and Policy in Mental Health, 31*(6), 495–502.

Yuan, B., Jian, W., He, L., Wang, B., & Balabanova, D. (2017). The role of health system governance in strengthening the rural health insurance system in China. *International Journal for Equity in Health, 16*(1), 44.

Zhang, J., Chen, X., Gao, X., Yang, H., Zhen, Z., Li, Q., Lin, Y., & Zhao, X. (2017). Worldwide research productivity in the field of psychiatry. *International Journal of Mental Health System, 11*, 20.

Zhou, W., & Xiao, S. (2015). Existing public health surveillance systems for mental health in China. *International Journal of Mental Health System, 9*(1), 3.

Chapter 10
The Rise of the Therapeutic in Contemporary China

Jie Yang

Abstract This chapter examines the notion of therapy and its growing significance in the social, political, and affective life in China during the last four decades. Specifically, it explores the ways in which the languages, ideas, and practices of psychology have been applied to various domains for different purposes and imperatives including addressing the current mental health epidemic. This therapeutic ethos acts as both a mode of thinking and imagination. Since therapy suggests an illness or disease and it encompasses a dual process that both diagnoses (identifies an issue) and prescribes (offers solutions), this understanding can thus be easily appended to governance, problematizing (pathologizing, thus individualizing) social issues, and then proposing solutions. This mode of therapeutic governing involves a unique mode of psychologization in China, in which psychological expertise can be dispensed by non-experts with real consequences. It centers on the management of subjectivity. This mode of therapeutic governing accesses people's subjectivity through "care" and "permissive empathy" that renews the government's role as the "guardian of the people". This chapter contends that the ways this therapeutic ethos involved in Chinese society manifest the implicit complicity among therapy, the state, and market.

Keywords China · Therapy · Subjectivity · Therapeutic governance · Therapeutic economy · Therapeutic lifestyle

In recent decades, a therapeutic ethos has come to permeate social and political life in China. The emergence of this ethos has been concurrent with China's post-socialist transition to a market economy, which has brought socioeconomic dislocation and widespread mental distress, reportedly affecting over 100 million people (Chen 2010). One way to think about ubiquitous mental distress is through the

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concept of *ya jiankang* (亚健康 "subhealth"), an ambiguous state between health and illness (Yang 2018a). This condition now reportedly affects about 80 percent of the Chinese population (Liu 2008), due to epidemic levels of confusion, insecurity, and anxiety. This helps explain the current high demand for psychological answers and psychological services. The Chinese government has responded to this demand in part through therapeutic paradigms: addressing public life by fostering the psychoboom (Kleinman 2010; Huang 2014), tackling changes in family dynamics and responsibilities through highly gendered marriage counseling and the professionalization of parenting skills (Kuan 2015), and managing the devastating effects of economic restructuring, from persistent unemployment to drug addiction, through psychotherapeutic interventions (Yang 2015; Bartlett 2018).

Indeed, the rise of a therapeutic ethos seems to, at once, flow from and help constitute the psychoboom in which psychotherapy, psychological training, and psychometrics have blossomed (Kleinman 2010). The process of globalization serves as the backdrop for this dialectic. Since the early 2000s, as part of the outflow of Western psychological practices to the rest of the world (Watters 2011), China has been exposed to Western psychotherapy and psychiatry, with attendant treatment methods, techniques, and psychopharmaceuticals. Importantly, the languages, ideas, and practices of Western psychotherapeutic expertise have also infiltrated Chinese society. Unlike previous, discrete moments in which psychology in China was used to improve narrowly defined social domains and functions—for example, in the treatment of political dissidents in Mao's era (Munro 2002)—psychology today suffuses a wide range of institutions, practices, and discourses. Now Western psychology has achieved the status of cultural authority in China. This trend has also stimulated a turn to and revitalization of Chinese cultural tradition among psychologists as well as its incorporation into practice of local and indigenous healing resources especially since 2013 when the first Chinese Mental Health Law took effect; this law focuses on psychiatric hospital care predominantly based on Western biomedicine as *the* legitimate mental health treatment model.

While absence of and underdiagnosis of mental illness has long been a serious issue in China, owing to limited mental healthcare resources, more recently, the situation is reversed: people have been subject to overdiagnosis or misdiagnosis, or even mislabeled as mentally ill. This is true, for example, in the case of rising suicides among Chinese officials, who are often posthumously labelled "depressed" by non-medical investigators (see Yang 2018b). Overdiagnosis can also extend to those who oppose the government including petitioners and dissidents, which highlights the power of psychological discourse and its possible misuse as a governance tool.

Indeed, by popularizing psychological knowledge, the government and the public may invest it with ideological and ethical content, turning psychological knowledge and techniques into modes of control. In this process, imbuing diverse social domains with a therapeutic ethos shifts the focus from practices informed by Marxist materialism and social reality to psychology or "heart"-based practices, the heart being a key concept in Chinese culture. Heart-based practices rely on narratives and interpretive stances rather than on "objective" reality (Illouz 2008). Thus, in today's

context, the heart (or interiority) takes on multiple roles: as a locus of agency, a venue for knowledge production, a nexus of cultural expression, a mode of self-management, and a target of power. The mode of therapeutic governing that emerges with this new heart-based scene wields a more hegemonic form of power; the state/therapist approaches its people/clients by opening up and moving their hearts for various purposes through "care" and "permissive empathy" (Parsons 1965) or through psychological discourses that shape the public's psychological imagination.

Therapy then becomes more than a method for healing psychological and mental distress. It is a strategy for solving social issues in a distressed, ill-ordered, and increasingly stratified society. Therapy putatively narrows the gap between social stratification/distress and alleged social harmony. That is, therapy not only addresses the psychological and emotional consequences of the widespread socioeconomic dislocation, but is also used to meet political, economic, and social needs, for example, the need to renew socialist ideals truncated by the ongoing post-socialist transformation and the desire for advancing economy by creating new jobs related to psychotherapy and developing the mental health industry. For the government, it is a ready means of engaging people, showing "care," and renewing socialist ethics.

The Notion of Therapy

In this chapter, I view the notion of therapy as multivalent and polysemic. Therapy encompasses languages, ideologies, practices, and expertise, but it is also a metaphor to represent, discuss, and deliver solutions for social issues. Thus, therapy exceeds medical domains to exert influence in other arenas of social life. For example, therapy can be associated with *renqing* or *ganqing* (人情, 感情 "human feelings" or "compassion") in the Chinese context, which is viewed as having healing effects (Kipnis 1997); thus, a friendly, compassionate visit to someone who is sick or in difficulty can be "therapeutic."

While therapy does not seem to be a core principle of traditional Chinese medicine, it has even become attached to its practices. The ideal medical principle proposed in *Huangdi Neijing*, "the Inner Canon of the Yellow Emperor," is *bu zhi yi bing zhi wei bing* (不治已病治未病 "not treating diseases but preventing diseases"). The holistic approach to illness in traditional Chinese medicine is thus not typically based on a disease model and does not foreground treatment or therapies, focusing instead on everyday practices of self-cultivation and nurturing life.

However, the concept of therapy seems to have gained new traction and has assumed new social and political significance in China especially since the 1990s with unfolding economic restructuring. It is used to fill the gap created by the contradictory processes caused by China's integration into the globalization process. As Bourdieu observes, the globalization process is "a kind of *historical acceleration* which caused two forms of economic organization, normally separated by a gap of several centuries and making contradictory demands on their participants, to co-exist . . ." (2000:18, emphasis in original). More specifically, therapy is deployed

to patch up the vacuum created by the releasing of market force and the decline of belief in communism by ordinary people. To some extent, therapy connects both of China's goals of economic development through market expansion and sociopolitical stability through the party's continued claims to renew socialist ethics of "caring" for the people as their "guardian."

At the same time, in the context of globalization and economic restructuring in China, therapy has become enmeshed with and helps reformulate traditional concepts of self-care and life-nurturing. The rollback of state support for health care has compelled people to pay increasing attention to their own health and well-being. Thus, economic necessity has dovetailed with individual nurture of life. Traditional practitioners now seem to take a more positive view of therapeutics.

Therapeutic Governance

The Chinese government's current emphasis on *yi ren wei ben* (以人为本 "the people as the basis of governing) and *min xin shi zui da de zhengzhi* (民心是最大的政治 "the attention to the hearts of the people is the biggest politics"), combined with a greater emphasis in the post-Mao era on people's private and internal lives, has foregrounded the role of the heart and psychology in the art of governing. Such an emphasis implies that the great challenge for the Chinese communist party in maintaining its legitimacy is how to open up and move people's hearts in order to align them with the party's ideologies and rules amidst rapid change. Thus, *xinli hua* (心理化 roughly "psychologization"), the attention to and through the heart or treating social and cultural issues in personal and psychological terms, or through biomedical rationalities, becomes integral to governing (Yang 2018a).

Given the global context of neoliberal approaches to care and the global rise of therapeutic governance, China is not alone in turning to therapeutic governance. Yet its case involves different and even unique practices. In the Western literature on this trend, we see psy experts playing a key role in governmentality (Miller and Rose 1994) and the therapeutic state (Szasz 2001; Polsky 1991; Nolan 1998). In China, conversely, psy experts are dispensable; non-medical agencies and institutions (including governments), and even the public, participate in this mode of control, for example, through informal diagnosis (Chen 2010; Yang 2017). This non-medical approach is partly a lingering effect of Maoist perceptions of mental illness as social or ideological pathology, and partly a product of the capricious, sovereign power of the Chinese state. For instance, in the aforementioned case of suicides among Chinese officials, the government accepts informal diagnoses by media and employers that blame the deaths on biomedical depression. This move serves the government's own need for expediency and limited scrutiny of the problematic bureaucracy. Informal diagnosis may also flow from the traditional practices of self-cultivation in nurturing life. With enough exposure to the media and government-sponsored training, anyone can become a mental health "expert." But low expert responsibility leaves psy power open to abuse and ignorance.

Therapeutic governing in China is also implemented when psychological techniques are wedded with welfare networks, especially targeting vulnerable groups. Unlike the Western therapeutic (welfare) state, which tends to normalize and integrate marginalized people (to the mainstream) to minimize the role of the state in the lives of individuals (Polsky 1991) and usually promote freedom, China's welfare programs including poverty relief and re-employment programs emphasize care and the *nurture* of disgruntled members of disadvantaged groups (for example, unemployed men) to appease them and sustain stability. These processes highlight the "benevolence" of the state, transforming the poor from subjects with rights to objects of care (Yang 2015). By embracing therapeutic practices and ideologies in this way, power can operate at a distance. Therapeutic governance is not a repressive force; it is, rather, akin to a new style of thought, "endowing individuals with new competencies, aptitudes and qualities" (Miller and Rose 1994: 36). Indeed, while Western therapeutic governing posits the self as fragile, requiring continuous therapeutic guidance (Furedi 2004), therapeutic governing in China promotes a positive vision of realizing human potential. At the individual level, this may not even be perceived as the exertion of power but instead as personal growth and development. One's potential is realized with the help of positive psychology, *zheng nengliang* (正能量 "positive energy"), and the positive values of Chinese cultural tradition (Yang 2018a). That is, people approach therapeutics as individuals, not perceiving the role of government in the actualization of their "potential." While people focus on self-growth, the government seeks order and control. Chinese therapeutic governance is thus subtle, operating at the most intimate levels.

Therapy and Subjectivity

This intimacy means that Chinese therapeutic governance centers on the management of subjectivity. Psychology has provided people with new concepts through which to conceive themselves and the world, as well as with techniques of care, healing, and self-fashioning. As individuals are "made up" (Hacking 1986) through particular forms of psychology (often those endorsed by the government in China), their subjectivity can ally with and reproduce state interests. People are too obsessed with themselves to notice much of anything else. Their attention is kept focused on themselves through the socialization into hegemonic instantiations of what Teo (2018) calls "neoliberal forms of subjectivity" (hereafter NLFS). NLFS "colonizes all forms of subjectivity" (2018:583), and its approach to problem solving is to work on one's own feelings as "individualized, psychologized and privatized products" (2018:590). These forms of subjectivity foreclose any feelings of solidarity or collectivity. They highlight the fundamental individuation at the heart of neoliberal forms of subjectivity, leading to an incapacity of individuals to feel connected beyond their immediate circle (Yang 2018a). In general, therapeutic practice represents "the contemporary mood of individualization" (Furedi 2004:21).

Furthermore, therapy penetrates individual subjectivity in ways that other forms of power cannot. Talcott Parsons (1965) pointed out that while other institutional interventions may leave individual subjectivity untouched, therapy brings with it the possibility of influencing people's internal lives. Rather than judge or moralize their suffering or behaviors, therapists empathize with individuals and establish a sense of "permissiveness" with them (Parsons 1965: 317). Through such permissive empathy, therapists can gain privileged access to the people's subjectivity. They are also able to grant compliance through providing individuals with a diagnosis. In embracing a therapeutic ethos, the Chinese government gains this special access. Further, psychological "care" for the people highlights the role of the state as people's "guardian," part of the party's "guardian discourse," contributing to its legitimacy (Shi and Lu 2010). In general, therapy can help the government forge new points of contact with the public while establishing a less antagonistic relationship between governors and governed in China.

Psychologization

One key mechanism of Chinese therapeutic governing is *xinli hua* (心理化 "psychologization"). Psychologization can be understood as a mimesis of the vital by the social. According to Georges Canguielham (1989), as far as health, disease, and healing are concerned, an organism and a society are very different things. The therapist knows in advance what normal state to establish in an individual organism, while in the case of society, she does not know (Canguielham 1989). Organisms are the norm for a doctor's restorative activity, while social norms are invented (Canguielham 1989). The norms of docility, legality, productivity, punctuality, civility and the like do not reflect a vital order, but rather, paradigms established by sociopolitical authorities seeking order and control. Social organization might copy vital organization, but these are never the same. In copying the vital, social norms presuppose an understanding of vital organization, allowing for its mimesis within the scope of social possibilities. By treating social situations as vital, therapists or governments can attribute the causes of trouble to individuals, blaming the vital organism (person) rather than the system.

For example, between the mid-1990s and the early 2000s, the Chinese government, recognized the threat to order and stability posed by mass unemployment as a result of state enterprise restructuring. It thus undertook a national re-employment project. But instead of focusing on job supply, the project has adopted an individualized and psychologized approach. Techniques of counselling and positive psychology are built into programs with the aim of transforming the attitudes, emotions, and thought processes of the unemployed in order to help them adapt to the market economy. Class-based socioeconomic issues are thus transformed into a matter of individual emotion or psychology. As part of this process, former communist party officials have become trainers in various types of therapy, representing both a new (therapeutic) turn in the Chinese experience and an adaptation of Maoist methods.

Indeed, since the early days of Chinese communist rule, there has been a presumed dialectical relationship between ideology and mentality, including mental illness: correcting one's political ideology in Mao's era would allow one to recover from mental illness. The putative reason why people became mentally ill was that their heads were filled with an excess of selfish ideas and personal concerns, which could be eradicated through the traditional communist ideological orientation (thought work) and medication.

In this context, attention to genuine psychological disorders among unemployed workers is sparse. Instead, the state-sponsored re-employment programs are inundated with psychological knowledge, particular modes of judgement, and interventions. Complicity between the Chinese state and the market is discernible, as multiple forms of counselling are increasingly commercialized alongside the gradual collapse of work units as the basis of material, emotional, and psychological support for state workers. Instead of the "freedom" promised by Western psychotherapy, these Chinese forms of counselling or psychological training targeting redundant workers emphasize "care" by the government. Care renews socialist promises, not to mention the paternalistic relationship between governors and governed that marked the Maoist era.

Therapeutic Economy

Liaoyu jingji (疗愈经济 therapeutic economy) refers to economic development that banks on people's confusion, insecurity, loneliness, and distress (especially anxiety and depression in China today) as well as ill health with the purpose of healing. It is a business model based on vulnerability and suffering. Within China's psychoboom, the heart and ambiguous interiority have been tapped for developing a therapeutic economy, and both have become (new) sites and resources for value extraction and entrepreneurial capital. In China, there are two main ways the therapeutics is involved in the market economy: one is commercialized therapeutic practices including counseling and psychosocial or psychospiritual trainings, and the other is the therapeutic ethos infused in advertising, commodities, and services to promote consumption.

China's mental health woes have contributed to rapidly developing mental health and wellness industries. These include private mental hospitals, vast self-help genres (books, websites, TV shows, etc.), commercialized counseling, therapeutic pedagogies (on psychomoral and psychospiritual training), and the sale of psychopharmaceutical drugs. The Internet has enabled this market to grow rapidly. Counseling is mostly practiced online through the immensely popular Chinese phone app WeChat (微信). In search of profit, psychotherapists now focus on group training for white-collar workers in big corporations as part of thier *tuanjian* (团建 "team building") or online group counseling, more than one-on-one private talk therapy. Psychotherapy has gradually become integral to China's new media and the market economy.

Meanwhile, widespread anxiety, loneliness, and alienation have also spurred new businesses such as *peiban jingji* (陪伴经济 "the companion economy"). Websites and (online) shops have been set up to help clients cope with negative emotions including anger, loneliness, sadness, and shyness, by sending them congratulations, apologies, and empathy, offering anger management or bed-warming services, and finding marriage partners or surrogate girlfriends or boyfriends for holiday seasons to avoid parental nagging. New professions such as *peilian* (陪聊 "chatting companions" or "companionable counselors") have also emerged to help people cope with distress and suffering. Companionable counseling is highly gendered, mainly carried out by laid-off women workers turned housemaids or by rural migrants turned domestic workers (Yang 2015). This dovetails with the government's vague gendered re-employment strategy. These are typical women's jobs; ambiguous job descriptions and lack of state regulation have intensified the exploitation of women's psychological and affective labor (Yang 2015).

Therapeutic Consumption and Ecopsychology

With the advent of the psychoboom in China, therapeutic consumption has gone up drastically—that is, consumption of commodities or services for one's happiness and fulfillment. Chinese advertising has now explicitly deployed psychological precepts and techniques to sell products and services, linking commodities with particular states of psychological or emotional being. Such advertising implies that through "consuming" certain commodities or services, the consumer's identity will be transformed; by ingesting a drug or using a product, one expects to achieve health, lifestyle, happiness, or fulfillment. Commodities thus become transformational objects and consumption a transformative and therapeutic process. Therapeutic consumption tends to target people who suffer sub-health in China. Products or services advertised to relieve people's distress and cure ills are often called *zhiyu xi* (治愈系 "therapy series").

One such *zhiyu xi* is the natural health trend, including ecotourism, ecopsychology, and forest health cultivation or *senlin kangyang* (森林康养 "forest therapy"). *Senlin kangyang* is a new discipline adopted by Chinese universities, including Beijing Forestry University, that incorporates high-quality forest resources into traditional and modern medicine. According to the central government's 5-year forest development plan, China aims to have 500 health service centers in forest zones nationwide by 2020. All of these approach nature as a basis of healing, health, enlightenment, and success. Ecotourism and ecopsychology are of special interest now due to concerns about the mental health effects of air pollution in China. Psychiatrists I have spoken to say they have seen a slight increase in psychological symptoms correlated with air pollution—mostly anxiety over the possibility of pollution-related illness. While the doctors are cognizant that anxiety is sensitive to climate change in general (i.e., seasonal affective disorder, SAD), the circumstances in China today are unique: atmospheric changes are human-driven, caused by

large-scale industrial activities, often unfettered by inadequate environmental regulation, sometimes increased by corruption. Thus, distress related to smog ("smog-blues") might have both social and environmental significance.

> In response, for example, in suburban Beijing such as in Changping, organic farms and mountainside "heart-soul oxygen bars" (心灵氧吧) have become popular tourist sites, and psychologists counsel tourists via de-stressing activities, such as shredding cornstalks and talking to animals. These forms of psychological relief combine nature-based healing with counselling based on traditional therapeutic modes that rarely look beyond the individual, family, or interpersonal dimensions for causes of stress, ignoring structural or political causes. This approach attempts to cultivate healthy subjects who can cope with the environmental and health effects of China's modernization and socioeconomic transformation.

Ecopsychology dips into tradition to assist in its aims. While Confucianism has long been used to legitimize social hierarchy and sociopolitical stability, in China today, there is a backlash against it, while Daoism is on the rise—as both a healing resource and a (seemingly) depoliticized mechanism to cultivate harmony between human beings and the environment. The government recently invoked Wang Yangming, the neo-Confucian scholar of the Ming Dynasty who integrated Daoist and Buddhist precepts and doctrines into Confucianism, to promote its own take on "holism." The government encourages citizens to holistically balance work and family as a means of addressing the "existential" crisis (including suicides) especially within Chinese officialdom. This invocation of Wang Yangming and the push for holism signal a more recent shift in governing from a focus on the interpersonal to the existential. Likewise, in ecotourism and ecopsychology, discursive practices of counseling and bodily and sensory modes of communication and healing are merged. Counselors draw upon both Chinese cultural traditions (i.e., Daoism) and Western psychology to create resources for self-cultivation and self-help.

Counseling offered during ecotours seldom starts with identifying symptoms among participants. Rather, it begins with something happening on the trip—for example, a type of food, a scenic view, or an animal. This helps participants cultivate conscious and reflective attention through multisensory approaches—listening to the sounds of forest, feeling the wind, and smelling the grass. They are encouraged to experience authentic local culture (for example, the minority ethnic culture in West Hunan Province) as a means of distracting themselves from or even evading their troubles or difficulties at home.

Therapeutic Lifestyles: Self-Preservation and Self-Therapy

For some, a Western understanding of therapy involves experts identifying an emotional deficit in people/clients as the starting point for healing—a move that highlights vulnerability (Furedi 2004). But in China, the notion of therapy does not rest on an implication of victimhood. This is not only because of the non-reliance on expertise in China but also because ordinary people exercise self-therapy or self-healing voluntarily on a daily basis as the folk saying indicates that *ziyu shi zui*

zhongyao de yangsheng (自愈是最重要的养生 "Self-therapy/healing is the most important part of life-nurturing"). Currently, there is widespread grassroots fetishism of *yang sheng* (养生"nurturing life") in China. For example, in Chinese cities, the popular and highly commercialized *yangsheng guan* (养生馆 "life-nurturing center") combines the Confucian practice of *xiushen* (修身 cultivating the self) with the life-nurturing tradition to promote the art of living—turning one's life into a work of art—and then a form of governance of life (see also Farquhar and Zhang 2012). These centers also use neoliberal techniques of eliciting the desire of citizens to stay beautiful and healthy (and thus happy and productive) as a means of diminishing or shirking the effects of economic or political liabilities. This form of self-care and self-therapy constitutes an embodied, holistic (including psychological and aesthetic) solution to broader social and economic problems that may negatively affect people's bodies and health.

Another example of daily self-therapy in China can be found in the emerging popularity, since 2017, of the trend of *foxi* (佛系 "Buddha-like"). The *foxi* lifestyle highlights detachment—a choice that appeals to many Chinese caught in sociopolitical struggles and distress. It aims to relieve distress and cure people of ills. *Foxi* resembles other forms of self-preservation, such as the Chinese art of *nande hutu* (难得糊涂 "It is hard to pretend muddleheadedness") (Mattyssen 2015). *Nande hutu* originated in the thinking of Zheng Banqiao (1693–1765), a Qing Dynasty official, philosopher, and artist from Jiangsu Province, whose ideas have regained popularity in China since the 1990s and have given rise to the popular practice of *hutuxue* (糊涂学 "the study of muddleheadedness"). It means that while everyone wants smartness, real smartness, which is hard to do, is to be muddled. *Nande hutu* encompasses a kind of smartness that requires self-restraint (from getting angry) and emotional or cognitive reconstruction in order to rationalize what happened to them and move on with life. It is a kind of feigned muddledness, including methods of coping with feelings of helplessness and vulnerability and ignoring and refusing to judge anger triggers. The phrase *foxi* was originally Japanese, part of the Otaku subculture. In China, *foxi* is not related to Buddhism. It first appeared on WeChat in an article entitled "The first group of the post-90s generation has become monks" (December 11, 2017) (Xin Shi Xiang 2017). The article immediately went viral across Chinese social media because it resonated with millions of young people who adopt a casual and calm attitude in the face of mounting social pressures. The article described young people who foster a "Buddha-like" mindset and advocate a Zen way of living. They remain detached and resist ambition in all realms, from career to marriage to food. These Buddha-like youths believe they have seen through the illusions of the material world. They try to avoid conflict, refuse to get emotionally involved, and take a Zen-like perspective toward success and setbacks alike.

According to the original WeChat article on *foxi,* their philosophy is "It's okay to have, and it's okay not to have; no competition, no fight, no winning or losing." *Foxi*, then, can be seen as a form of passive resistance rather than pessimism. Urban young Chinese born after the 1990s are akin to America's Generation X. They are unlikely to be better off than their parents, as economic opportunities dwindle and

the easy big money is gone. For them, success is increasingly hard. Thus, the optimism and positive psychology of "chicken soup for the soul"-type self-help, which was hugely popular with a slightly older generation (born in the 1980s) and which meshed easily with the inspirational propaganda of the Chinese government, clashes with their reality. These young people face skyrocketing housing prices, relationship difficulties caused by a widening gender imbalance, and narrow paths to success. The common theme in many of their Buddha-like stories is that effort is futile. For example, "Buddha-like childrearing" proposes a laidback approach to parenthood, in stark contrast to the intense tiger-mom parenting that is currently popular in China. "There are not that many kids who will really amount to much, so why give them an exhausting childhood?" The difficulties faced by this generation also lead them to describe themselves in mocking tones as "prematurely balding," "monks or nuns," or the "middle-aged obese." While they are nowhere near these things, they certainly feel like they are. Their motto is "Life itself is hard enough, and we just can't afford to make it harder on our own."

Thus, a *foxi* youth wants nothing because she or he expects nothing. Unsurprisingly, there has been a backlash against the mindset, particularly among the older generation. This older generation argues that *foxi* is based in pessimism, indolence, and sloth, leading to a reduced work ethic, lack of self-motivation, and an apathetic demeanor. The trend has even caught the attention of the *People's Daily*, the official paper of the Communist Party, which published two articles on Buddha-like Youth (Shi 2017). The *Daily* wrote, "This may just be a way for young people to explore their position in society," acknowledging that the identity was a reaction to "life's quick rhythms." The assessment is positive compared to the government's reaction to *sang wenhua* (丧文化 "the funeral culture"), another Chinese millennial attitude that has cropped up since mid-2016. *Foxi* parallels and constitutes *sang wenhua*, a subculture that encouraged people to openly embrace and even competitively perform despair, burnout, misfortune, and everyday failures, representing people without desires, ambitions, or aims. While cynicism and humor are both fundamental to these stories, the "Buddha-like" protocols take the pessimism and futility suggested by the funeral culture as a baseline and gently suggest a way forward—preserving oneself and adapting to changes rather than being too hard on oneself to destroy oneself (Liang 2017).

In general, the *sang* "funeral" lifestyle is characterized by unrelenting, sardonic despondency, an approach the *People's Daily* called "pessimistic and hopeless." Indeed, years of a strict one-child policy and a rapidly developing economy have placed great pressure on young people to succeed academically as one narrow path to professional success. Now, some are happily resigned to being ordinary. The two subcultures share origins in the cutthroat competition in Chinese. Although *People's Daily* is now worried about these aspiring Buddha-like people who take nothing seriously, these youngsters do not find their lifestyle depressing. In general, the *foxi* lifestyle appears to be a less stressful, more self-centered, and relatively healthy one. In contrast with Western therapy, the self-therapizing *foxi* lifestyle does not imply vulnerability or lack, and it is self-driven and, arguably, strategic.

Conclusion

The chapter explores the articulation and practice of the therapeutic ethos in the affective, social, and political life in China. The notion of therapy suggests an illness or problem that can be used to pathologize both individual and public issues. Therapy itself encompasses a dual process that both diagnoses (identifies an issue) and prescribes (offers solutions). This understanding of therapy can thus be easily appended to governance, constituting an amenable way of problematizing (pathologizing or individualizing) social issues and then proposing solutions, a hegemonic form of governing. It is a unity of opposites—both control and care, thus highlighting the complicity between therapy, market, and the state. This therapeutic governing involves a unique mode of psychologization in China, in which psy expertise is dispensed by non-experts with real consequences. This analysis also foregrounds the fact that more than a conduit of power, therapy has now been integrated into China's economic and social life, affecting people's everyday discourses and practices/lifestyles. As a mode of both thinking and imagination, therapy has also become a modality for social critique and contestation.

References

Bartlett, N. (2018). Idling in Mao's shadow: Heroin addiction and the contested therapeutic value of socialist traditions of laboring. *Culture, Medicine, and Psychiatry, 42*(1), 49–68.

Bourdieu, P. (2000). Making the economic habitus: Algerian workers revisited. *Ethnography, 1*, 17–41.

Canguilhem, G. (1989). *The normal and the pathological: Georges Canguilhem, with an introduction* by Michel Foucault, translated by Carolyn R. Fawcett in collaboration with Robert S. Cohen. New York: Zone Books.

Chen, Z. (2010). Resolving the pain/threats posed by the mentally ill. *Outlook Weekly*, May 31, 36–37.

Farquhar, J., & Zhang, Q-S. (2012). *Ten thousand things: Nurturing life in contemporary Beijing*. New York: Zone Books.

Furedi, F. (2004). *Therapy culture*. London: Routledge.

Hacking, I. (1986) The invention of split personalities. In A. Donagan et al. (Eds.), *Human Nature and Natural Knowledge* (pp. 63–85). Dordrecht: Reidel.

Huang, H.-Y. (2014). The emergence of the psycho-boom in contemporary urban China. In H. Chiang (Ed.), *Psychiatry and Chinese history* (pp. 183–204). London: Pickering & Chatto.

Illouz, E. (2008). *Saving the modern soul: Therapy, emotions, and the culture of self-help*. Berkeley: University of California Press.

Kipnis, A. (1997). *Producing Guanxi: Sentiment, self, and subculture in a North China Village*. Durham: Duke University Press.

Kleinman, A. (2010). The art of medicine: Remaking the moral person in China: Implications for health. *The Lancet, 375*(9720), 1074–1075.

Kuan, T. (2015). *Love's uncertainty: The politics and ethics of child rearing in contemporary China*. Oakland: University of California Press.

Liang, Y. (2017). Yearender-China Focus: China's "Buddha-like" Youth Quietly Accept Life for What It Is. *Xinhuanet.* http://www.xinhuanet.com/english/2017-12/28/c_136857895.htm

Liu, Y. (2008). *Xintai Gaibian Mingyun* (Attitude Changes One's Fate). Audio-Visual Press of China's National Administrative Academy.
Mattyssen, M. (2015). Zheng Banqiao's *Nande Hutu* and 'the art of being muddled' in contemporary China. *Contemporary Chinese Thought, 46*(4), 3–25.
Miller, P., & Rose, N. (1994). On therapeutic authority: Psychoanalytic expertise under advanced liberalism. *History of the Human Sciences, 7*(30), 29–64.
Munro, R. (2002). *Dangerous minds: Political psychiatry in China today and its origins in the Mao era*. New York: Human Rights Watch and Geneva Initiative on Psychiatry.
Nolan, J. L. (1998). *The therapeutic state: Justifying government at century's end*. New York: New York University Press.
Parsons, T. (1965). *Social structure and personality*. New York: Free Press.
Polsky, A. J. (1991). *The rise of the therapeutic state*. Princeton: Princeton University Press.
Shi, L. (2017). "The people's daily discusses 'Buddha-like youth': If one follows the trends, they will lose their selves." https://new.qq.com/omn/20171212/20171212G0ZBVS.html
Shi, T., & Lu, J. (2010). Cultural impacts on people's understanding of democracy. Paper presented at the 2010 American Political Science Association Annual Meeting, Washington, D.C., September 1–5.
Szasz, T. S. (2001). The therapeutic state: The tyranny of pharmacy. *The Independent Review, 4*, 485–521.
Teo, T. (2018). Homo Neoliberalus: From personality to forms of subjectivity. *Theory & Psychology, 28*(5), 581–599.
Watters, E. (2011). *Crazy Like Us: The Globalization of the American Psyche.* New York, London, Toronto, Sydney: Free Press.
Xin Shi Xiang. (2017) *The First Group Who Were Born in the 1990s Have Already Become Monks.* https://zhuanlan.zhihu.com/p/31934937
Yang, J. (2015). *Unknotting the heart: Unemployment and therapeutic governance in China*. Ithaca: Cornell University Press.
Yang, J. (2018a). *Mental health in China: Change, tradition, and therapeutic governance*. Cambridge: Polity Press.
Yang, J. (2018b). 'Officials' heartache': Depression, bureaucracy, and therapeutic governance in China. *Current Anthropology, 58*(5), 596–615.

Part II
Mental Health in the Chinese Diaspora

Chapter 11
The Overseas Chinese Communities in Southeast Asia and the Pacific

Dudley L. Poston and Huanjun Zhang

Abstract In this chapter we present historical overviews and analyses of current data on the overseas Chinese populations in the three Southeast Asian countries of Indonesia, Malaysia, and the Philippines and in the three Pacific countries of the United States, Canada, and Australia. We also present and discuss current data on the numbers of overseas Chinese throughout the world and its major regions, and we note how these distributions have changed over the past decades. We also present a discussion of the different types of emigrations from China and show how they figured into the immigrations of Chinese into the six Southeast Asian and Pacific countries just noted. In our chapter, we define an overseas Chinese person as a Chinese individual who resides outside the People's Republic of China, Taiwan, Hong Kong, or Macau. We discuss and justify this definition in more detail in our chapter. We show that in around 2018, there were nearly 48.7 million overseas Chinese residing in over 149 countries. Also, of the three Southeast Asian countries receiving the major focus in our chapter, Indonesia has the most Chinese of all the countries in the world, almost 8.4 million. The other two Southeast Asian countries, Malaysia and the Philippines, have, respectively, the third largest number of overseas Chinese (6.6 million) and the seventh largest number (1.5 million). The United States has the fourth largest number of Chinese of all the countries in the world (4.6 million). The other two Pacific countries of Canada and Australia have, respectively, the sixth largest number of Chinese (1.6 million) and the eleventh largest number (0.95 million).

Keywords Overseas Chinese · Diaspora · Immigration · Emigration · Ming · Qing · Trader · Coolie · Sojourner · Descent

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Introduction

The overseas Chinese are spread all over the world. They live in almost every country of the world, with most in Asia (Poston Jr. and Wong 2016). A famous Chinese poem states that "wherever the ocean waves touch, there are overseas Chinese" (Poston Jr. and Yu 1990; Mung 1998; Zhou 2009). In this chapter we present historical overviews and analyses of current data on the overseas Chinese populations in the Southeast Asian countries of Indonesia, Malaysia, and the Philippines and in the Pacific countries of the United States, Canada, and Australia. We also discuss data on the numbers of overseas Chinese throughout the world and its major regions, and we note how these distributions have changed over the past several decades.

We define an overseas Chinese person as a Chinese individual who resides outside the People's Republic of China, Taiwan, Hong Kong, or Macau. We discuss this definition in more detail later. We show that in around 2018, there were nearly 48.7 million overseas Chinese residing in over 149 countries.

We use the term "overseas Chinese" in our chapter not because we believe that the label represents a symbolic meaning signifying a foreign presence by virtue of race. Instead we use the term principally because of its continued and accepted use in the international arena (Fitzgerald 1972; von Brevern 1988; Wang 1991; Poston Jr. et al. 1994; Mung 1998; Poston Jr. and Wong 2016) and because there is really no convenient and short alternative phrase to refer to Chinese people who live abroad.

Major Types of Emigrations from China

The first emigrations of note of Chinese people from China began in the 1400s during the early years of the Ming Dynasty under the direction of Zheng He (1371–1433), an explorer, diplomat, and fleet admiral in China. Between 1403 and his death in 1433, he conducted numerous expeditionary voyages to Southeast Asia, South Asia, and Eastern Africa. And Chinese voyages continued for several years after his death. Some of the first emigrations from China occurred in conjunction with Zheng's expeditions (Dreyer 2007; Levathes 1996). The magnitude of Zheng's fleet and his command deserve mention. At any one time, he commanded over 200 ships with a combined crew of over 20,000. One of his ships was purported to be over 400 feet long. Compare Zheng's fleet with that of Christopher Columbus and his three ships and crew of 90. The Santa Maria, the largest of Columbus's three ships, was but 85 feet long. Zheng's fleet and resources greatly exceeded those of Columbus and other early European explorers such as Vasco da Gama and Ferdinand Magellan.

Zheng's voyages extended beyond Southeast Asia. Indeed, the naval historian Gavin Menzies goes as far as to argue that Zheng and his ships from China likely reached America in around 1421, some 70 years before Columbus (Menzies 2008) and that Zheng's fleet – although not Zheng himself – reached Venice in 1434 and had a hand in igniting the European Renaissance (Menzies 2009).

Emigrations from China continued after the Ming Dynasty and began in earnest during the Qing Dynasty. The major emigration waves from China started in the later part of the nineteenth century with more than two million Chinese departing the country for destinations in Southeast Asia, Hawaii, the West Indies, California, and Australia (Wang 1978). Prior to these times, the population of all of China would seldom exceed 80 million people. But after the establishment of the Qing Dynasty in 1644, there were reductions in mortality, and the population kept growing well past the 80 million limit. By 1850, there were 420 million people living in China, six to eight times the traditional level of 60–80 million that was the demographic norm 200 years or so previously. The Qing Dynasty was the first dynasty to bring about and to maintain a population size above 100 million. Indeed it was the only dynasty to live up to the perpetual Chinese ideal of "numerous descendants" (Poston Jr. and Wong 2016).

Pan has written that these phenomenal increases in the Chinese population occurred in a country "where there had appeared no new kinds of material, technical or political improvement to absorb the proliferation of people … (the large increases in population thus resulted in) destitution, corruption, apathy, and the breakdown of public order and personal morality" (Pan 1990: 43). Overcrowding, political upheavals, and the desires for personal and family improvements led to large numbers of persons leaving China.

What have been the main kinds of emigration from China? According to Wang Gungwu (1991), there have been four principal patterns over the past two centuries. The first is the *Huashang* (华商) (Chinese trader) pattern; it is characterized by merchants and traders and eventually their families leaving China and going abroad to establish businesses in the host countries. Typically comprised at first mainly of males, after one or two generations, many of these merchants "settle down and bring up local families" (Wang 1991: 5). The more prosperous their businesses, the more likely they maintained "their Chinese characteristics, if not all their connections with China" (Wang 1991: 5). *Huashang* migration has been the prominent model of Chinese emigration to many Asian countries, particularly to Southeast Asia (Legge 1886; Fitzgerald 1965).

The *Huashang* pattern of Chinese emigration has predominated throughout history. Indeed the first recorded emigration from China followed the *Huashang* pattern (Zhu 1991) and occurred during the Qin Dynasty (221–207 BC). It was to either Japan or the Philippines. Whereas the other three patterns we discuss in the paragraphs below have occurred during particular time periods, the *Huashang* pattern has always occurred and continues to this very day (Wang 1991; Redding 1990; Poston Jr. et al. 1994; Poston Jr. and Wong 2016).

According to Wang (1991), the second pattern is the *Huagong* (华工(苦力)) (Chinese coolie) pattern, which occurred from the 1840s through the 1920s, when Chinese migrated to North America and Australia. This migration involved "coolie trade" in low-level occupations that were concentrated in gold mining and railway building (Campbell 1923; McKenzie 1925; Stewart 1951; Kung 1962; Mei 1979). Pan (1990: 61) has written that the Chinese coolie migrants "went to work in virgin territory across the world … [and] most lived by the sweat of their brow." It was the coolie trade which "took the bulk of the Chinese to the New World, with shipload

after shipload reaching Cuba, Peru and … British Guiana in the years between the 1840s and 1870s" (Pan 1990: 67). In the late 1870s and 1880s, many Chinese went to Hawaii and to California. Pan has observed that "by 1870, one out of every four workers in California was Chinese" (Pan 1990: 94).

The third emigration type is the *Huaqiao* (华侨) (Chinese sojourner) pattern, one strongly comprised of well-educated professionals. This pattern was dominant for several decades after the fall of the Qing Dynasty in 1911 and was strongly tied to feelings of nationalism. Education was largely recognized as a deep commitment to promote Chinese culture and national salvation among the overseas Chinese. Fitzgerald has written that the common belief then was that "without Chinese education, there can be no overseas Chinese" (Fitzgerald 1972: 41). Beginning in the 1920s, many teachers went to countries of Southeast Asia to instruct the children of Chinese immigrants (Pan 1990: 206), and this trend continued until the 1950s (Poston Jr. and Luo 2007).

According to Wang, the fourth pattern is the *Huayi* (华裔) (Chinese descent) pattern, which is a more recent phenomenon, mainly prevalent since the 1950s. It involves persons of Chinese descent living in one foreign country migrating to another foreign country. A good example is the Chinese in Southeast Asia, many of whom have migrated to countries in Western Europe in recent decades, "especially since the 1950s when some Southeast Asian nations made those of Chinese descent feel unwanted" (Wang 1991: 9). The Chinese are disproportionately overrepresented in the commercial classes of most every Southeast Asian country, and in some of these countries, they "are big players in the national economies" (Pan 1990: 226). Their economic successes are all the more remarkable when one remembers that "the Chinese in Southeast Asia have always been disliked for having profited from the indigenous reluctance to make money" (Pan 1990: 226). So when Thailand, and then the Philippines, followed by Indonesia and later Malaysia, began to explicitly lock the Chinese out of various sectors of their economies to promote the prosperity of their indigenous peoples, many Chinese simply left those countries and moved elsewhere.

Of the four major patterns, the *Huashang* is the most elementary and has been occurring for the longest period of time. Indeed, much of today's global migration of Chinese follows the *Huashang* pattern. Wang has speculated that with few exceptions, future Chinese migrations "will be based on the *Huashang* pattern and supplemented by the new *Huayi* pattern, with some features of the *Huaqiao* pattern surviving here and there" (Wang 1991: 12).

The Chinese in Southeast Asia and the Pacific

We now present brief historical sketches of the overseas Chinese communities in the three Southeast Asian countries of Indonesia, Malaysia, and the Philippines and in the three Pacific countries of the United States, Canada, and Australia. Later, we present quantitative analyses of current data about Chinese peoples in these and other countries.

Indonesia

The immigration of Chinese to Indonesia and other parts of Southeast Asia first began, as noted above, in the early years of the Ming dynasty, via the expeditions of Zheng He. The Chinese used the islands of the Indonesian Archipelago as intermediate locations for their trade with India and the Middle East.

One of the first settlements of Chinese in Indonesia occurred in the 1600s in Batavia, now the capital city of Jakarta. This community was then and is today the largest Chinese community in Indonesia. Heidhues has written that "Chinese junks came annually to the harbor, and Chinese settlers increasingly spilled over into the countryside of Java, out of the control of the few Europeans living in the walled town …" (Heidhues 1999: 152).

Following the *Huashang* pattern, most of the immigrants to Batavia and other Indonesian locations along the north coast were males who first married local, usually non-Muslim women. Women were later brought from China allowing the more well-to-do Chinese men to marry and mix with Chinese women. The lower-class Chinese settlers tended usually to marry non-Chinese women. But starting in the late nineteenth century, Chinese men in Java began more so to marry Chinese women. The introduction of steamships "made it easier to bring Chinese brides to Java, facilitating travel to the (Chinese) homeland for those with means. New migrants could establish families which were more purely Chinese, retaining Chinese language, dress and customs" (Heidhues 1999: 157).

Lynn Pan's (1990) *Sons of the Yellow Emperor: The Story of the Overseas Chinese* provides some interesting and fascinating stories of the emigrations of numerous Chinese families, many of whom followed the *Huashang* pattern. Here is the story of Liem Sioe Liong, who was born in 1916 in Fuqing, Fujian Province, China, as the second son in a very poor Chinese peasant family. When he was 16, he set up a noodle stand in his home village. A year or so later when war started between China and Japan, he immigrated to Indonesia to the central Javanese town of Kudus to help his older brother manage and run a small peanut oil business. The first few years in Indonesia were rough and difficult. The Chinese immigrants, especially those from Fujian Province, suffered discrimination and prejudice on the part of the local Indonesians. But little by little, Liem became more involved in the trading and smuggling of cigarettes, sugar, cloves, and numerous other commodities. He established many firms to further his business activities. Eventually all cars, motorcycles, minibuses, and trucks made, assembled, or distributed in Indonesia passed through one of Liem's establishments. Pan has observed that "hardly an area of Indonesian economic life escapes penetration by the tentacles of the Liem group of companies" (Pan 1990: 234). When Liem died in 2012, he was reported to be the richest person in Indonesia.

Through hard work and endurance, the Chinese have succeeded and established themselves in Indonesia building and conducting local businesses and related economic activities. One reads of Chinese markets along the rivers, and flotillas of Chinese houseboats that were half home and half shop. Pan has written that in

Indonesia and "all over Southeast Asia, it was a Chinese who sold you a drink, a chicken, a needle, a lamp, a catty of rice, a length of cloth, a bag of spices, a quantity of anything that was essential to everyday living" (Pan 1990: 129). Since the early years of the Ming, Indonesia has been a major destination of Chinese immigrants. Currently, as we will show below, Indonesia has the largest number of overseas Chinese of any country in the world.

Malaysia

The country of Malaysia consists of a number of states and territories separated by the South China Sea into two regions of about the same size, Peninsular Malaysia and East Malaysia. Although the two regions are about equal in size geographically, most of the country's 32.5 million population – around 80 percent – lives in Peninsular Malaysia. About one-fifth of the country's population is overseas Chinese, and most of them also live in Peninsular Malaysia.

Human habitation in Malaysia goes back around 40,000 years. But the earliest Chinese settlement was a small community in Malacca established around 1400 by Fujianese traders "who came to engage in the thriving maritime trade of the sultanate" (Tong 1999: 172). These Chinese settlers were mostly men, and they intermarried with local women, comprising a "tiny minority within the Malaysian Chinese population today, residing primarily in Malacca and Penang" (Tong 1999: 172). The Chinese population increased in size and assumed major positions of economic influence in the society. So ubiquitous were the Chinese that Isabella Bird (1831–1904), the English traveler and explorer, spoke of her time in Malaya in 1879 as follows: "I have written a great deal about the Chinese and very little about the Malays, the nominal possessors of the country, but the Chinese may be said to be everywhere, and the Malays nowhere. You have to look for them (the Malays) to see them" (Bird 1883: 201).

Chinese settlement in Malaysia was not very significant demographically until the early 1800s. Mass immigration into the country was "prompted by new economic opportunities created by the British mercantile and administrative presence in the Straits Settlements, i.e., Penang, Malacca and Singapore, established in 1826, and in the Malay states after 1874, as well as by adverse economic and political conditions in China" (Tong 1999: 172). Most of the Chinese immigrants were from Fujian and Guangdong provinces and were poor and illiterate peasants and coolies. They mainly followed the *Huagong* pattern of Chinese emigration we discussed earlier.

Japan invaded Malaya in December of 1941 and occupied the country until August of 1945. While all Malayans suffered under the Japanese military occupation, the Chinese were the most harshly treated. "Some 40,000 Chinese were killed in purges. Chinese associations were replaced by the Japanese-sponsored Overseas Chinese Associations… Thousands of Chinese urban dwellers were relocated to rubber plantations and jungle land to cultivate food crops" (Tong 1999: 174). After the Japanese surrendered in 1945, the Malayan Communist Party (MCP) assumed

control of the country. When the British returned to the country in mid-1945, they worked alongside the MCP. The MCP was "a landmark in the development of Chinese politics in Malaya … (because it was committed) to the establishment of a multiracial Communist state" (Tong 1999: 174). With independence and decolonization in the mid-1940s, the Chinese began to obtain increasing independence. Peninsular Malaysia became the Federation of Malaya in 1948 and achieved independence in August of 1957. The federation of Malaya united with North Borneo, Sarawak, and Singapore in September of 1963 and became Malaysia. In 1965, Singapore left the federation (Baten 2016).

The Chinese benefitted tremendously when Malaysia achieved independence. Chinese economic activities expanded and diversified. "Small- and medium-sized Chinese enterprises established a strong presence in light manufacturing, food processing, and production of household consumer goods. Rapid urban expansion resulted in active Chinese participation in the real estate and construction industries" (Koon 1999: 175).

Philippines

The Chinese perhaps first immigrated to the Philippines during the years of the early Ming as part of the expeditions of Zheng He. Pan has written that one of the very first Chinese settlements in Southeast Asia was comprised of Chinese from Fujian province in around 1405 in the area known today as Manila. Indeed when the Spaniards first entered the Philippines in the 1570s, the Chinese were already there. The Spaniards were met in the Manila area by Chinese traders "who sailed up in their junks and greeted them with a great warlike display, beating on drums, playing on fifes, and firing rockets and cannons" (Pan 1990: 31). But there are no records of the specifics.

Starting in around the 1570s, there was a prosperous trade between Manila and Mexico resulting in an ever-larger Chinese settlement in the Philippines. The Chinese brought in silk to Manila which they traded for silver from Mexico. These interactions resulted in as many as 20,000 Chinese residing in the Manila area in 1600 and between 20,000 and 30,000 Chinese living there for most of the seventeenth century.

Let us mention here the issue of silk from China, a precious commodity in great demand not only in the Philippines. Silk was first developed in China perhaps as early as 6000 BC, but certainly by 3000 BC. It was first reserved for the emperors but later began to be exported in around 1000 BC, first reaching Europe and the Indian subcontinent, leading to what became known as the Silk Roads from northwestern China to Europe and beyond. Silk was a prized commodity. Indeed its increased volume and availability in the Mediterranean caused some consternation. It has been reported that Seneca (4 BC–65 AD) "was horrified by the popularity of the thin flowing material, declaring that silk garments could barely be called clothing given that they hid neither the curves nor the decency of the ladies of Rome" (Frankopan 2017: 19).

Silk was only one of the many commodities coming from China to the Philippines. The Chinese also provided extensive commercial and service activities in Manila and became virtually indispensable to the local economies and communities. "The Chinese greatly outnumbered the Spaniards (especially in Manila) who feared their economic power, cultural difference, and the possibility they might seek aid from nearby China to overthrow Spanish rule in the Philippines" (Wickberg 1999: 188). As a consequence, many of the Spaniards fought with the Chinese, and there were uprisings and massacres in the early 1600s and the late 1630s when more than 20,000 Chinese were killed. Nevertheless, the Chinese returned and remained in the Philippines for its economic opportunities, despite the restrictions imposed on them by the Spaniards.

These resentments, suspicions, and conflicts continued into the 1700s when the Spaniards introduced controls to limit the number of Chinese immigrants to the Philippines. Sometimes, the Filipinos were on the side of the Chinese and defended them from the Spaniards. Other times, the Chinese and the Filipinos were on opposite sides. In the mid-nineteenth century when Spain opened the Philippines to worldwide trade and economic activity, even greater numbers of Chinese were allowed to immigrate to the Philippines. When the United States assumed control of the country in 1898, there were over 100,000 Chinese there. "Chinese were now settled in every part of the Philippines and had entered many new lines of work: collectors and distributors of export crops and imported goods, rice and cotton millers, labor contractors, and operators of small *sari-sari* (miscellaneous goods) retail stores in remote villages" (Wickberg 1999: 188). The Chinese were now not only in Manila but in many other parts of the country.

One of the most famous persons born in the Philippines was a descendant of a Chinese person who immigrated to the Philippines from China several generations earlier following the *Huashang* pattern. Giok Kuan Co was a young 6-year-old boy when he left Tongan County in Fujian Province in 1841 with his 24-year-old father and migrated to the Philippines. In the Philippines, Giok Kuan Co was later baptized by the Spaniards and became known as Jose Cojuangco. Jose started as a carpenter in Manila, established a large business specializing in sugar and rice, and also became a money lender. He accumulated a great deal of land in the Philippine province of Tarlac. He married, had children, and they married and had children, and this Chinese-Filipino family grew and prospered. The great-granddaughter of Jose Cojuangco (Giok Kuan Co) was María Corazon Sumulong "Cory" Cojuangco-Aquino, who was born in the Philippines in 1935 and died in 2009. She served as the eleventh President of the Philippines and was the first woman ever to hold that office. Often regarded as the "Mother of Philippine Democracy," she was also the first female to serve as a president in all of Asia (Pan 1990: 154–155).

United States

Chinese immigrants to the United States were banned for almost a century, but in recent decades, their numbers have increased dramatically (Sung 1967; Poston and Wong, 2016). Indeed, starting in 2013 to the present, there have been more immigrants to the United States from China than from any other country in the world, including Mexico. In 2013, there were 150,000 immigrants to the United States from China, compared to 125,000 immigrants from Mexico (Jensen et al. 2015). This pattern has been maintained since 2013.

Chinese first came to the United States in large numbers with the discovery of gold in California in 1848. California's Chinese population jumped from approximately 50 persons in the late 1840s to more than 25,000 by 1852 (Lai 1999: 261). In the early 1860s, the Central Pacific Railway Company was established to lay lines from Sacramento eastward, while a rival company began laying lines westward from Omaha, Nebraska. "The Central Pacific had the harder task, for the line from Sacramento had to cross the massive granite slab of the Sierra Nevada and mile after arid mile of the Nevada and Utah deserts" (Pan 1990: 55). Chinese were hired by the Central Pacific as laborers when Irish immigrants faltered. When the so-called Golden Spike was laid in 1869 in Promontory, Utah, connecting the western line from Sacramento with the eastern line from Omaha, the Central Pacific had almost 14,000 Chinese workers on its payroll, comprising over 80 percent of its workforce (Pan 1990; Cassel 2002). The western half of the railroad could not have been built without the overseas Chinese laborers (Ambrose 2001; Chang 2019).

Most of the early Chinese immigrants coming to the United States to mine gold and to work on the railroad were Cantonese villagers from the Pearl River Delta in Guangdong Province, mainly from *Siyi*, the four counties on the west flank of the delta (Lai 1999: 261).

Despite these major contributions of the Chinese to the US economy and society, immigration from China ended up being severely restricted between 1882 and 1943. But the Immigration and Nationality Act of 1965 eliminated national origin, race, and ancestry as bases for immigration. Since 1968 when the above law came into effect, thousands of Chinese immigrants have entered the United States every year, and the Chinese immigrant population has increased tenfold.

During the many decades the Chinese have been in the United States, their social status has undergone significant change. The socioeconomic status of this one time laboring ethnic group has improved considerably. Sociologists now regard the Chinese as one of the most "successful" of the minority groups in America (Wong 1980).

The initial immigrations of Chinese to the United States did not follow the *Huashang* emigration pattern that was so common for Chinese immigrants to most Southeast Asian countries. Instead the *Huagong* pattern of migration was followed. Poston Jr. and Luo (2007: 328) have noted that "during the rapid growth period of the frontier economy in the U.S. between 1850 and 1880, thousands of Chinese immigrated, mainly to the western United States, under the indenture system as

miners, railroad workers, and agricultural laborers. They also came as cooks, laundrymen, and in other jobs that American workers did not want. Later, they were instrumental in building the western part of the trans-continental railroad." The emigrants under the *Huagong* pattern were usually men of peasant origins, and their migrations were often temporary because a "large proportion of the contract laborers returned to China after their contract came to an end" (Wang 1991: 6).

Canada

There are several main periods of Chinese immigration to Canada (Ng 1999: 234). The initial period was between 1858 and 1884, and it involved large numbers of immigrants from Guangdong and Fujian provinces. The Canadian pattern in this era was similar to the early immigrations of Chinese to the United States, fueled first by gold mining and then by the opportunity for construction work in British Columbia. "The building of the Canadian Pacific Railway in 1880-84 brought in 17,000 Chinese" (Ng 1999: 234). Some came to Canada after finishing similar employment in the United States, but most came directly from southern China. As was the situation with respect to the early waves of Chinese immigration to the United States, the early waves of Chinese immigration to Canada followed the *Huagong* pattern.

A period of restricted entry started in 1885 and continued until 1923. This was largely a response of Canadians to the competition the Chinese posed to other workers and to their perceived cultural differences. Chinese were still able to enter Canada during this period but had to pay a head tax of C$50 per immigrant, later increased to C$100 in 1900 and to C$500 in 1903. A more stringent Chinese immigration law was implemented in 1923. Under this exclusion law, "no more than two dozen Chinese were admitted in the following 24 years…The Chinese population shrank and so did many Canadian Chinatowns" (Ng 1999: 235).

The fourth era of Chinese immigration to Canada was a renewed immigration period that began in 1947 and continued through 1967. This immigration was mainly geared toward family reunion, allowing spouses and children to join the older immigrants. "To qualify for admission, the applicants had first to make their way from mainland China to Hong Kong, then go through checking and security clearance procedures under the sponsorship of their relatives in Canada" (Ng 1999: 235). Major immigrations from China to Canada started in 1967 and continue to this day. Immigrants are no longer mainly from Guangdong and Fujian provinces. Indeed, Chinese immigrants now hail not only from mainland China and Taiwan but also from Singapore, Hong Kong, Malaysia, and other countries. They are mainly attracted to Canada by its "more democratic and peaceful environment and supposedly greater economic opportunities" (Ng 1999: 236). These days there are large concentrations of Chinese not only in Vancouver on the west coast but also in the major eastern cities of Toronto and Montreal. We show below that Canada today has the sixth largest number of overseas Chinese of all the countries in the world and the second largest number of non-Southeast Asian countries.

In Canada these days, Chinese are welcomed as citizens. "To become Canadian, Chinese need not discard their cultural heritage; indeed such heritage should be preserved for the enrichment of Canadian life" (Ng 1999: 241).

Australia

Of the six countries specifically covered in this chapter, Australia has the fewest overseas Chinese, just under one million in 2014. Immigration from China to Australia has mainly occurred in the latter part of the nineteenth century and since the 1960s. Inglis (1999: 274) has noted that these two immigrations have "coincided with watersheds in Australian history." It was during the latter decades of the nineteenth century when Australia's population grew most rapidly, culminating in the establishment of the nation of Australia in 1901. And since the 1960s, the Australian government moved away from assimilation of the population to one of multiculturalism. Plus the economy was restructured during this time, leading to more involvement of the country with the newly independent and growing countries of Asia (Inglis 1999).

Despite these two recent periods of large numbers of Chinese immigrating to Australia, there is archeological evidence indicating a Chinese presence in Australia much prior to European colonization. But similar to the first immigrations of sizable numbers of Chinese to the United States and to Canada, the first sizable group of Chinese immigrated to Australia in the early 1850s with the discovery of gold. However, Pan has noted, these large numbers of Chinese entering Australia in the 1850s led to "a spring of racialist emotions. 'Mongolian filth' and 'locusts' were two epithets hurled at (the Chinese) by hostile members of the local (Australian) population" (Pan 1990: 57). Actions were taken by the British officials in Australia to restrict the numbers of Chinese entering the country, and these later evolved into what became known as the "White Australia Policy" (Pan 1990).

Australia began in the 1950s and 1960s to relax the "White Australia Policy," but the numbers of Chinese did not increase appreciably. "A third of the Chinese were Australian-born, a quarter had been born in China, and another 40 percent had been born elsewhere in Asia" (Inglis 1999: 275), and most of this latter group were Chinese students. But with the election in 1972 of a Labor government, the "White Australia Policy" was finally abandoned. This occurred about the same time as the diplomatic recognition by Australia of the People's Republic of China. The numbers of Chinese immigrants began to increase. The overseas Chinese population in Australia reached almost one-half million by 1996, and as we will show in Table 11.2, it had almost doubled in size by 2014. "Chinese migrants came (to Australia) in search not so much of the New Gold Mountain as political and personal security, and a less politically polluted environment" (Inglis 1999: 275).

According to the United Nations, Australia is one of the most urbanized countries in the world, with nearly 90 percent of its population living in urban areas (United Nations 2014). New South Wales and its capital city of Sydney attract up to

40 percent of all the immigrants to Australia, and the percentage is even higher for immigrants from Asia. Over half of the Chinese population in Australia who were born in the PRC, Hong Kong, and Macau reside in New South Wales. Importantly, the "geographical distribution of Chinese (in Australia) reflects the diverse educational, kinship, geographical and economic networks which have molded settlement patterns, and in the case of Indochinese refugee groups, the role of government resettlement policies" (Inglis 1999: 278).

The Size and Distribution of the Overseas Chinese Populations

Our previous analyses of the overseas Chinese (Poston Jr. and Mei-Yu 1990; Poston Jr. et al. 1994; Poston Jr. 2003; Poston Jr. and Wong 2016) examined their distributions throughout the world in the 1980s, the 1990s, and the 2010s. In our prior research, just as in the research we present in this chapter, we defined the overseas Chinese very broadly as all Chinese persons living outside the People's Republic of China and Taiwan and, after 1997–1999, also living outside Hong Kong and Macau, including the *Huaren* (华人), (naturalized citizens of Chinese descent) and the *Huayi* (华裔) (the descendants of Chinese). The definitions of the overseas Chinese vary from country to country and from scholar to scholar. No definition is unfailingly sharp and concise because the decision on whether or not a person or a group is Chinese tends to be made by governments, both Chinese and foreign, by the larger societies alongside and where the Chinese settlers live, and often by individual scholars (Williams 1966; Poston Jr. et al. 1994; Poston Jr. and Wong 2016).

The overseas Chinese population of the world numbered around 27 million people in the early 1980s, 37 million in early 1990, 39 million in around 2001, and 40 million in around 2011. It reached almost 49 million in 2018. The 2011 population of overseas Chinese was 4.4 times that in 1948. Europe and the Americas had relatively high growth rates, Africa intermediate, and both Asia and Oceania low. Individual countries also had different rates of overseas Chinese population change, with Western European countries, the United States, Canada, Australia, New Zealand, and some of the Asian countries having higher than average annual growth rates.

Although the overseas Chinese in the early 1980s lived in virtually all parts of the world, their distribution was uneven. From the early 1980s to the early 1990s, they comprised a small minority in most countries. More than 90 percent lived in Asia in the early 1980s, and almost 88 percent lived in Asia in the early 1990s. In both periods, over 80 percent of the overseas Chinese residing outside Asia lived in more developed countries. Of the more than 40 million overseas Chinese living in 149 countries in 2011, almost 30 million, or 73 percent, lived in 35 Asian countries. The data we report in this chapter will take us forward another 7 years to 2018.

In Table 11.1, we report for the 8 years of 2011 to 2018 the numbers of overseas Chinese residing in the major world regions. We obtained the data for each of the years in the table from the online data link provided by the Overseas Community

Table 11.1 Distribution of overseas Chinese in the world, 2011–2018 (in 10,000)

Year	Total	Asia	America	Europe	Oceania	Africa
2011	4031	3004	750	156	95	25
2012	4136	3072	769	161	107	27
2013	4178	3066	790	170	113	40
2014	4250	3101	811	176	117	47
2015	4330	3128	834	196	119	53
2016	4462	3203	867	215	121	57
2017	4749	3391	930	225	145	58
2018	4869	3426	953	225	154	111

Source of Data: Overseas Community Affairs Council, Taiwan. The Numbers of Overseas Chinese (歷年海外華人人數, [Pinyin, Linian Haiwai Huaren Renshu]); accessed at https://data.gov.tw/dataset/9738

Affairs Council, Taiwan (see link at the base of Table 11.1). The primary sources of most of the data gathered by the Taiwan offices around the world are the national censuses of the countries, and the secondary sources include statistical and data publications from the United Nations and the US Central Intelligence Agency.

There were 40.3 million overseas Chinese in the world in 2011, increasing to 48.7 million by 2018. In 2011, almost 75 percent of the overseas Chinese resided in Asian countries. By 2018, the share of overseas Chinese living in Asian countries had dropped slightly to 70.3 percent.

We present in Table 11.2 the numbers of overseas Chinese in 2014 in the twenty countries with the largest numbers of overseas Chinese and the percentage of all overseas Chinese in each country. Indonesia has the most Chinese of all the countries in the world, almost 8.4 million (Table 11.2), representing 17.2 percent of all overseas Chinese. Thailand and Malaysia have the next greatest representations of overseas Chinese, seven million and 6.6 million, respectively. The non-Southeast Asian country with the largest number of Chinese residents is the United States, with almost 4.6 million, almost one in ten (9.3 percent) of all the overseas Chinese in the world. Canada (1.58 million, 3.3 percent), the Philippines (1.50 million, 3.1 percent), and Australia (950,000, 2.0 percent) have, respectively, the sixth, seventh, and eleventh largest overseas Chinese populations. Of the 20 countries with the largest numbers of Chinese residents, nine are Asian countries, seven of which are Southeast Asian.

Characteristics of Countries with the Largest Numbers of Overseas Chinese

Finally, we ask whether there are any noticeable regularities with respect to the locations of the overseas Chinese in the countries around the world. For instance, are more overseas Chinese found in richer or in poorer countries? Are more found

Table 11.2 The twenty largest overseas Chinese populations in the world in 2014

	Number of overseas Chinese in 2014	Percent of global overseas Chinese population
Indonesia	8,360,000	19.67
Thailand	7,000,000	16.47
Malaysia	6,580,000	15.48
United States	4,550,000	10.71
Singapore	2,870,000	6.75
Canada	1,580,000	3.72
Philippines	1,500,000	3.53
Myanmar	1,220,000	2.87
Vietnam	1,030,000	2.42
Peru	990,000	2.33
Australia	950,000	2.24
Japan	690,000	1.62
South Korea	530,000	1.25
France	500,000	1.18
Russia	490,000	1.15
United Kingdom	460,000	1.08
Brazil	300,000	0.71
South Africa	250,000	0.59
Italy	210,000	0.49
New Zealand	170,000	0.40
All other countries	2,270,000	5.34
Total overseas Chinese	42,500,000	100.00

Source: Overseas Community Affairs Council, Taiwan. http://www.ocac.gov.tw/OCAC/File/Attach/10/File_54.pdf

in urban or rural countries? Are Chinese more prevalent in large or in small countries? Also, does the number of overseas Chinese in a country decline with increasing distance from China?

Ecological theories of migration and settlement patterns (Hawley 1950; Poston Jr. and Frisbie 2019) suggest that there should be more overseas Chinese in richer, urban, and large countries (both in terms of population size and geographic area). Further, the classic distance decay theory of migration (Ravenstein 1885; Zipf 1946) suggests that the farther a country is from China, the smaller should be its number of overseas Chinese.

To answer the above questions, we used circa 2011 data on the size of the overseas Chinese population in all the countries of the world (Poston Jr. and Wong 2016). We used their absolute population size, rather than their relative population size, because a relative number tends to minimize the presence of overseas Chinese in countries with large overall populations and exaggerates their presence in small countries. For example, as we noted above, Indonesia has the largest number of

overseas Chinese, over eight million, but the Chinese only comprise just over 3 percent of Indonesia's population. Conversely, Brunei has just over 50,000 overseas Chinese, but they comprise over 12 percent of Brunei's population. Indonesia's overseas Chinese population has much greater worldwide and national demographic, economic, and political impacts with regard to Chinese activities and the in-migration of Chinese to Indonesia, than that of Brunei's. Yet the relative size of the overseas Chinese population in Brunei is four times that in Indonesia.

In Table 11.3, we report zero-order correlations among the countries of the world with Chinese residents between the logged population size of their overseas Chinese population and several variables reflecting the ecological characteristics mentioned above, namely, per capita GNP, percentage urban, population density per square kilometer, population size (logged), geographic area in square kilometers, and the distance in kilometers from Guangzhou, the capital city of Guangdong Province, the major province from which Chinese emigration historically has come (Kwong 1987; Pan 1990; Redding 1990).

The correlations in the first column of the table refer to all 148 countries in the world with 100 or more overseas Chinese in 2011; the correlations in the second column pertain to those 77 countries with overseas Chinese populations of over 5000 in 2011. Among all 148 countries, the correlations in Table 11.3 show a positive association between the logged values of the size of the overseas Chinese population and the logged values of the country's total population and its geographic area; the larger the population and the larger the geographic area of a country, the larger the number of overseas Chinese in the country. Also, the richer the country in terms of per capita GNP, the larger the number of overseas Chinese. And the farther the country is from Guangzhou, the smaller its number of overseas Chinese. We found no statistically significant correlations between the number of overseas Chinese and either percentage urban or population density.

Turning next to the relationships among those 77 receiving countries with at least 5000 overseas Chinese, we find the same results regarding the correlations between the number of overseas Chinese and the size of the host country (both population and geographic area) and the distance of the country from Guangzhou. However,

Table 11.3 Zero-order correlation coefficients between the number of overseas Chinese (logged) and six demographic and ecological characteristics: 148 and 77 countries in the world, circa 2011

Demographic/ecological	Correlation coefficients	
Characteristics of the country	148 countries	77 countries with 5 K+ Chinese
Per capita GNP	0.233**	0.090
Percent urban	0.151	0.055
Population density	0.113	0.232*
Population size (log)	0.540***	0.579***
Geographic area (square kilometers)	0.354***	0.395***
Distance (in km) from Guangzhou	−0.160*	−0.282**

*$p < 0.05$
**$p < 0.01$
***$p < 0.001$

there are two differences in the correlations for the 77 countries compared to those for all 148 countries.

First, overseas Chinese were found to be more numerous in the richer countries when we focused on all 148 countries, but when we restrict the analysis to only those 77 countries with at least 5000 overseas Chinese, the relationship becomes insignificant. This reversal in statistical significance is likely due to the fact that most of the poorer countries, i.e., those with low values of GNP and with fewer overseas Chinese, are no longer included in the analysis.

Second, when focusing on the 77 countries with at least 5000 overseas Chinese, we find a significant correlation between the number of overseas Chinese and population density per square kilometer; $r = 0.232$. The more densely populated the country, the greater the number of overseas Chinese. However, this association is highly conditioned by the extreme outlier of Singapore, the country with the fifth largest number of overseas Chinese and the highest population density of all the countries in the world. When we remove Singapore from the analysis, the correlation coefficient between the number of overseas Chinese and population density declines to a level of insignificance; $r = 0.027$.

Conclusion

Of the four main patterns of emigration from China throughout history – *Huashang*, *Huagong*, *Huaqiao*, and *Huayi* – the *Huashang* (Chinese trader) pattern is the most elementary and persevering. Much of today's global migration of Chinese is *Huashang*, and most future Chinese migrations will be *Huashang*. The second pattern, the *Huagong* (Chinese coolie), occurred in most countries from the 1840s through the 1920s and occurs very little today, as is the case regarding the third pattern, the *Huaqiao* (Chinese sojourner), which was dominant mainly for several decades after the fall of the Qing Dynasty in 1911 and was strongly tied to feelings of nationalism. The fourth pattern, the *Huayi* (Chinese descent), is a more recent phenomenon, prevalent mainly since the 1950s. It involves persons of Chinese descent who live in one foreign country and migrate to another. This pattern still occurs, albeit on a limited basis, among some Chinese in Southeast Asian countries who have migrated to countries in Western Europe in recent decades when officials have locked them out of various sectors of their economies to promote the advance of their indigenous peoples.

In our brief historical sketches of the Chinese diasporas in the three Southeast Asian countries of Indonesia, Malaysia, and the Philippines, and in the three Pacific countries of the United States, Canada, and Australia, one common theme is the significant amount of hostility directed against the early Chinese immigrants to these countries. Another is the recognition these days in most countries of the social and economic advantages of having large populations of Chinese living there.

The basic findings of our earlier research about the distributions of the overseas Chinese throughout the world in the 1980s, the 1990s, and the 2010s indicate the

substantial growth of the Chinese diaspora, from around 27 million persons in the early 1980s to around 40 million in 2011. By 2011, the overseas Chinese population was 4.4 times larger than it was in 1948. While most overseas Chinese have always lived in Southeast Asian countries, the proportion has declined slightly in recent years.

New data for the 8 years of 2011 through 2018 on the numbers of overseas Chinese residing in the major regions of the world show that the number has increased from just over 40 million in 2011 to over 48.7 million in 2018. Data on the numbers of overseas Chinese in 2014 in the 20 countries with the largest overseas Chinese populations show that Indonesia has the largest population of overseas Chinese in the world, over 8.4 million. The United States has the fourth largest number of overseas Chinese of all the countries in the world, over 4.5 million. The other four countries featured in this chapter also have sizable representations of Chinese. Thailand has seven million overseas Chinese, the second largest of all the countries in the world. Malaysia has 6.6 million, the third largest; Canada has 1.6 million, the sixth largest; the Philippines has 1.5 million, the seventh largest; and Australia has 950,000, the eleventh largest.

Finally, we examined the characteristics of countries that may be associated with the size of their overseas Chinese populations. We found that there are more Chinese in rich than in poor countries, but the relationship loses its statistical significance when we restrict the analysis to only those countries with 5000 or more Chinese. There are more Chinese in countries with large populations and in geographically large countries. We also found solid evidence of a distance decay function in that the farther away the country is from Guangzhou, China, the smaller is its number of overseas Chinese.

Chinese emigrants began to move to other Asian countries, particularly in Southeast Asia, more than 2000 years ago. Large numbers of Chinese migrated from China to virtually every other country of the world during the nineteenth and early twentieth centuries. As of 2018, over 48.7 million overseas Chinese resided in more than 140 countries around the world. The overseas Chinese are the minority in all countries with the exception of Singapore where they comprise just over half of the population. Slightly more than 70 percent of the overseas Chinese today live in Asia, especially in the Southeast Asian countries, and over 80 percent of the Chinese who live outside Asia reside in more developed countries. There is no reason to believe that the distribution of the overseas Chinese in the world as described in this chapter will change dramatically in the near future.

Today, the direction and magnitude of Chinese international migration are very much influenced by the migration policies of the sending and receiving countries. Three of the countries featured in this chapter, namely, Australia, Canada, and the United States, along with New Zealand, are the main receiving countries these days of Chinese immigrants. Immigration today, however, is strictly limited and enforced in most countries of the world. The growth patterns of the overseas Chinese in the years ahead will likely be more affected by international emigration and immigration policies than by the demographic processes of fertility and mortality which, for overseas Chinese, are similar to those of populations in the host countries.

The overseas Chinese population in the world in 2018 numbered almost 49 million people, a population size larger than the total population of Poland (38.4 million), Iraq (40.2 million), Uganda (44.1 million), Argentina (44.5 million), or Spain (46.7 million), and only three million smaller than South Korea (51.8 million). The Chinese diaspora is the third largest in the world, behind those of Ireland and Germany (Poston Jr. and Wong 2016). The overseas Chinese have had, and will continue to have, important and significant influences in many countries around the world, especially the six countries featured in this chapter, and are certainly not an inconsequential population.

References

Ambrose, S. E. (2001). *Nothing like it in the world: The men who built the transcontinental railroad 1863–1869*. New York: Simon and Schuster.

Baten, J. (2016). *A history of the global economy, from 1500 to the present*. New York: Cambridge University Press.

Bird, I. L. (1883). *The golden chersonese and the way thither*. New York: G. P. Putnam's Sons.

Campbell, P. C. (1923). *Chinese coolie emigration to countries within the British Empire*. London: P. S. King and Son Ltd.Chosun Ilbo. 2013.

Cassel, S. L. (2002). *The Chinese in America: A history from gold mountain to the new millennium*. Lanham: AltaMira Press.

Chang, G. (2019). *Ghosts of gold mountain: The epic story of the Chinese who built the transcontinental railroad*. New York: Houghton Mifflin.

Dreyer, E. L. (2007). *Zheng He: China and the oceans in the early Ming, 1405–1433*. New York: Pearson Longman.

Fitzgerald, C. P. (1965). *The third China: The Chinese communities in South-East Asia*. London: Angus and Robertson.

Fitzgerald, S. (1972). *China and the overseas Chinese: A study of Peking's changing policy, 1949–70*. Cambridge: Cambridge University Press.

Frankopan, P. (2017). *The silk roads: A new history of the world*. New York: Vintage Books.

Hawley, A. H. (1950). *Human ecology: A theory of community structure*. New York: Ronald Press.

Heidhues, M. S. (1999). Indonesia. (pp. 151–168). In L. Pan (Ed.), *The encyclopedia of the Chinese Overseas*. Cambridge, MA: Harvard University Press.

Inglis, C. (1999). Australia. (pp. 274–285). In L. Pan (Ed.), *The encyclopedia of the Chinese Overseas*. Cambridge, MA: Harvard University Press.

Jensen, E. B. J., Knapp, A., Peter Borsella, C., & Nestor, K. (2015). The place-of-birth composition of immigrants to the United States: 2000 to 2013. Paper presented at the annual meeting of the Population Association of America, San Diego, CA, April 30 – May 2.

Koon, H. P. (1999). Chinese economic activities. (Page 175). In L. Pan (Ed.), *The encyclopedia of the Chinese Overseas*. Cambridge, MA: Harvard University Press.

Kung, S. W. (1962). *Chinese in American life*. Seattle: University of Washington Press.

Kwong, P. (1987). *The New Chinatown*. New York: Hill and Wang.

Lai, H. M. (1999). The United States. (pp. 261–273). In L. Pan (Ed.), *The encyclopedia of the Chinese Overseas*. Cambridge, MA: Harvard University Press.

Legge, J. (1886). *A record of Buddhist Kingdoms: Being an account by the Chinese Monk Fa-hein of his travels in India and Ceylon (A.D. 399–414) in search of the Buddhist books of discipline*. Oxford: The Clarendon Press.

Levathes, L. (1996). *When China ruled the seas: The treasure fleet of the Dragon Throne, 1405–1433*. Oxford, UK: Oxford University Press.

McKenzie, R. D. (1925). The oriental invasion. *Journal of Applied Sociology, 10*, 120–130.
Mei, J. (1979). Socioeconomic origins of emigration: Guangdong to California, 1850–1882. *Modern China, 5*, 463–501.
Menzies, G. (2008). *1421: The year China discovered America*. New York: William Morrow and Company.
Menzies, G. (2009). *1434: The year a magnificent Chinese fleet sailed to Italy and ignited the renaissance*. New York: William Morrow and Company.
Mung, E. M. (1998). Groundlessness and Utopia: The Chinese diaspora and territory. (pp. 35–48). In E. Sinn (Ed.), *The last half century of Chinese Overseas*. Hong Kong: Hong Kong University Press.
Ng, W. C. (1999). Canada. (pp. 234–247). In L. Pan (Ed.), *The encyclopedia of the Chinese Overseas*. Cambridge, MA: Harvard University Press.
Pan, L. (1990). *Sons of the yellow emperor: The story of the Overseas Chinese*. London, UK: Mandarin Paperbacks.
Poston, D. L., Jr. (2003). Overseas Chinese. (pp. 130–133). In P. Demeny & G. McNicoll (Eds.), *Encyclopedia of population*. New York: Macmillan Reference USA.
Poston, D. L., Jr., & Luo, H. (2007). Chinese student and labor migration to the United States: Trends and policies since the 1980s. *Asian and Pacific Migration Journal, 16*, 323–355.
Poston, D. L., Jr., & Yu, M.-Y. (1990). The distribution of the Overseas Chinese in the contemporary world. *International Migration Review, 24*, 480–508.
Poston, D. L., Jr., & Frisbie, W. P. (2019). Ecological demography. Chapter 26 (pp. 697–712). In D. L. Poston Jr. (Ed.), *Handbook of population* (2nd ed.). Cham: Springer Nature.
Poston, D. L., Jr., & Wong, J. H. (2016). The Chinese diaspora: The current distribution of the Overseas Chinese population. *Chinese Journal of Sociology, 2*, 348–373.
Poston, D. L., Jr., Mao, M. X., & Mei-Yu, Y. (1994). The global distribution of the Overseas Chinese around 1990. *Population and Development Review, 20*, 631–645.
Ravenstein, E. G. (1885). The laws of migration. *Journal of the Statistical Society of London, 48*, 167–235.
Redding, S. G. (1990). *The spirit of Chinese capitalism*. New York: Walter de Gruyter.
Stewart, W. (1951). *Chinese Bondage in Peru: A history of the Chinese Coolie in Peru, 1849–1874*. Durham: Duke University Press.
Sung, B. L. (1967). *Mountain of gold: The story of the Chinese in America*. New York: Macmillan Company.
Tong, N. S. (1999). Malaysia. (pp. 172–186). In L. Pan (Ed.), *The encyclopedia of the Chinese Overseas*. Cambridge, MA: Harvard University Press.
United Nations. (2014). *World urbanization prospects, highlights. 2014 Revision*. New York: United Nations.
von Brevern, M. (1988). *Once a Chinese, always a Chinese? The Chinese of Manila-tradition and change*. Manila: Lyceum Press.
Wang, S.-W. (1978). *The organization of Chinese Emigration, 1848–88*. San Francisco: Chinese Materials Center.
Wang, Gungwu. (1991). *China and the Chinese Overseas*. Singapore: Times Academic Press.
Wickberg, E. (1999). The Philippines. (pp. 187–199). In L. Pan (Ed.), *The encyclopedia of the Chinese Overseas*. Cambridge, MA: Harvard University Press.
Williams, L. E. (1966). *The future of the Overseas Chinese in Southeast Asia*. New York: McGraw-Hill.
Wong, M. G. (1980). Changes in Socioeconomic status of the Chinese male population in the United States from 1960 to 1970. *International Migration Review, 14*(4), 511–524.
Zhou, M. (2009). *Contemporary Chinese America: Immigration, ethnicity, and community transformation*. Philadelphia: Temple University Press.
Zhu, G. (1991). A historical demography of Chinese migration. *Social Sciences in China, 12*, 57–84.
Zipf, G. K. (1946). The P1 P2/D hypothesis: On the intercity movement of persons. *American Sociological Review, 11*, 677–686.

Chapter 12
Mental Health Issues Among Chinese Communities in Malaysia: A Cultural and Historical Approach

Rachel Sing-Kiat Ting, Pei-Lynn Foo, and Nicole Lee-Thung Tan

Abstract This chapter presents the experiences of Chinese in Malaysia, in the context of mental health services. As the second largest ethnic group in Malaysia, the Chinese population is diverse in its subculture, education, generation, geography, and degree of assimilation to the mainstream culture. The chapter introduces the ecological characteristics in Malaysia and how they shape the unique mental health challenges of the Chinese. Though the Chinese are known for their multilingual ability, strong work ethic, emphasis on education, and family piety, clashes between traditional and modern values, their marginalized position in the Malaysian political arena, the stereotype of the economically successful minority, and the "brain drain" of young well-educated Chinese have all caused a strain in Chinese individuals and families across the lifespan. Moreover, they face both external and internal barriers in getting quality mental health care. It is therefore imperative to promote a mental health service model that is able to meet Chinese psychological needs, as well as being sensitive to the culture and history of the Chinese communities.

Keywords Chinese in Malaysia · Mental health · Indigenous and culture psychology

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History of the Chinese in Malaysia

Malaysia has a multi-ethnic naturalized population of about 28.4 million that is made up of three major ethnic groups, Malays (68.6%), people of Chinese descent (23.4%), and the Indian ethnic group (7.0%). The remaining 1.0% consists of the aboriginal people and people of mixed ethnicities (Department of Statistics Malaysia 2016). The population of Chinese in Malaysia is 6.65 million, only slightly less than the population of Hong Kong (7.4 million).

Historically, the Chinese have been settling in Malaya since the days of the Malacca Sultanate, when the Straits of Malacca was a major trading route in the fifteenth century AD. Many Chinese traders settled and integrated into the Malayan culture since then. The second large wave of Chinese entering Malaysia, consisting largely of planters, traders, and tin miners, was after Penang was founded in the late 1700s. Migration from mainland China became more established after the founding of Singapore in the early 1800s, with Chinese immigrants moving into manufacturing, banking, and timber trading (Tan et al. 2005). A total of about 17 million Chinese entered the Malay Peninsula by the nineteenth century, due to the poverty in coastal rural China and the employment opportunities in the British colony (Ching and McKenna 1990). Chinese in Malaysia call themselves "Hua Ren" (華人) – overseas born Chinese – rather than "Zhong Guo Ren" (中國人), the political nationality of Mainland Chinese.

Largely through trading and mining, the Chinese have been instrumental in the economic development of Malaysia, especially with regard to commerce and industry. A British administrator in Malaya was quoted as saying:

> Under present conditions, the Chinese are the bone and sinew of the Malay states. They are the labourers, the miners, the principal shopkeepers, the capitalists, the holders of the revenue farms, the contributors to almost the whole of the revenue; we cannot do without them. (Tan et al. 2005)

Reinforced by the British policy to keep the different ethnic groups in separate sectors, the Chinese were seen as leading in business and trading (resulting in the "success minority myth"), while Malays dominated politics and government administration, and Indians provided blue-collared manpower (Fu 2007). As a result, the Chinese came to be perceived as a "threat" to Malays, to whom the British left political power after Malaya's independence in 1957. The resulting racial tension led to the historical tragedy on 13 May 1969, where hundreds of Chinese were killed in a racial riot following an unsatisfactory election result for the Malay group (Ness 1972). During this time, many Chinese fled to join Singapore due to their fear of racial violence and victimization. In 1971, the New Economic Policy was introduced with the objectives of eradicating poverty in the Malay group and eliminating racial differences in economic function and geographical location. Despite preferential treatment under this policy of Malays in education and economy, the Chinese still flourished in business ventures (Fu 2007).

Influenced by the Confucian work ethic, the early Chinese settlers and their descendants have been regarded as hardworking and determined, leading to the

stereotype of Chinese being the most entrepreneurial people. Today, many Chinese have ventured into and succeeded in various contemporary vocational areas. They also make up the bulk of the population in most urban areas of Malaysia today (Carstens 2005; Heng 2006). However, in recent years, despite an increasing wealth gap within the Chinese community, little attention has been paid to the marginalized Chinese from lower socioeconomic background (FMT Reporters 2017).

Unique Ecology and Diversities Within the Chinese Community

We have previously argued that the Chinese in Malaysia are different from other Chinese societies originating from more homogeneous countries and also different from other ethnic groups in Malaysia itself (Ting and Foo 2019). We would describe four major environmental factors as having decisive influence on Chinese in Malaysia – education, language, cultural practices, and political status.

Education System

Early Chinese settlers set up an independent Chinese education system, mow under the private schooling system in Malaysia. Chinese can choose to enter a private Chinese school or public school, which differ in language of instruction and in philosophy of teaching. Concepts and values related to Confucian teachings are preserved in the Chinese schools (Ingrid 1998; Lee 2007). This difference in education system has implications for cultural identity and even in political orientation (Tan 2000).

According to Tan (2007), the Chinese in Malaysia can be broadly categorized into two groups based on their exposure to different language medium in education. Members of the first group, constituting 85% of Chinese, build their cultural identity around three pillars: the Chinese-language schools, Chinese newspapers, and Chinese ethnic corporations. They are described as typically being independent business people, whose main concern is political stability for good economic returns. The second group, 15% of Chinese, consists of those who speak mainly English and are not educated in the Chinese schools. Members of this group are often disparagingly referred to by the first group as "bananas" (i.e., yellow skin [Chinese], white core [pro-Western culture]) (Tan 2007). Sometimes, these two "types" of Chinese co-exist within the same family due to generational differences in educational backgrounds. This difference in educational backgrounds is likely also to influence their beliefs and attitudes toward mental illness as well as help-seeking methods.

In a recent study, Ho et al. (2018) found that Chinese high schoolers, despite coming from the two educational systems (Independent Chinese Secondary School (ICSS) and National Secondary School (NSS)), all scored high on Chinese identity. Interestingly, students from NSS were found to have a more salient Chinese identity even though their proficiency in and use of Chinese language was lower than that of students in ICSS. In addition, the qualitative aspect of this study revealed that NSS students deemed the Chinese language as an important representation of their identity that keeps the togetherness of the Chinese group. For ICSS students, the Chinese language is more of a useful tool for global communication and continuation of education.

Language and Dialect Diversity

With regard to language and culture, although most Chinese are conversant in the Malay language – the national language – most retain their original traditions and mother tongue from their ancestral ties to China. Multilingual ability is more prevalent among Chinese in Malaysia than among Chinese elsewhere, such as Taiwan, Hong Kong, Indonesia, and Thailand. Tan (2005) estimated that there were approximately 5.4 million Chinese dialect speakers in 2000, 94.27% of Chinese in Malaysia at that time (Department of Statistics 2001). Heng (2006) categorized early Chinese settlers into five major dialect groups, Hokkien (37%), Hakka (22%), Cantonese (19%), Teochew (12%), and Hainanese (4%). Influenced by the Malay and English languages, some Chinese develop their own unique Chinese dialects, such as the Penang Hokkien which is unique and distinct to the northern peninsular region (Ong and Tan 2017).

Cultural and Religious Practice

Preservation of language and cultural practices enables the Chinese to preserve their identity as Chinese, unlike their counterparts in Indonesia and Thailand where national identity precedes ethnic identity. In fact, many still identify themselves as "Chinese," even if they are acculturated Malaysians for more than a generation (Ang 2013). Confucianism plays a prominent role in learning core Chinese cultural values (Lee-Wong 2000; Yick and Gupta 2002). Most of the Chinese are Christians, Taoists, and Buddhists in Malaysia (Chong et al. 2013). The elements of these different religions influence perceptions of mental health despite modernization and westernization. For instance, Taoism, Confucianism, and Buddhism teach the virtue of restraining excessive behaviors and suppressing strong emotions (Yip 2005). For this group, healing methods for mental health problems are more likely to be tied to folklore beliefs and practices, such as shamanism or traditional Chinese herbal treatments (*Zhong yao*) (Chang et al. 2017; Edman and Koon 2000).

Sociopolitical Status

Given their economic strength and recognized leadership, Chinese do possess some political influence in the ruling parties as well as the opposition, although ethnic Malays hold the dominant political power in the country, and the political involvement of Chinese is decreasing (Freedman 2000).

In terms of inter-racial relationships, Chinese seem to prefer to remain within their own group, forming cliques at schools and at workplaces. Due to the ethnic-based political structure ("Malay supremacy") in Malaysia, ethnocentric sentiments, which remain entrenched within each ethnic group, discourage meaningful inter-racial interaction. The existing affirmative policy for the Malay group relating to educational opportunity (such as "90:10" pre-university admission ratio) has cultivated a strong sentiment among Chinese who do not enjoy equal right of tertiary education and consequent disadvantage in public sector employment (Chiu 2000; Lee 2012). This sociopolitical atmosphere has resulted in increased migration to more developed countries ("brain drain") by Chinese since the 1980s. Those who have remained face psychological insecurity as an ethnic minority. Rising racial tension can be seen in recent years due to some ethnic Malay groups' rhetoric on "Ketuanan Melayu" ("Malay Supremacy" in English) and description of the ethnic Chinese as "Pendatang" (i.e., immigrants) and second-class citizens, which further harm positive inter-ethnic relations (Han 2015).

Even after the 2018 general election in Malaysia, with claims that Malaysia is being "reformed" by the more "liberal" leading party, the ex-Education Minister, Maszlee Malik, has attracted criticism following his comments (as cited in The Straits Times 2019) on the importance of retaining the race-based pre-university quota in Malaysia.

Due to a different political context and geographical distance, Chinese in East Malaysia form a distinctive culture and community that is different from the Chinese in West Malaysia (Chin 1981; Hing and Tan 2000). Sabah and Sarawak joined the independent Malaya in 1963 to form the Federation of Malaysia. Prior to independence, both were ruled by the British governors and the Malay Raja (king). East Malaysians usually do not possess as strong a sense of Malaysian nationality as do those from West Malaysia ("Civil movement" 2013; "GE 13: Movement" 2013; Rintod 2013).

Taking the current sociopolitical challenges faced by the Chinese into consideration, it is understandable that, in comparison to the other ethnic groups in Malaysia, the Chinese have been found to have the lowest level of happiness and subjective well-being (Minkov and Bond 2017). Continuing emigration and a low birth rate are resulting in a decline of the Chinese population in the country. The proportion of Chinese in Malaysia dropped by 4.5% to a total of 24.6% of the total population in 2010 (Department of Statistics 2011) to 23.4% in 2016 (Jabatan Perangkaan Malaysia 2016) and by a further 0.2% from 2017 to 2018. It is estimated that the proportion of Chinese will continue to drop to 20% by 2040 (Department of Statistics 2011).

Mental Health Protective Factors in the Chinese Community

The Chinese communities in Malaysia are characterized by a number of protective factors that support well-being, including the following:

Business vitality: The Chinese in Malaysia have a history of entrepreneurial success and leadership in economic development. They have high visibility in business, nationally and internationally. Although they do not hold much political power, their contribution to the Malaysian economy has been widely acknowledged (Gomez 1999).

Strong adaptability: The Chinese have a history of resilience through immigration and differentiation from China while building a new home and identity in a new land. Within a century, the Chinese became the second largest ethnic group in Malaya and continue to make an important contribution to the nation. In spite of the hardship experienced, particularly at the beginning of the twentieth century, the Chinese have adapted and flourished.

Strong family values: The strong family lineage and concept of filial piety have kept Chinese families intact. According to the 2010 Census of Population and Housing (Department of Statistics Malaysia 2011), the Chinese have the lowest divorce rate among all the ethnic groups. Filial piety, still highly emphasized, serves as a protective factor for the aging population as children are expected to take care of the elderly and family business (Simon et al. 2014; Iskandar et al. 2014). The tight networks based on blood-tie relationships have served as a buffer against social oppression and marginalization (Ng et al. 2011; Yeh et al. 2013). When there is mental illness in the Chinese family, all the family members feel obligated to take care of the ill family member, decreasing reliance on the social welfare system (Chang and Horrocks 2006).

Belief in good education: Malaysia is the only country outside China and Taiwan with a comprehensive and complete Chinese education system. It is also the only country in Southeast Asia that has perpetuated the Chinese education system established during the colonial era (Ang 2017). This illustrates the importance attached by the Chinese community to a good education, despite the lack of funding from the government. There are five private tertiary education institutes established by the Chinese community in which Mandarin is the medium of teaching (Wan et al. 2020). Chinese parents also often strive to send their children to foreign countries or private institutes for better opportunities in education.

Strong work ethic: The strong work ethic among the Chinese is a continuation of the "survival" mentality since centuries ago, and referred to by scholars as "Confucius dynamism" (Hofstede 2003). The older generation of Chinese continue to expect to pass on their business to their children (Iskandar et al. 2014).

Mental Health Challenges Experienced by the Chinese Community

Despite the Chinese community's many strengths and assets, clashes between tradition and modern values, the marginalized position in the Malaysian political arena, the stereotype of overachiever in education, and the "brain drain" of young well-educated Chinese have all caused strain in Chinese individuals and families (Sukumaran 2017). According to the 2015 Malaysia National Health and Morbidity Survey (NHMS), there has been an increase in mental health problems from 1996 to 2015 in both Chinese adults and children (Ahmad et al. 2015; Ministry of Health Malaysia 2015).

Children: Pressures for Achievement

In the past decade, the increase of mental health problems among the child and adolescent population in Malaysia has become a significant concern. Comparing data from the Malaysia National Health and Morbidity Surveys (NHMS) of 1996, 2006 and 2011, the prevalence of mental health problems among children and adolescents (between the ages of 5 to 15 years) increased by 49.2% from 1996 to 2011, with many struggling especially with emotional, conduct, hyperactivity, peer, and social problems (Ministry of Health Malaysia 2015). In the 2015 survey, the NHMS also identified Chinese children as having the second highest prevalence of mental health problems, next to the indigenous population (Ministry of Health Malaysia 2015). Another study confirmed that mental health problems among Chinese children increased by a staggering 366.7% from 1996 to 2006 (Ahmad et al. 2015). Specifically, many Chinese children struggle with psychological distress, anxiety, depression, and even suicidal thoughts (Alphonsus 2012). While depression among Chinese children could be associated with family factors, social factors, age and gender, ethnicity and culture, and physical factors (Zgambo et al. 2012), it is not clear which of these factors are most important in explaining the increase.

It is known that among many traditional Chinese societies, the pressure to excel and achieve begins at a young age and is closely tied to the Chinese family's interests (Hau and Ho 2010). Failure to achieve and meet high standards reflects poorly on the individual child and has an impact on the Chinese family's face, image, pride, and integrity. Such achievement-oriented upbringing and emphasis on family interests can be problematic for children, especially in the absence of adequate parental and social support, familial and household stability, and positive coping resources. The pressures and stress early in life may undermine mental health adaptability in young children which may have continuing consequences later in life (Wang 2015; Alphonsus 2012; Bernama 2016; Zgambo et al. 2012). Such academic stress may be continued until the college stage where Chinese have been found to have higher levels of stress and lower coping skills in comparison with other ethnic groups (Mazlan et al. 2012).

Adolescents: Pressures from Authoritarian Parents

The identity crisis of Chinese teenagers surfaces in their choices of friendships, dating relationships, and career paths, as parental authority is still highly emphasized (Chen and Liew 2015). While traditional Chinese parents expect their children to be "obedient and filial," not many teenagers today can conform to such social norms and expectations. In a study with 14–16-year-old students from private schools in Malaysia, Chinese youth's anxiety level is best predicted by more "anxious parenting styles" and less "parental emotional warmth" compared to other ethnic groups. (Mousavi et al. 2016). The insecure parenting styles for many Chinese families might subject their children to multiple psychological problems. In a survey of 2927 secondary school children, Chinese students were found to have the highest rate of depression among all ethnic groups (55%), which was associated with low academic performance and alcoholism (Latiff et al. 2016). Similar results were found in another study in Sarawak where Chinese adolescents had the highest rate of depression among all ethnic groups (Ghazali and Azhar 2015). Suicidal ideation and attempts are also found to be higher in Chinese adolescents in both West and East Malaysia – 13.7% and 10.7%, respectively – compared to adolescents from other ethnic groups (Ahmad and Cheong 2014).

Based on the Health Ministry's 2017 National Health and Morbidity Survey (NHMS) statistics, 21% of Chinese adolescents have depression, and 36% of Chinese adolescents have anxiety; Chinese teenagers also rank second highest on prevalence of suicidal behaviors, next to Indian ethnic group (Ministry of Health 2017). It was also found that "Internet addiction" was highest among Chinese adolescents. Behavioral problems and teenage delinquency are rising as substance abuse becomes more prevalent in Malaysia (Singh et al. 2017). According to a survey conducted in Penang (Guan and Rahimi 2015), self-harm behaviors have also become prevalent among Chinese teenagers (56.8%), especially among female students (33.7%).

Adults: Family Differentiation Versus Lineage

Though the Chinese have been persistent in keeping their cultural heritage, increasingly, hybridized cultural identity could be clashing with traditional social norms. For example, several studies found that parental authority still plays a key factor for individuals of Chinese descent in determining their career goals (Chen and Liew 2015; Tang 2002; Iskandar et al. 2014). Issues with authority figures are frequently a challenge that adult Chinese have to work through in the therapy room. According to the first author's clinical practice over the past 20 years, many Chinese adult clients complain about the interference of their parents in their daily life decisions. Finding their own voice in the traditional Chinese household would be a lifelong challenge due to the pressure to be the "perfect child." Some traditional Chinese

also value multigenerational living under the same roof (三代同堂) as a sign of prosperity for the family clan, although conflicts between in-laws and those who seek individuation from the family of origin may not be infrequent. Risk for postnatal depression and suicide among Chinese women may be exacerbated by an unsupportive family system, such as lack of support from the husband or conflicts with in-laws (Yusuff et al. 2014). Having to struggle with the patriarchal family system (e.g., in-law problems) increases Chinese married women's vulnerability to mental illness, especially depression (Arifin 2015).

Chinese adults who uphold a stronger preference for familial "face" and shame concerns were more likely to report higher levels of psychological distress. The effort invested in managing interpersonal dynamics within the family can be psychologically taxing and distressing, especially in the event of failure to sustain interpersonal harmony among family members (Mak and Chen 2010). The need to be perfect in order to avoid negative consequences is also related to body image dissatisfaction and eating disorders among Chinese women aged 18–46 years (Choo and Chan 2012). In reviewing 39 studies related to suicide in Malaysia, Armitage et al. (2015) found that the Chinese have a high risk of suicide attempts, comparable to that of the Indian group which is also an ethnic minority in Malaysia.

Older Adults: Somatic Complaints and Empty Nest Syndrome

Based on the 2010 population census, one out of eight Chinese was aged 60 years and above, which was the highest compared to other ethnicities in Malaysia, because of lower fertility, emigration, and longer life expectancy among the Chinese (Chai and Hamid 2015; Tey 2016).

The Chinese community is known for its "international family" constellation, where younger Chinese who pursue higher education in developed countries remain in those countries for better living conditions and stable subsistence, while they would have limited opportunities for employment and promotion in Malaysia (Ward and Hewstone 1985). This kind of emigration is known as the "second wave diaspora among Chinese" (Ling 2008; Tan 2005). This pattern of migration, what Poston and Zhang (this volume) refer to as the *Huayi* (华裔) pattern, is the migration of people of Chinese descent living in one foreign country (in this case, Malaysia) to another foreign country (frequently the USA, Australia, New Zealand, Canada, or the UK). However, this creates a vacuum in the Chinese community in Malaysia, where the aging cohort lacks support from the younger cohort. Many older adults suffer from "empty nest" syndrome, with loneliness and depression, as their children and grandchildren are abroad, which goes against the cultural tenets of filial piety and family ethics (Simon et al. 2014). Care for the aged Chinese in Malaysia is a looming future challenge (Chai and Hamid 2015).

Many older generation Chinese continue to believe in traditional Chinese interpretations of mental health problems and in traditional Chinese medicines in their treatment. Depression is most frequently experienced somatically and in terms of interpersonal dysfunction (Chan 1990; Kleinman 1982; Watters 2011). Their losses

and griefs might not be understood by mental health practitioners or taken seriously by their family members if negative emotions are being expressed rather indirectly with somatic symptoms (Mak and Chen 2010; Ting 2008).

Gaps in Mental Health Services

Chinese in Malaysia seek mental health services at quite low rates (Krishnaswamy et al. 2012), and there are substantial barriers to seeking help from mental health professionals.

Stigma Toward Mental Health Issues

Though there is an increased awareness of mental health among the Chinese, mental illness and seeking help from mental health professionals are still highly stigmatized (Dollery and Yu 2011). As a developing country, the institutionalization of mental illness is still prevalent in the healthcare model of Malaysia (Chong et al. 2013), which perpetuates the negative stereotype of the mental health professions. In addition, the injunction to "never air your laundry outside the family" is still deep-rooted among the Chinese. Despite their degree of urbanization and mental health literacy, urban Chinese still prefer their family and religious networks over mental health professionals when seeking help for issues such as depressive symptoms (Loo and Furnham 2012). The stigma toward mental illness and the implication of personal and familial failure, weakness, and shame contribute to low rates of help-seeking and service utilization (Hwang 2006; Mak and Chen 2010). Chinese family caregivers in Malaysia still play the biggest role in the care and support of family members/relatives who suffer from severe and persistent mental illness. This also creates physical and mental burdens for these family members due to shame and embarrassment (Chang and Horrocks 2006; Chong et al. 2013).

Cost-Benefit Concerns

An additional barrier to help-seeking is the "pay structure" of mental health services. The existing healthcare insurance schemes in Malaysia do not provide coverage for mental illness. Certain mental health problems may require multiple therapy sessions that can be a financial burden to some. This situation discourages Malaysians from putting mental health as their priority (Hassan et al. 2018). Some Chinese are reluctant to pay a professional fee to seek help from "talk therapy." They would rather opt for other forms of treatment, such as traditional herbal medicines for symptom relief, which is also consistent with their belief system (Chang et al. 2017; Chen 1981).

Lack of Multilingual and Culturally Sensitive Mental Health Services

For linguistic minorities, mental health interventions conducted in clients' native language have been found to be more effective (Griner and Smith 2006) than interventions in the dominant language. In Malaysia, 56.6% (77 of 136) of known active clinical psychologists are of Chinese descent (personal communication with Malaysia Society of Clinical Psychologists). While the number of Chinese clinical psychologists has almost doubled in the past 15 years, Chinese counselors constitute only 12.7% (907 out of 7157) in the registry of the Malaysian Counseling Association (Ng 2005; Lembaga Kaunselor Malaysia 2016). With such a limited number of Chinese psychologists and counselors serving the whole Chinese community of 6.65 million (ratio, 1:7332), there is a major service gap in the system. Moreover, most psychological testings are conducted in English and normed on Western populations. Psychological assessment in Malaysia is still largely culturally and linguistically biased. The lack of Chinese translated and locally normed tools for intelligence and personality testing has been an impediment to the provision of culturally appropriate and fair services considering that 85% of Chinese in Malaysia identify one of the Chinese dialects as their mother tongues (Tan 2007).

As counseling and clinical psychology is still a young profession, and there are not many culturally competent senior Chinese counselors or therapists available, the younger generations of mental health professionals often lack supervision and role models, leaving them to stumble their way in gaining more clinical and educational experience (Ching and Ng 2010; Haque 2005). According to a survey, the mental health profession in Malaysia is dominated by individual-oriented therapists who practice individual therapy which might be inadequate to address complicated family-based conflict and pathology (Mohamed and Rahman 2011; Ng 2007; Ching and Ng 2010), which are common among the Chinese.

Uneven Distribution of Mental Health Services

Most mental health services are concentrated in big cities, such as Kuala Lumpur and Penang (Ng 2007). According to the latest statistics, there are 410 registered psychiatrists in Malaysia of whom 213 work in the government sector. Capital cities such as Kuala Lumpur have the highest density of psychiatrists, while the East Malaysian state Sabah has the lowest ratio of psychiatrists to population (0.54 per 100,000 population). In short, there is a severe shortage of psychiatrists in Malaysia based on the World Health Organization's recommendation of 1:10,000. (Ng et al. 2018). In addition, there is a shortage of psychologists, counselors, psychotherapists, and social workers, particularly in remote areas and states.

Suggestions for Future Mental Health Services

In order to overcome the aforementioned barriers, we propose the following strategies to improve access to effective and culturally sensitive mental health services for Chinese in Malaysia.

Contextualizing Mental Health Theories and Paradigms

While reviewing and researching empirical studies related to Chinese in Malaysia, the authors found that ethnicity was seldom a major factor addressed in the literature. The Chinese group was often the "comparison group" to the Malay group, and the findings were generally interpreted through the lens of the dominant group, with Chinese culture invisible or not examined. Another common problem is that Chinese are often "lumped" with other ethnic groups as a "one Malaysian" sample, which obscures their distinct mental health needs. While many anthropologists and sociologists have studied the diversity of the Chinese, Malaysian psychologists have not developed a theoretical framework to understand and explain ethnic differences and uniqueness in our own country. Most of the psychological models employed by Malaysian psychologists are either a direct translation or importation from developed Western countries. Psychology practice occurs almost exclusively in the Euro-American tradition (Dueck et al. 2007). As Malaysia gained its independence from Britain only in 1957, it is understandable that Western health service models are widely adopted and recognized. The Chinese are often scrutinized for their "lack of mental health literacy" based on DSM and for not seeking professional treatment (Loo and Furnham 2012). There is still little awareness of the need to indigenize mental health services in Malaysia to reflect the local Chinese culture and needs.

Considering the current trend of racial segregation and the tight-knit Chinese community, mental health professionals could utilize community-based services to promote mental health awareness and services to this population. Instead of practicing from a private-practice model, community psychology could help in destigmatizing and demystifying psychotherapy, building a safety net of secondary preventive measures, and decreasing the prevalence of mental illness among the Chinese. For instance, as family is a big player in shouldering the burden of mental illness management, building a support system for family caregivers would be vital so that they could also share reliable mental health resources with each other. Another big helping hand in Malaysia is the vitality of its non-governmental and nonprofit organizations (NGOs), including religious communities. The government could collaborate with NGOs and religious communities to reach out to the rural and the high-risk Chinese populations and train more lay helpers within the community to reduce the stigma associated with seeking help from the outsiders. De-institutionalizing mental health care and promoting community-based care would reduce the stigma of mental illness and match the strong ties that are characteristic of Chinese society (Ting

and Sundararajan 2018). There is also the advantage of mobilizing peer-mentoring groups, such as parenthood groups, adolescent mentoring programs, and support groups for family/caretakers of the severely mentally ill, among the Chinese community. In rural areas where mental health resources are scarce, the training of lay counselors and peer counselors who come from diverse backgrounds would be a high priority. It is anticipated that local counselors would be able to reach out to the Chinese family units in a more culturally appropriate manner than is possible for external consultants. Ultimately, developing a Chinese psychology theory in Malaysia would help to counteract the misinterpretation of Chinese behavior by Western approaches (Ting and Thong 2019).

Enhancing Multicultural Competency and Literacy in Mental Health Professional Training Program

While it is not possible to train sufficient multilingual staff, it is realistic to train multiculturally competent therapists in post-graduate programs. It is highly recommended that higher education institutions mandate multicultural therapy as core coursework in counseling training programs. For therapists who are providing services to the Chinese community, it would be imperative to have a clear understanding of Chinese culture and subcultures through reading and cultural immersion experiences. For example, many Chinese still view mental health in a strong-ties perspective and express their symptoms in interpersonal terms (Palmer 2015), which might not be understood by a therapist with poor cultural literacy. With multicultural competency, a good therapist will first examine his/her own biases and values toward different groups of Chinese. Multicultural competency training would include close supervision of intern counselors working with the Chinese and help trainees work through their own cultural stereotypes and counter-transference challenges with various clients.

As many Chinese still practice folk religions (e.g., Taoist) and ancestor worship, Chinese mental health practitioners have already started integrating their religious faith into their research and practice, such as mindfulness and meditation for Buddhist therapists and prayers and scriptures for Christian therapists (Ting and Ng 2012). Therapists are encouraged to talk to different religious leaders in the Chinese community for wider exposure. Academicians could also study the effects of such integrated therapeutic approaches for empirical evidence. Instead of adopting a dualistic viewpoint of mind-body interaction, learning to view mental health from a traditional Chinese medical perspective might also be helpful to build holistic care for the more traditional Chinese individuals.

Cultivating the Next Generation of Chinese Service Providers

It is highly encouraged for the next Chinese generation to pursue a career in the mental health professions due to the great need among its own community. In the past, careers in the mental health field have been also associated with the stigma of mental illness. However, there is a turn in the last decade, where greater visibility of psychology and mental health practices among the Chinese can be seen. The establishment of Chinese counseling centers and associations and the blossoming of counseling seminars and various continuing education courses have led to a wider acceptance and understanding of counseling and mental health within the Chinese society. More Chinese are expressing interest in psychology and counseling courses. These demands further stimulate the expansion of psychology departments in some private institutions in Malaysia (EduAdvisor 2017).

Many textbooks and literature in counseling/psychology have been translated into Mandarin in Taiwan, Hong Kong, and China, and Chinese Malaysian counselors could benefit from such overseas resources by accessing firsthand knowledge from their counterparts in other countries. There is also more interchange with Taiwan counselors to develop skills through intensive training and workshops. Some Chinese counselors/therapists have started to publish their own works (such as Bridge Communication Press), as well as to contribute to newspaper/journal columns (such as *Sin Chew Daily* and *Guang Ming Daily*). Online media exposure and radio interviews could also help to destigmatize the mental health field, as well as promote social status of counselors (Hanafiah and Bortel 2015).

In addition, a substantial number of Chinese counselors/therapists speak at least one Chinese language/dialect (Ng 2007). Most, if not all, Chinese therapists are also able to speak and write in English and Malay (Ng 2007). Chinese therapists are therefore often able to reach out to a non-Chinese clientele without the need for translators, as well as serving the Chinese community. Unlike other ethnic groups who are usually monolingual or dual lingual, multilingual Chinese therapists have wider access and flexibility in providing much needed services to the general Malaysian population.

Building a Chinese-Friendly Society Through Advocacy and Public Policy

The public slogan of “Satu Malaysia” (One Malaysia) promoted by the previous Malaysian government with the intention to unite the ethnic groups into one nationality has not been encouraging toward ethnic studies. Emphasizing national identity over ethnic identity is a strategy that encourages assimilation and reduces tension between multiple ethnic groups. Yet, if efforts are not balanced by celebrating diversity under the umbrella of nationality, cultural heritage would disappear, and the identity of any ethnic group would be compromised. We advocate for a moderate

public policy to embrace the diversity within the Malaysian population, as well as a mental health field that fosters peaceful dialogue between Chinese and other ethnic groups. All Malaysian citizens, including the Chinese, should have equal access to mental health services in the public arena. The government sectors should also ensure ethnic diversity among employed mental health practitioners (e.g., psychiatrists, counselors, psychologists) to serve the diverse Malaysian population. Many trained Chinese clinical psychologists or counselors were actually "drained" to foreign countries, such as Australia and Singapore, as they found current employment in Malaysian government sectors not achievable. Though there is no overt racial oppression and violence toward the Chinese at the moment, the existing racial quota in the government education and employment systems could restrict development of Chinese mental health practitioners. It is timely for all mental health professionals, regardless of ethnic backgrounds, to come together to share resources in the community and promote inter-racial harmony.

Conclusion

This chapter is an attempt to introduce the complicated mental health issues faced by a heterogeneous group like the Chinese in Malaysia. It is our hope to stimulate further dialogue about this unique population rather than perpetuating any existing ethnic stereotype. The sociopolitical struggle is quite obvious as Malaysia is a relatively new country struggling to find its multiracial-multicultural identity after more than 60 years of independence from Britain. It is therefore imperative to cultivate a mental health system that is open to serving the Chinese population, as well as being sensitive to its historical and cultural background.

References

Ahmad, N., & Cheong, S. M. (2014). Suicidal ideation among Malaysian adolescents. *Asia-Pacific Journal of Public Health, 26*(5), 63–69.

Ahmad, N., Muhd Yusoff, F., Ratnasingam, S., Mohamed, F., Nasir, N. H., Mohd Sallehuddin, S., et al. (2015). Trends and factors associated with mental health problems among children and adolescents in Malaysia. *International Journal of Culture and Mental Health, 8*(2), 125–136. https://doi.org/10.1080/17542863.2014.907326.

Alphonsus, A. (2012, June 18). Chinese youths top suicide list. *Free Malaysia Today.* Retrieved from http://www.freemalaysiatoday.com/category/nation/2012/06/18/chinese-youths-top-suicide-list/

Ang, I. (2013). Beyond Chinese groupism: Chinese Australians between assimilation, multiculturalism and diaspora. *Ethnic and Racial Studies, 37*(7), 1184–1196. https://doi.org/10.1080/01419870.2014.859287.

Ang, M. C. (2017). Chinese Education in Malaysia. Oxford Research Encyclopedia of Education. https://doi.org/10.1093/acrefore/9780190264093.013.220.

Arifin, S. R. B. M. (2015, June). *Postnatal depression across cultures: A qualitative study in Malaysia*. Paper presented at NMAHP Research Unit Mini Conference 2015, Glasgow, Scotland.

Armitage, C. J., Panagioti, M., Abdul Rahim, W., Rowe, R., & O'Connor, R. C. (2015). Completed suicides and self-harm in Malaysia: A systemic review. *General Hospital Psychiatry, 37*(2), 153–165. https://doi.org/10.1016/j.genhosppsych.2014.12.002.

Bernama. (2016, September 12). Mental health of Malaysian students cause of worry: Health Ministry. *The New Straits Times*. Retrieved from https://www.nst.com.my/news/2016/09/172683/mental-health-malaysian-students-cause-worry-health-ministry

Carstens, S. A. (2005). *Histories, cultures, identities: Studies in Malaysian Chinese worlds*. Singapore: Singapore University Press.

Chai, S. T., & Hamid, A. (2015). Population ageing and the Malaysian Chinese: Issues and challenges. *Malaysian Journal of Chinese Studies, 4*(1), 1–13.

Chan, D. W. (1990). The meaning of depression: The Chinese word associations. *Psychologia, 33*, 191–196.

Chang, K. H., & Horrocks, S. (2006). Lived experiences of family caregivers of mentally ill relatives. *Journal of Advanced Nursing, 53*(4). https://doi.org/10.1111/j.1365-2684.2006.03732.x.

Chang, M. L., Tam, A., & Mohd Suki, N. (2017). Moderating effect of races towards consumers' feeling of TCM usage. *Handbook of research on leveraging consumer psychology for effective customer engagement*. https://doi.org/10.4018/978-1-5225-0746-8.ch020.

Chen, P. C. Y. (1981). Traditional and modern medicine in Malaysia. *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology, 7*, 127–136. https://doi.org/10.1016/0271-7123(81)90032-8.

Chen, L- S., Liew, S- A. (2015, February). *Factors influencing career decision making difficulties among graduating students from Malaysian private higher educational institutions.* Proceedings of the 8th Asia Pacific business research conference, Kuala Lumpur, Malaysia.

Chin, J. M. (1981). *The Sarawak Chinese*. New York: Oxford University Press.

Ching, F. Y., & McKenna, R. B. (1990). *The Kuomintang Movement in British Malaya, 1912–1949*. NUS Press. ISBN 978-9971-69-137-0.

Ching, M. S., & Ng, K. M. (2010). Counseling in Malaysia: History, current status, and future trends. *Journal of Counseling & Development, 88*, 18–22.

Chiu, Y. F. (2000). Educational opportunities for Chinese in Malaysia. *International Journal of Educational Research, 33*(6), 585–591.

Chong, S. T., Mohd, S. M., & Er, A. C. (2013). The mental health development in Malaysia: History, current issue and future development. *Asian Social Science, 9*(6), 1–8. https://doi.org/10.5539/ass.v9n6p1.

Choo, S. Y., & Chan, C. K. Y. (2012). Predicting eating problems among Malaysian Chinese: Differential roles of positive and negative perfectionism. *Personality and Individual Differences, 54*, 744–749.

Civil movement to call for self-government, nationhood for Malaysia's Sarawak. (2013, April 15). *Nationalia Aureli Argemí.* Retrieved from https://www.nationalia.info/new/9822/civil-movement-to-call-for-self-government-nationhood-for-malaysias-sarawak

Department of Statistics, Malaysia. (2001). Population and Housing Census 2000. In *Distribution and basic demographic characteristics report.* Available from http://www.statistics.gov.my/English/pageDemo.htm

Department of Statistics Malaysia. (2011). *Population distribution and basic demographic characteristic report 2010.* Retrieved from https://www.dosm.gov.my/v1/index.php?r=column/cthemeByCat&cat=117&bul_id=MDMxdHZjWTk1SjFzTzNkRXYzcVZjdz09&menu_id=L0pheU43NWJwRWVSZklWdzQ4TlhUUT09

Department of Statistics Malaysia. (2016). *Current population estimates, Malaysia, 2014–2016.* Retrieved from https://web.archive.org/web/20160812014710/, https://www.statistics.gov.my/index.php?r=column%2FcthemeByCat&cat=155&bul_id=OWlxdEVoYlJCS0hUZzJyRUcvZEYxZz09&menu_id=L0pheU43NWJwRWVSZklWdzQ4TlhUUT09

Dollery, R., & Yu, H. (2011). *Investigation into the mental health support needs of international students with particular reference to Chinese and Malaysian students.* UK: University of Nottingham. Retrieved from https://docplayer.net/40192587-Investigation-into-the-mental-health-support-needs-of-international-students-with-particular-reference-to-chinese-and-malaysian-students.html

Dueck, A., Ting, S.-K., & Cutiongco, R. (2007). Constantine, Babel, and Yankee Doodling: Whose indigeneity? Whose psychology? *Pastoral Psychology, 56*, 55–72.

Edman, J. L., & Koon, T. Y. (2000). Mental illness beliefs in Malaysia: Ethnic and intergeneration comparisons. *International Journal of Social Psychiatry, 46*(2), 101–109.

EduAdvisor. (2017). Find and compare psychology degree courses in Malaysia. Retrieved from https://eduadvisor.my/psychology-degree-institutions/

FMT Reporters. (2017, November 17). Report: Chinese community has the biggest income gap. *Free Malaysia Today*. Retrieved from http://www.freemalaysiatoday.com/category/nation/2017/11/17/report-chinese-community-has-the-biggest-income-gap/

Freedman, A. L. (2000). *Political participation and ethnic minorities: Chinese overseas in Malaysia, Indonesia, and the United States*. New York: Routledge.

Fu, C. Q. (2007). *A different Chinese*. Petaling Jaya: Strategic Information and Research Development Centre.

GE13: Movement wants full autonomy for Sarawak. (2013, April 14). *The Star Online.* Retrieved from https://www.thestar.com.my/news/community/2013/04/14/ge13-movement-wants-full-autonomy-for-sarawak/

Ghazali, S. R., & Azhar, A. (2015). Depressive symptoms, gender, and ethnicity: An exploratory study among cross ethnic adolescents in Sarawak, Malaysia. *Malaysian Journal of Youth Studies, 13*, 141–152.

Gomez, E. T. (1999). Chinese business in Malaysia: accumulation, ascendance, accommodation. Retrieved from https://books.google.com.my/books?hl=en&lr=&id=mc460XYAnQMC&oi=fnd&pg=PP2&dq=Chinese+Business+in+Malaysia:+Accumulation,+Ascendance,+Accommodation+-+Edmund+Terence+Gomez+ &ots=o2SzM6u4AH&sig=ycho___h7cD93kbwcxm2Aa9FkM8&redir_esc=y#v=onepage&q=Chinese%20Business%20in%20Malaysia%3A%20Accumulation%2C%20Ascendance%2C%20Accommodation%20-%20Edmund%20Terence%20Gomez&f=false.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 531–548.

Guan, T. E., & Rahimi, C. A. (2015). Prevalence of self-hurt behavior among Chinese adolescents in Malaysia. *International Journal of Humanities, Arts and Social Sciences, 1*(2), 108–113.

Han, B. (2015, November 10). Malaysia's Chinese diaspora: The other side of the story. *The Diplomat.* Retrieved from https://thediplomat.com/2015/11/malaysias-chinese-diaspora-the-other-side-of-the-story/

Hanafiah, A. N., & Bortel, T. V. (2015). A qualitative exploration of the perspectives of mental health professionals on stigma and discrimination of mental illness in Malaysia. *International Journal of Mental Health Systems*. https://doi.org/10.1186/s13033-015-0002-1.

Haque, A. (2005). Mental health concepts and program development in Malaysia. *Journal of Mental Health, 14*(2), 183–195.

Hassan, M. F., Hassan, N. M., Kassim, E. S., & Hamzah, M. I. (2018). Issues and challenges of mental health in Malaysia. *International Journal of Academic Research in Business and Social Sciences, 8*(12), 1685–1969. https://doi.org/10.6007/IJARBSS/v8-i12/5288.

Hau, K.-T., & Ho, I. T. (2010). Chinese students' motivation and achievement. In M. H. Bond (Ed.), *The Oxford handbook of Chinese psychology* (pp. 187–204). New York: Oxford University Press.

Heng, P. K. (2006). Patterns of Chinese settlement. In L. Pan (Ed.), *The encyclopedia of the Chinese overseas* (2nd ed.). Singapore: Editions Didier Millet.

Hing, L. K., & Tan, C. B. (Eds.). (2000). *The Chinese in Malaysia*. New York: Oxford University Press.

Ho, P. Y., Chew, F. P., & Thock, K. P. (2018). Constructing Chinese identity through the Chinese language: A comparative study of two different secondary education systems in Malaysia. *Asia-Pacific Social Science Review, 18*(2), 1–15.

Hofstede, G. (2003). *Culture's consequences: Comparing values, behaviors, institutions, and organizations across nations* (2nd ed.). Thousand Oaks: Sage Publication.

Hwang, K. K. (2006). Constructive realism and Confucian relationalism: An epistemological strategy for the development of indigenous psychology. In U. Kim, K. Yang, & K. Hwang (Eds.), *Indigenous and cultural psychology: Understanding people in context*. New York: Springer.

Ingrid, G. (1998). *An identity dilemma: A comparative study of primary education for ethnic Chinese in the context of national identity and nation-building in Malaysia and Singapore*. Oslo: Scandinavian University Press.

Iskandar, H. T. A., Muhammad, S. A., Sakinah M. Z., Lim, S. C., & Nur Azuki, Y. (2014). Interaction between Chinese family business and cultural differences in Malaysia. *Asian Social Science, 10*(10). https://doi.org/10.5539/ass/v10n10p118

Jabatan Perangkaan Malaysia. (2016, July 22). Anggaran Penduduk Semasa, Malaysia, 2014–2016. Pejabat Ketua Perangkawan Malaysia. Retrieved from https://www.dosm.gov.my/v1/index.php?r=column%2FpdfPrev&id=SzVuRjlvV3JsUXUyOStZcTQyNEVGQT09&fbclid=IwAR1xUDtweJP8LxigvFc77LWuf3NsuELIp3IEqwDwzrZzZa4ccavnUPSTcbk

Kleinman, A. (1982). Neurasthenia and depression: A study of somatization and culture in China. *Culture, Medicine, and Psychiatry, 6*, 117–190.

Krishnaswamy, S., Subramaniam, K., Jemain, A. A., Low, W. Y., Ramachandran, P., Indran, T., & Patel, V. (2012). Common mental disorders in Malaysia: Malaysian mental health survey, 2003–2005. *Asia-Pacific Psychiatry, 4*, 201–209. https://doi.org/10.1111/j.1758-5872.2012.00180.x.

Latiff, L. A., Tajik, E., Ibrahim, N., Abubakar, A. S., & Ali, S. S. B. A. (2016). Depression and its associated factors among secondary school students in Malaysia. *Southeast Asian Journal of Tropical Medicine and Public Health, 47*(1), 131–141.

Lee, E. L. (2007). The Chinese Malaysians' selfish mentality and behaviors: Rationalizing from the native perspectives. *China Media Research, 3*(4), 91–101.

Lee, H. A. (2012). Affirmative action in Malaysia: Education and employment outcomes since the 1990s. *Journal of Contemporary Asia, 42*(2), 230–254. https://doi.org/10.1080/00500782.2012.668350.

Lee-Wong, S. M. (2000). *Politeness and face in Chinese culture*. Frankfurt am Main: Peter Lang.

Lembaga Kaunselor Malaysia. (2016). *Laporan Tahunan 2016 Lembaga Kaunselor*. Retrieved from https://www.lkm.gov.my/kpwkm/uploads/files/LAPORAN%20TAHUNAN%20LEMBAGA%202016%20%20.pdf

Ling, H. S. (2008). *Negotiating Malaysian Chinese ethnic and national identity across borders* (Masters thesis). Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.1007.8237&rep=rep1&type=pdf

Loo, P. W., & Furnham, A. (2012). Public knowledge and beliefs about depression among urban and rural Chinese in Malaysia. *Asian Journal of Psychiatry, 5*, 236–245. https://doi.org/10.1016/j.ajp.2012.02.003.

Mak, W. W. S., & Chen, S. X. (2010). Illness behaviour among the Chinese. In M. H. Bond (Ed.), *The Oxford handbook of Chinese psychology* (pp. 421–439). New York: Oxford University Press.

Mazlan, L. B., Bahari, F., & Ardillah, F. (2012). Stress and coping skills among university students: A preliminary research on ethnicity. *Southeast Asia Psychology Journal, 1*, 31–37.

Ministry of Health Malaysia. (2015). *National health and morbidity survey 2015 volume II: Non-communicable diseases, risk factors & other health problems*. Retrieved from http://www.iku.gov.my/images/IKU/Document/REPORT/nhmsreport2015vol2.pdf

Ministry of Health Malaysia. (2017). N*ational health and morbidity survey (NHMS) 2017: Key Findings from the Adolescent Health and Nutrition Surveys.* Retrieved from http://iku.moh.gov.my/images/IKU/Document/REPORT/NHMS2017/NHMS2017Infographic.pdf

Minkov, M., & Bond, M. H. (2017). A genetic component to national differences in happiness. *Journal of Happiness Studies, 18*(2), 321–340. https://doi.org/10.1007/s10902-015-9712-y.

Mohamed, Z., & Rahman, A. (2011). Counseling practitioners in Malaysia: Socio-demographic profile and theoretical approaches in counseling process. *International Journal of Business and Social Science, 2*(22), 184–188.

Mousavi, S. E., Low, W. Y., & Hashim, A. H. (2016). Perceived parenting styles and cultural influences in adolescent's anxiety: A cross-cultural comparison. *Journal of Child and Family Study, 25*, 2102–2110. https://doi.org/10.1007/s10826-016-0393-x.

Ness, G. D. (1972). May 13: Before and after. by Tunku Abdul Rahman; Malaysia: Death of a democracy. by John Slimming; the May 13 tragedy: A report by The National Operations Council; the May thirteenth incident and democracy in Malaysia. by Goh Cheng Tiek. *The Journal of Asian Studies., 31*(3), 734–736. https://doi.org/10.1017/s0021911800137969. JSTOR2052316.

Ng, W. S. (2005). *Psychotherapists in Malaysia: A preliminary study of clinical psychologists.* Unpublished doctoral Clinical Research Project for the completion of the Doctor of Psychology (Psy.D.) degree.

Ng, W. S. (2007, August). *Cultural identity of psychotherapists in Malaysia.* Paper presented at the World Mental Health Congress at Hong Kong Polytechnic University, Hong Kong.

Ng, M. N., Bhugra, D., Mcmanus, F., & Fennell, M. (2011). Filial piety as a protective factor for depression in survivors of childhood abuse. *International Review of Psychiatry, 23*(1), 100–112. https://doi.org/10.3109/09540261.2010.544645.

Ng, C. G., Toh, C. L., Francis, B., Tan, S. Y. (2018). Psychiatrists in Malaysia: the ratio and distribution. *MJP Online Early*. Retrieved from https://www.researchgate.net/publication/328261835_Psychiatrist_in_Malaysia_Ratio_and_Distribution

Ong, K. H., & Tan, J. (2017). *Penang Hokkien on life support.*. Retrieved from http://penangmonthly.com/article.aspx?pageid=7412&name=penang_hokkien_on_life_support

Palmer, B. B. (2015). Concepts of mental health in Malaysia. *International Journal of Mental Health, 44*(3), 253–258. https://doi.org/10.1080/00207411.2015.1037133.

Rintod, L. (2013, May 30). Working towards reinstating Sarawak's sovereignty. *Free Malaysia Today.* Retrieved from http://www.freemalaysiatoday.com/category/nation/2013/05/30/working-towards-reinstating-sarawaks-sovereignty/.

Simon, M. A., Chen, R., Chang, E., & Dong, X. (2014). The association between filial piety and suicidal ideation: Findings from a community-dwelling Chinese aging population. *The Journals of Gerontology: Series A, 69*(2), 90–97. https://doi.org/10.1093/gerona/glu142.

Singh, S. K., Yap, K- H., Reidpath, D. D., & Allotey, P. (2017, August). *Binge drinking and associated risk behaviours among youth in three ethnic groups in Malaysia.* Paper presented at 31st annual conference of the European Health Psychology Society from the 29th of August to the 2nd of September 2017, Padua, Italy.

Sukumaran, T. (2017, May 20). What's causing Malaysia's ethnic Chinese brain drain? *South China Morning Post.* Retrieved from http://www.scmp.com/week-asia/politics/article/2095012/whats-causing-malaysias-ethnic-chinese-brain-drain

Tan, L. E. (2000). Chinese schools in Malaysia: A case of cultural resilience. In K. H. Lee & C. B. Tan (Eds.), *The Chinese in Malaysia* (pp. 228–254). Selangor: Oxford University Press.

Tan, J. (2007). 马来西亚的华人:一个族群, 两种观点[Malaysian Chinese: One Ethnicity, Two Perspectives] Special issue in Sin Chew Forum, *Sin Chew Jit Poh*, on October 28, 2007.

Tan, C. -B. (2005). Chinese in Malaysia. In M. Ember, C. R. Ember, & I. Skoggard (Eds.), *Encyclopedia of diasporas: Immigrant and refugee cultures around the world* (pp. 697–706). New York: Springer.

Tan, T. J., Ho, W. F., & Tan, J. L. (2005). *The Chinese Malaysian contribution*. Kuala Lumpur: Centre for Malaysian Chinese Studies.

Tang, M. (2002). A comparison of Asian American, Caucasian American and Chinese college students: An initial report. *Journal of Multicultural Counselling and Development, 30*(2), 124–135.

Tey, N. P., Siraj, S. B., Kamaruzzaman, S. B., Chin, A. V., Tan, M. P., Sinnappan, G. S., & Müller, A. M. (2016). Aging in multi-ethnic Malaysia. *Gerontologist., 56*(4), 603–609. https://doi.org/10.1093/geront/gnv153

The Straits Times. (2019, May 19). Malaysia's unpopular Education Minister Maszlee Malik stumbles into another controversy. *The Straits Times*. Retrieved from https://www.straitstimes.com/asia/se-asia/malaysias-unpopular-education-minister-maszlee-stumbles-into-another-controversy

Ting, R. S., & Foo, P. L. (2019). Counseling Chinese communities in Malaysia: The challenges and needs in mental health service deliverance. In A. J. Jegathesan & S. S. Abdullah (Eds.), *Multicultural counseling applications for improved mental healthcare services* (pp. 23–49). Hershey: IGI Global. https://doi.org/10.4018/978-1-5225-6073-9.ch002.

Ting, S. –K. (2008). *Who am I talking to: The effect of language on bilingual Chinese expression of self-concept and depressive emotion*. Germany: VDM Verlag Dr. Mueller e.k.

Ting, R. S. -K, & Ng, L. O. (2012). Use of religious resources in psychotherapy from a tradition-sensitive approach: Cases from Chinese in Malaysia. *Pastoral Psychology: Special Issues, 61*, 941–957.

Ting, R. S. K., & Sundararajan, L. (2018). Culture, cognition, and emotion in China's religious ethnic minorities: Voices of suffering among the Yi. In *Palgrave studies in indigenous psychology*. Cham, Switzerland: Palgrave Macmillan Publication.

Ting, R. S. K. & Thong, J. A. (2020). Global Psychology: Symphony or Elephant. In Sundararajan, L., Yeh, K. H. & Huang, K. K. (Eds). Global Psychology from Indigenous Perspectives: Visions inspired by K. S. Yang. "Palgrave Studies in Indigenous Psychology" book series by Palgrave MacMillan Publication. Chapter 13, 225–244. https://doi.org/10.1007/978-3-030-35125-0_13

Wan, C. D., Lee, M. N. N., Sirat, M., & Heng, W. Z. (2020). Identities of Chinese Community-based higher education institutions in Malaysia: an exploration study using the concept of 'Roots'. *International Journal of Chinese Education, 9*(1), 68–88. https://doi.org/10.1163/22125868-12340120

Wang, S. B. (2015, November 2001). 是谁偷走了孩子的快乐. [Who stole the happiness from the children?]. KwangHwa Newspaper. Retrieved from https://www.google.com/search?q=google+translate&rlz=1C1CHBF_enMY847MY847&oq=google+translate&aqs=chrome..69i57j0j69i65j69i60l3.2183j0j7&sourceid=chrome&ie=UTF-8

Ward, C., & Hewstone, M. (1985). Ethnicity, language and intergroup relations in Malaysia and Singapore: A social psychological analysis. *Journal of Multilingual and Multicultural Development, 6*, 271–296. https://doi.org/10.1080/01434632.1985.9994207.

Watters, E. (2011). *Crazy like us: The globalization of the American psyche*. New York: Free Press.

Yeh, K. H., Yi, C., Tsao, W., & Wan, P. (2013). Filial piety in contemporary Chinese societies: A comparative study of Taiwan, Hong Kong, and China. *International Sociology, 28*(3), 277–296. https://doi.org/10.1177/0268580913484345.

Yick, A. G., & Gupta, R. (2002). Chinese cultural dimensions of death, dying and bereavement: Focus group findings. *Journal of Cultural Diversity, 9*, 32–42.

Yip, K. S. (2005). Family caregiving of clients with mental illness in the People's Republic of China. *International Journal of Psychosocial Rehabilitation, 10*(1), 35–42.

Yusuff, A. S. M., Tang, L., Binns, C. W., & Lee, A. H. (2014). Prevalence and risk factors for postnatal depression in Sabah, Malaysia: A cohort study. *Women and Birth, 28*(1), 25–29.

Zgambo, M., Kalembo, F., He, G., & Wang, H. (2012). Depression among Chinese children and adolescents: A review of the literature. *International Journal of Child, Youth and Family Studies, 4*(1), 442–457. https://doi.org/10.18357/ijcyfs34.1201211543.

Chapter 13
The Contentious Social Positions of People of Chinese Descent in Indonesia

Hans Pols and Eunike Sri Tyas Suci

Abstract Individuals of Chinese descent have always occupied an ambiguous position in Indonesian society. In the Dutch East Indies, the Dutch colonial administration relied on Chinese immigrants for trading, manufacturing, and tax farming. A number of ethnic Chinese businessmen became very wealthy. During the nineteenth century, colonial law placed the ethnic Chinese in a separate category. In the early twentieth century, China claimed citizenship to all overseas Chinese, which made their citizenship status ambiguous. This continued to be the case after Indonesia gained independence and led many to question their commitment to the new nation. Throughout colonial and modern times, the ethnic Chinese in Indonesia have often been subjected to attacks, violence, and discrimination; at times, these outbursts of violence were lethal. During the Suharto years, Chinese Indonesians were forced to assimilate, Chinese schools were closed, and all Chinese Indonesian newspapers and magazines were outlawed. After 1998, these prohibitions have been outlawed, yet the contentious social position of Chinese Indonesians remains. The ecological overview presented in this chapter of the position of Chinese Indonesians in Indonesian society provides some indications of areas of possible resilience and risk for mental disorder, and of possible needs for mental health services in Indonesia. Mental health research on specific population sub-groups is not well-developed and should receive greater attention. This is particularly important in relation to the Indonesian population of Chinese descent, the largest Chinese diaspora population outside of China, which has played and continue to play a uniquely important role in Indonesian society.

Keywords Dutch East Indies · Indonesia · Chinese Indonesians · Mental health · Discrimination · Violence

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For at least seven centuries, but most likely much longer, various ethnic groups inhabiting areas within the boundaries of modern China have migrated to the Indonesian archipelago. Like many other groups of migrants, most of them married locals; acquired local customs, habits, and religious practices; and assimilated into local populations. Most of the descendants of these early Chinese migrants no longer speak any of the languages spoken in China, have made themselves at home in the archipelago, and only identify with China to a limited degree. A smaller community of more recent arrivals continues to speak one of the Chinese languages and strongly identifies with their country of origin. Some Chinese migrants arrived as merchants; a small proportion of them became wealthy. Others arrived as indentured labourers, living lives of poverty while being exploited on plantations, in mines, and in factories. Despite the diversity among Indonesians of Chinese descent, politicians and government officials in both the Dutch East Indies and Indonesia have generally viewed them as a distinct and more or less homogeneous group whose members could be identified easily and unambiguously. Through legal measures and other government interventions, they have consistently emphasised that they are not part of the indigenous population of the Indonesian archipelago, leading to a paradoxical situation in which individuals whose families have resided there for several generations and who consider themselves fully Indonesian are treated as "essential outsiders" who should be distrusted and are preferably sidelined (Reid 2009). At crucial times, those in power have turned people of Chinese descent into scapegoats to distract popular attention from economic mismanagement or political turmoil.

In independent Indonesia, most of the biases and political measures targeting Chinese Indonesians remained. Excluding a small minority, most Chinese Indonesians speak Indonesian exclusively and consider themselves fully Indonesian, as their ancestors moved from China several generations ago. Despite the fact that most Indonesians count various ethnic groups from the archipelago as their ancestry as well as Dutch, other Europeans, Arabs, and Chinese, they continue to be divided in artificial and mutually exclusive ethnic groups, thereby essentialising ethnic identity. Chinese Indonesians continue to be viewed as foreign "Others" who do not truly belong to the nation (Chirot and Reid 1997). At times, this inspires acts of violence and, more frequently, various forms of discrimination and exclusion. The ambivalent attitude of many Indonesians toward Chinese Indonesians leaves many of the latter in a state of permanent insecurity, which has significant consequences for their wellbeing and mental health. This condition is exacerbated in those Chinese Indonesians who have suffered attacks and violence.

Chinese Migration to the Archipelago

Individuals and families who used to live in the area that makes up modern China started to arrive in the Indonesian archipelago as early as 1292, when several thousand soldiers belonging to Mongolian armies arrived in Karimunjawa, a small island

north of Java, to attack the Singhasari Kingdom. After the cessation of hostilities, some of these soldiers settled on the north coast of East Java (Daradjadi 2013). Migration continued during the fifteenth century, when mariner Cheng Ho (also named Zheng He) led groups of Chinese Muslims from the east coast of China to settle on Java's northern coast (Tan 2008). During the sixteenth century, groups of Chinese traders from at least four different ethnic groups, the Hokkien, Hakka, Teochiu, and Cantonese, began migrating to the archipelago. The various groups of Chinese migrants had different economic backgrounds and occupations. Among the first group of migrants, for example, were Hokkien traders, who mainly settled near harbours and trading centres. Most ethnic Teochiu migrated to Kalimantan and engaged in agriculture, while ethnic Cantonese were skilful in industry and mostly migrated to Java (Turner 2003). Initially, Chinese migrants arrived without family members and married local women; they blended in with the local population by adopting the local language as well as local culinary preferences, clothing styles, and religious practices. These migrants are referred to as "Peranakan Chinese".

Chinese migrants came to the Indonesian archipelago for various reasons, but mostly to build a better life for themselves. After the Dutch East Indies Company (VOC) established their headquarters in Batavia in 1619, it became the most important Dutch trading centre in Asia. Chinese traders played a central role in the VOC's intra-Asian trade; the number of Chinese junks that came to Batavia steadily increased during the following decades. Chinese migrants came to dominate Batavia's economic activities: they served as traders, shopkeepers, carpenters, and construction workers, and became the lifeblood of the city (Blussé 1986; Setiono 2003). The Dutch East Indies Company imposed levies on gambling, opium, and spirits, which became a significant part of its revenue. It auctioned the collection of various taxes to the highest bidder ("tax farming"); several Chinese migrants had their bids accepted and started to collect taxes, tolls, and port levies in the Dutch colony. In addition, Batavia's Chinese inhabitants had to pay a relatively high poll tax to exempt them from manual labour (Blussé 1986). Through these taxes and levies, the majority of Batavia's budget was funded by its Chinese inhabitants. After 1860, Chinese migrants also settled in the areas surrounding Batavia, where wealthier Chinese established sugar mills, employing poor Chinese migrants. In building Batavia as a city and establishing agriculture in the surrounding areas, Chinese migrants played a central role in the city's economic life.

For several decades, the economic dominance of Chinese migrants in Batavia served the interests of the Dutch East Indies Company well. However, in the early years of the eighteenth century, conflict arose after the international sugar trade collapsed, hitting Chinese sugar traders hard and putting thousands of Chinese migrants out of work. Rumours spread that the VOC was planning to forcibly resettle them in Sri Lanka, which was, at the time, under Dutch control. In October 1740, about 100 Chinese workers protesting excessive taxation by the Dutch were arrested. Protests erupted, followed by riots and looting. To regain control over the situation, Governor General Adriaan Valckenier ordered his militias to forcibly end the riots. In the ensuing weeks, more than 10,000 Chinese men, women, and children were massacred by the Dutch militias, assisted by several ethnic groups residing in Batavia (Tan

2008). This was the first massacre of individuals of Chinese descent in the Indonesian archipelago. Survivors fled to the north coast of Central Java where they united with Javanese groups in a battle against the Dutch. This uprising is now called the *Perang Sepanjang (also named Geger Pacinan)*; it lasted for 3 years (1740–1743) (Daradjadi 2013). This coalition of Javanese and Chinese forces demonstrates that both groups joined forces against the colonial administration.

One of the legacies of the 1740 Batavia massacre was the increasing gulf between Chinese migrants and all other ethnic groups. Following the massacre, Chinese migrants were forced to live outside the city walls in designated quarters. The colonial administration continued to delegate tax and toll collection to them. The British interregnum in the Indies (1811–1816) reinforced these arrangements (Cary 2015). Chinese migrants were also allowed to open small shops to sell opium, on which the colonial administration held a monopoly. Despite the fact that most Chinese migrants and their descendants exclusively spoke local languages and felt more at home in the archipelago than in China, prejudice against them increased during the following decades. Prince Diponegoro, the well-known Javanese aristocrat who led the Java war from 1825 to 1830, for example, reinforced existing prejudices after losing a battle near Surakarta in 1826, after he had spent the night with a Chinese woman (Kwartanada 2019). He subsequently instructed his soldiers to refrain from romantic liaisons with Chinese women. Although he was aware that the mother of his most trusted uncle and best commander, Prince Joyokusumo, was Chinese. She was the second wife of Sultan Hamengku Buwono II and had a Javanese name: Mas Ayu Sumarsonowati (Setiono 2003, p. 201). In his pronouncement, Diponegoro portrayed the Chinese as a separate group, while he must have been aware that they were deeply interwoven with the Javanese.

Different groups of Chinese migrants started to arrive in the Deli area around Medan on the East Coast of Sumatra after tobacco plantations were established there in the 1870s. Because this area was sparsely populated, plantation owners recruited large numbers of indentured labourers (*coolies*) among the poorest in China (Pols 2016). Later, workers were also recruited from Java. Working conditions were appalling and physical abuse common, making comparisons with slavery apt (Stoler 1985). Meanwhile, plantation owners made extremely high profits—often referring to the "Deli miracle". Chinese workers were also recruited to work in the tin mines on Bangka and Belitung Islands (Sumatra) under trying conditions (Heidhues 1992). These large groups of migrants remained poor for several generations, contradicting the stereotype that Chinese migrants were unusually wealthy.

The distinct status of Chinese migrants and their descendants in colonial society was reinforced by the legal system adopted by the Dutch colonial administration during the last quarter of the nineteenth century. This system distinguished three separate groups: Europeans, foreign Orientals (mainly the Chinese, but also Arabs and people from India), and "natives", in effect institutionalising legal apartheid (Fasseur 1994). According to this legal system, Europeans were subject to Dutch legal provisions, while indigenous people were left in the care of village heads and other indigenous officials, following the implicit legal rules and sensitivities of their own ethnic group. The Chinese were subject to European law with

respect to property and trade, while they could follow their own principles with respect to inheritance and family law. In the Dutch colonial legal code, individuals of Chinese descent were set apart from the rest of the population of the Indies while reinforcing their essential roles in the colonial economy. It made them vulnerable to popular anger during economic downturns and political crises, diverting attention from the inherently exploitative nature of colonial society.

In the 1880s, Malay newspapers, books, and magazines started appearing in several cities in the Dutch East Indies, often financed by Chinese entrepreneurs and featuring the writings of Chinese, Indo-Europeans, and Indonesians. These publications popularised the use of Malay, which later became Indonesia's national language. They often discussed progress and how science, technology, and medicine could change life in the Indies for the better. Moderate nationalist ideas were frequently discussed in these papers as well (Adam 1995). Apparently, educated Chinese, Indo-Europeans, and Indonesians were entertaining similar ideas and shared the same ideals about the future of the colony. Unfortunately, any potential for cooperation was shattered shortly after the turn of the twentieth century, following the colonial administration's abolition of revenue farming in the 1890s. This deprived the Chinese of the economic opportunities they had enjoyed for over a century. Enterprising Chinese Indonesians sought new economic opportunities in *kretek* cigarettes, batik, and other industries, where they started to compete with members of the budding Indonesian middle class.

This situation was exacerbated by the rise of nationalist republican sentiment in China, which was eagerly followed by the Chinese in the Dutch East Indies. In 1900, they established the *Tiong Hoa Hwee Koan* (Chinese Guildhall); the following year, this association introduced Chinese schools, which quickly spread over the Indies. Representatives from both the Qing dynasty and China's Republican movement sought closer association with the Chinese in the Dutch colony. In 1909, the Qing dynasty ruled that all descendants of Chinese individuals were, in principle, Chinese citizens, regardless of where they were born; the following year, the colonial administration ruled that all persons born in the Indies of parents residing there were Dutch subjects. The Chinese residents of the Dutch colony therefore potentially had dual nationality (Aguilar Jr. 2001; Suryadinata 1978; Willmott 2009 [1961]). This predicament continued to cause difficulties for Chinese Indonesians until the 1980s. The Chinese revolution of 1911 overthrew the Qing dynasty and established the Republic of China, thereby ending over 2000 years of imperial rule and forming a modern Chinese state and increasing the self-confidence of the Chinese in the Dutch East Indies. Many cut off their queues and started to wear European clothing, expecting other Indonesians to treat them like they treated Europeans (Shiraishi 1997). After the establishment of the Islamic Association (*Sarekat Islam*) in 1912, trade associations (*kongsi*) in which the Chinese and Indonesians had worked together disintegrated, and a virulent anti-Sinicism spread over the colony.

During the last four decades of colonial rule, the Dutch colonial administration had successfully deprived Chinese Indonesians of the economic opportunities they had relied upon for more than two centuries. It was no longer dependent on the

Chinese for collecting taxes. Because people of Chinese descent had been relegated to a distinct social and legal realm, they could not challenge Dutch hegemony and were vulnerable to Indonesian antagonism and regular violence. Their paradoxical social position, characterised by a combination of economic strength, lack of political power, and vulnerability to popular violence, survived the colonial era; in independent Indonesia, it was exploited by politicians to further their own ends.

The Indonesian Revolution, 1945–1949

The resentful attitudes among Indonesians towards the ethnic Chinese because of their perceived wealth and privileged status in the Dutch East Indies strengthened during the war of independence. After August 1945, many Chinese Indonesians chose the side of the Indonesian Republic and were eager to play their part by forming militias (Budianta 2011). Several Chinese businessmen provided the Republican forces with much-needed funds by smuggling goods to Singapore. Despite this, many Chinese Indonesians were killed or forcibly relocated while their houses were burned and their stores looted, in particular in areas where the Dutch and Republican forces engaged in hostilities during the two Dutch military incursions (Heidhues 2012). The hostility of Indonesian armed groups was provoked by the involvement of a small number of Chinese Indonesians in the Dutch armed forces (Setiono 2003, p. 583). Many Chinese fled to the urban areas, which were under Dutch control, for safety; this only increased the suspicions against them. During the negotiations of the Round Table conference in 1949, where details surrounding the transfer of sovereignty were discussed, Chinese Indonesians were promised a relatively easy access to Indonesian citizenship. If they wished to become Indonesians, no further action was required. If however, they opted to become citizens of the PRC, they needed to renounce their Indonesian citizenship and register with the Chinese consulate—over 600,000 did so (Zhou 2019). Because of the hostility they had experienced during the Indonesian revolution, many were reluctant to become Indonesian citizens.

The Sukarno Era, 1950–1965

During the Sukarno era, the ambiguity surrounding the citizenship of Chinese Indonesians remained, as the People's Republic of China, like its predecessor, claimed all overseas Chinese as its citizens. Just like its predecessor, it viewed the so-called "overseas" Chinese as important resources to advance its interests abroad. After 1949, the Republic of China (Taiwan), while less outspoken in making such claims, made the situation even more complicated. Because both the PRC and the Indonesian government thought that many Chinese Indonesians had not been able to claim Chinese citizenship, a new citizenship treaty was negotiated. In August

1953, Sunario, the minister of foreign affairs, issued regulations detailing how foreigners could acquire Indonesian citizenship, which, eventually, led to the Citizenship Act of 1958 (Setiono 2003, p. 713; Suryadinata 1978, 1985; Zhou 2019). Because of the citizenship automatically granted to them by China, these regulations applied to Chinese Indonesians as well; they could only become Indonesian citizens if they officially renounced their Chinese citizenship. Many of the provisions of the 1958 Act were only implemented in the early 1960s. The process was arduous and provided civil servants with ample opportunity for demanding bribes. Nonetheless, as many as 390,000 ethnic Chinese renounced their Indonesian citizenship at this time. Those who opted for Indonesian citizenship were given naturalisation papers; civil servants continuously asked for these, charging higher fees for their services.

In response to the political situation in newly independent Indonesia, several Chinese intellectuals and political leaders established the Consultative Body for Indonesian Citizenship (*Badan Permusjawaratan Kewarganegaraan Indonesia*; Baperki) to advocate justice and equality for all Indonesians, including Chinese Indonesians. It supported an integrationist approach and viewed Chinese Indonesians as one of the many ethnic groups within the archipelago, characterised by their own specific culture and traditions. In reaction, other Chinese Indonesians advocated full assimilation, which meant that Chinese Indonesians would give up their specific cultural traditions, inter-marry, convert to Islam, and lose their distinguishing characteristics (Hoon 2008). The competing options of integration and assimilation have both been advocated by Chinese Indonesians and Indonesian politicians ever since, tensions between these views have never been fully resolved. Another fissure ran through the ethnic Chinese community: the majority was sympathetic to the PRC, while a smaller but vocal minority supported Taiwan. The Chinese Indonesian community became increasingly fractured as a consequence.

Even though leading politicians during the Sukarno era professed to treat Chinese Indonesians like all other citizens, they also wanted to promote economic activity among indigenous Indonesians. At times, they took measures to limit business opportunities of Chinese Indonesians and curtail their economic activity. In November 1959, President Sukarno decreed that foreigners were banned from running businesses in rural areas, a measure targeting those Chinese Indonesians who had failed to become Indonesian citizens. At the same time, more than 136,000 Chinese Indonesians had been deported to the People's Republic of China (Setiono 2003, p. 795). Consequently, most remaining Chinese Indonesians settled in urban areas. In 1963, when hyperinflation had crippled the Indonesian economy, several anti-Chinese riots occurred. The first one commenced after a Chinese Indonesian driver was acquitted for his involvement in a lethal traffic accident in Cirebon. Soon after, riots started in Bandung after a fight between Chinese and other students at the Bandung Institute of Technology. Soon, riots flared up all over Indonesia.

During Sukarno's Old Order, Chinese Indonesians did not enjoy a secure status as Indonesian citizens. Their political status remained vulnerable, and they were the object of discriminatory measures and, at times, violence. In 1956, Sukarno visited China for the first time and developed close political relationships with its leaders

under the *Poros Jakarta-Beijing* (Jakarta-Beijing axis) and the policy of Nasakom (*Nasionalisme, Agama, dan Komunisme*; Nationalism, Religion, and Communism). Although it might appear that this would lead to the improvement of the social situation of Chinese Indonesians, it at times made them vulnerable to further stigma and discrimination. When Indonesia and China enjoyed close diplomatic relations, China no longer attempted to involve Chinese Indonesians in supporting its cause. Yet both Taiwan and China were unable to contain the political activism of Chinese Indonesians (Zhou 2019). During the Suharto era (the "New Order"), the perceived association between Chinese Indonesians and communism would have severely adverse effects.

Suharto's New Order, 1966–1998

On 30 September 1965, a poorly executed coup took place during which six generals were assassinated. General Suharto took advantage of the chaos by declaring that the Indonesian Communist Party was behind this coup and assumed power. During the next few months, more than a million members of the Indonesian Communist Party, Communist sympathisers, and other individuals who, for some reason, were considered suspicious were assassinated, in what can be considered one of the worst political massacres of the twentieth century (Hearman 2018; Melvin 2018; Robinson 2018). Even though relatively few ethnic Chinese were killed, many suffered discrimination and extortion because of the alleged involvement of Communist China in the coup. In 1967, Indonesia had broken off diplomatic ties with China. Suharto sidelined Sukarno and became president in 1968. With generous assistance and financial aid from the United States, he established peace and order to support economic development. He initiated a forceful assimilationist policy towards Chinese Indonesians, who he suspected of Communist sympathies and a potentially disruptive force because of their unclear citizenship status. In early 1966, all Chinese schools were closed and Chinese organisations outlawed. The use of Chinese characters in public was prohibited. The Suharto regime encouraged Chinese Indonesians to adopt Indonesian names. During the New Order, full assimilation was viewed as the solution of the so-called Chinese problem (*masalah Cina*).

The forceful assimilation of Chinese Indonesians contained several contradictory elements. The government identification papers of Chinese Indonesians, for example, continued to indicate their ethnicity. Even if they had been naturalised as Indonesian citizens, Chinese Indonesians were expected to show their naturalisation papers at official occasions, which often entailed additional paperwork and expense. There were quotas for Chinese Indonesians at schools and universities; in addition, they were prohibited from occupying positions in the armed forces and the civil service. In 1980, Suharto issued two presidential regulations that detailed the naturalisation of the ethnic Chinese (Suryadinata 1985), which remained a lengthy and arduous process. Suharto's assimilationist policies differentiated Chinese

Indonesians more forcefully than ever before from all other Indonesian ethnic groups. According to Ariel Heryanto (1998), these policies were very effective in "othering the ethnic Chinese". He observes that Chinese Indonesians maintained their dominance in the economy while they held pariah status in the cultural and political spheres.

The regulations issued by the Suharto regime regarding foreigners (*Warga Negara Asing* or WNA) applied exclusively to Chinese Indonesians; Indonesians who descended from Indian citizens or Arabs, who also have a long history as migrants in Indonesia, were not singled out. The phrase *non-pribumi* ("non-native"; in short, *non-pri*) only designated individuals of Chinese descent. In addition, government regulations mandated the use of "Cina" instead of "Tionghoa"—the first term has strong pejorative connotations. Because Chinese Indonesians continued to be placed under the "magical power of the discursive phantom of the Communist threat" (Heryanto 1999, p. 151), they had little leeway to improve their social situation.

The social conditions of Chinese Indonesians improved somewhat during the 1990s. In 1990, Chinese premier Li Peng visited Jakarta marking the resumption of diplomatic relations, to create goodwill, and to negotiate business deals. At various locations, unofficial Chinese New Year celebrations were held, even though this was still illegal. Although a disproportionate number of Indonesian businesses were run by Chinese Indonesians, only a small number were wealthy. A few Chinese Indonesian business tycoons enjoyed close relationships with the powerful leaders of Suharto's New Order, cementing the popular perception that all ethnic Chinese were inherently corrupt. Even though a small number of very wealthy ethnic Chinese benefited from their association with the Suharto regime, they nevertheless continued to lack any political power and influence, which made them easy targets for manipulation.

The Fall of Suharto and *Reformasi*

In July 1997, Thailand's currency collapsed. Thailand's economic problems soon spread to other Asian nations, leading to the Asian financial crisis. The value of the Indonesian Rupiah dropped precipitously, and the Indonesian stock market crashed. The price of food, petrol, and other basic necessities increased up to 20% per month, causing widespread hardship, social unrest, and riots. Following a well-trodden strategy, the Suharto regime accused Chinese Indonesian businessmen of hoarding goods for future profit, leading to anti-Chinese riots in several locations. By the end of 1997, regular demonstrations were held in Jakarta and other major urban centres protesting the rising cost of living and the authoritarian nature of the Suharto regime, which was now widely seen as deeply corrupt. The regime was shaking on its foundations.

On 13 and 14 May 1998, the armed forces orchestrated riots in Jakarta by encouraging protesting crowds to loot Chinese Indonesian stores and burn them down.

Over 1000 people lost their lives, several Chinese Indonesians were murdered, and up to 400 Chinese Indonesian women were raped (Purdey 2006). Similar riots took place elsewhere. On 21 May, Suharto resigned, indicating the collapse of the New Order regime and inaugurating a period of political reform. The riots preceding Suharto's abdication made many Chinese Indonesians aware of their minority status and their vulnerability. For them, it constituted decisive proof that Suharto's assimilation project had failed (Purdey 2003). A significant number of Chinese Indonesians left the country (Winarnita et al. 2020). In reaction to the violence against Chinese Indonesian women, *Komnas Perempuan* (the National Women's Committee) was established (Anggraeni 2014). Investigations of the 1998 riots led to a greater awareness of sexual violence in Indonesia. Unfortunately, official reports failed to highlight that Chinese Indonesian women had been targeted exclusively, and many officials continued to deny that the mass rape even took place.

Indonesian politicians and economists, concerned that the country's economic recovery would be severely hampered if Chinese Indonesian businessmen emigrated, aimed to create a better social and political climate for Chinese Indonesians. In 1998, President Habibie issued a presidential instruction disallowing the official use of the term *pribumi*. Laws prohibiting the celebration of the Chinese New Year, the publication of Chinese newspapers, the teaching of Mandarin, and the use of Chinese characters in public were repealed during the following years by President Abdurrahman Wahid (Gus Dur). In reaction to these changes, several Chinese Indonesian political parties, Non-Government Organisations, and numerous cultural and social associations were founded. Novelists and filmmakers started to pay attention to the social position of Chinese Indonesians (Suryadinata 2001). It appeared that the social situation of Chinese Indonesians had improved. Unfortunately, recent events indicate that this trend has reversed.

In 2012, Chinese Indonesian politician Basuki Tjahaja Purnama (generally known by his Hakka nickname Ahok) became Jakarta's vice-governor alongside Joko Widodo. When the latter was elected president in 2014, Ahok became the governor of the special district of Jakarta. Ahok is widely seen as an extremely effective governor who successfully initiated several infrastructure projects and reduced corruption in the city government to an all-time low. In 2016, he was falsely accused of blasphemy based on an obviously doctored videorecording. In May 2017, he was sentenced to 2 years' imprisonment (Wijaya 2017). On Friday, 2 December 2016, a demonstration was held in support of the premise that Muslims should not accept being governed by non-Muslims, attracting more than 200,000 participants (Cochrane 2016). In his inauguration speech as Jakarta's new governor on 16 October 2017, Arab-Indonesian Muslim Anies Baswedan, in what was widely seen as a snub to his predecessor, argued that it was time for the *pribumi* to be the masters of their own land again (Ramadhani 2017; see also Setijadi 2019). These events indicate that an increasingly outspoken, militant and intolerant form of Islam has come to dominate Indonesia. Consequently, many Chinese Indonesians have once again become doubtful about their place in Indonesian society.

The Mental Health Status of the Ethnic Chinese in Indonesia

There is hardly any research on the mental health status of Chinese Indonesians—or any other ethnic group for that matter. The Ministry of Health regularly publishes statistics on the prevalence of the major psychoses and affective disorders by province, age group, gender, and occupation, but prevalence data by ethnic group are not provided (see, e.g. Badan Penelitian dan Pengenbangan Kesehatan (2019, pp. 221–233)). With a population of slightly less than 270 million, Indonesia only has circa 1000 psychiatrists. There is a severe shortage of mental health professionals and facilities for the care and treatment of mental illness. Articles presenting strategies for prevention and improvement of mental health services generally focus on increasing services, training more mental health personnel, and public health education, but do not elaborate on the mental health needs of specific ethnic groups (see, e.g. Ayuningtyas et al. (2018)). Mental health policy generally focuses on severe and persistent forms of mental illness such as schizophrenia and the practice of *pasung* (the practice of placing mentally individuals in wooden blocks or chaining them). Mental health conditions such as depression and the anxiety spectrum disorders, including post-traumatic stress disorder, have thus far attracted much less attention (Pols et al. 2019).

Although the Indonesian government has implemented discriminatory policies and regulations targeting the ethnic Chinese in the past, the relatively new mental health law of 2014 (UU No. 18/2014) explicitly states that mental health services should be provided fairly and non-discriminatively and should adhere to criteria including humanity, beneficence, transparency, accountability, comprehensiveness, and protection. However, because of the severe shortage of mental health personnel and mental health services, it is currently very difficult to meet most demands for mental health care. In large urban centres, there are several psychiatrists and clinical psychologists in private practice. Whatever services they offer is, of course, not related to any official government policy.

Despite the lack of targeted research on the mental health of Chinese Indonesians, there are various research traditions that can provide insight into the mental health of this ethnic group. Research on the psychological effects of racism and racial discrimination, for example, has demonstrated that they are associated with poor mental health and lower levels of wellbeing in targeted populations (Gil-Gonzalez et al. 2014; Harris et al. 2018). Racial discrimination can occur both on an institutional level and in the interpersonal sphere; the effects of both have an adverse effect on mental health (Harris et al. 2006). Both forms of discrimination have been and are currently experienced by ethnic Chinese in Indonesia. Various factors potentially mitigate these adverse effects.

First, studies on the adverse effects of racism and discrimination are normally conducted in countries where the minority groups that are the object of both are disadvantaged with respect to educational attainment, income, and access to health care and other services. The Chinese minority in Indonesia does not fit this pattern, as their income levels, educational attainment, and wealth are, on average,

somewhat above those of other ethnic groups. When middle- and upper middle-class families—not just Chinese Indonesians—are not satisfied with the services available in Indonesia, they generally travel to Singapore, Malaysia, or other countries. This also applies to higher education and health services. If wealthier Indonesians seek mental health services, they will generally consult private practitioners. Interviews with several private mental health practitioners indicate that they are aware of the specific mental health challenges of Chinese Indonesians. These insights, however, remain necessarily anecdotal and do not form part of government policy. Little is known about Indonesians accessing mental health services abroad, and anecdotal observations suggest that the number is very small.

Second, elements of Chinese culture potentially contain protective factors against emotional ill-health. As observed by Ting, Foo, and Tan (this volume) in their chapter about the ethnic Chinese in Malaysia, this group values hard work, education, restraining excessive behaviour and emotional expression, and a commitment to one's family. These authors list business vitality, strong adaptability, strong family values, a strong work ethic, and a belief in the value of education as protective factors. They nevertheless conclude that Chinese in Malaysia have the lowest level of happiness and sense of wellbeing as compared to other ethnic groups. They list high levels of familial pressure experienced by young people to do well during their studies and succeed in business, different value orientations of successive generations, and the absence of family members for older individuals as factors detrimental to mental health. The ethnic Chinese in Malaysia have faced similar forms of discrimination to those in Indonesia; it is therefore possible that some of their conclusions apply to Chinese Indonesians as well. It is possible that the protective cultural traits of the ethnic Chinese in Malaysia are present among Chinese Indonesians, albeit to a lesser extent because of the closure of Chinese schools during the Suharto era and the prohibition of the use of the Chinese language and the celebration of Chinese holidays. During the New Order, the transmission of a specifically Chinese cultural heritage was therefore more or less limited to family life. It is not unlikely that Chinese Indonesians face mental health challenges similar to those experienced by the ethnic Chinese in Malaysia.

Third, the characteristics of the ethnic identity of Chinese Indonesians differ from other ethnic groups because of the specific social and political context in which this identity is articulated. Social psychologist Henri Tajfel (1978) has argued that categorisation is common to everyday life and contributes to the development of group identities but can also motivate prejudice and discrimination. A common group identity tends to foster favouritism towards members of one's own group over others. Group membership offers identity, self-esteem, and various social, political, and economic advantages but also protection against discrimination. The social identity of the ethnic Chinese allows for a positive perception of distinctiveness, which might mitigate the effects of discrimination. The ethnic Chinese have continuously asserted agency, acting within and upon the social, political, and economic conditions they found themselves in (Chong 2018). Given the diversity among Chinese Indonesians, these actions at times alleviate and at other times reinforce social tensions and prejudice. The distinctiveness of Chinese culture

constitutes a form of social capital (Woolcock and Narayan 2000). Studies have demonstrated that social capital and mental health are correlated. Chen et al. (2015), for example, examined the association of social capital and perceived stress in China and found that individuals investing more in social capital experienced lower levels of stress.

Conclusions

Indonesia has long prided itself on its cultural, ethnic, and religious diversity, which has made it a tolerant, pluralist, and inclusive nation; these ideals are embodied in its national motto *Bhinneka Tunggal Ika* (ancient Javanese: "Unity in Diversity"). After the fall of Suharto, Indonesia embraced multi-culturalism. Yet, as Chang-Yau Hoon (2006) has pointed out, this concept at times erroneously assumes that ethnic groups can be easily identified, that the boundaries between ethnic groups are unambiguous, and that ethnic groups are relatively homogeneous. The avowed respect for minority cultures, Hoon argues, merely illustrates the generosity and tolerance of the dominant ethnic group. The cultures of minority groups, which are characterised by traditional dance, ethnic crafts, local cuisine, and somewhat outdated cultural traditions that are still alive in far-away rural areas, are viewed as merely decorative. This conception of multi-culturalism downplays the inherent variability within ethnic groups based on gender, class, religion, age, and residence. Among Chinese Indonesians, there is great variation in the ability to speak and read one of the main Chinese languages, orientation to China, religion, social class, and place of residence (Suryadinata 2001). Placing them all in the same ethnic group obscures more than it reveals.

This common conception of multi-culturalism does not acknowledge that most Indonesians identify with several ethnic groups and incorporate a variety of cultural forms in the way they articulate their personal identities. Over the centuries, large groups of outsiders have settled in the Indonesian archipelago, adopted local religion and cultural heritage, married locally, and become part of the indigenous population (Cribb 2019; Reid 1993). In Indonesia's urban areas, people from a great number of ethnic groups have lived side by side, have inter-married, and have formed new, hybrid cultures (Knörr 2018). Instead of emphasising the presence of distinct cultural groups, Indonesian culture can best be characterised by accommodation, mutual influence, blending, and the presence of a great variety of intermingled cultural forms. In a perspective emphasising hybridity, elements of Chinese Indonesian culture are present almost everywhere. This view counteracts the persistent idea that Chinese Indonesians are not indigenous and do not really belong in the Indonesian archipelago.

The view that Chinese Indonesians do not belong to the Indonesian nation originated in colonial times, when the Dutch colonial administration placed this group in a separate legal category and used them as a middle group in their exploitation of the population. Consequently, Chinese Indonesians have been viewed as essential

outsiders and are aware that they can be subject to inherently unpredictable acts of violence, which at times are idiosyncratic and, at other times, are inflicted or instigated by agents of the state. With the stigma and discrimination experienced by Chinese Indonesians for centuries, it is surprising that no comprehensive study on the mental health and wellbeing of Chinese Indonesians has been undertaken. It can be assumed that their ambiguous social position, past experiences of violence, and the latent threat of further violence affect their wellbeing and mental health in adverse ways. At the same time, various cultural elements may have functioned as protective factors. With the further development of mental health services, and with an eye to acknowledge past injustice, it is recommended that the specific mental health status and mental health service needs of Chinese Indonesians will become topics of research.

References

Adam, A. B. (1995). *The vernacular press and the emergence of modern Indonesian consciousness*. Ithaca, NY: SEAP.

Aguilar, F. V., Jr. (2001). Citizenship, inheritance, and the indigenizing of "orang Chinese" in Indonesia. *Positions, 9*(3), 501–533.

Anggraeni, D. (2014). *Tragedi Mei 1988 dan lahirnya Komnas Perempuan*. Jakarta: KOMPAS.

Ayuningtyas, D., Misnaniarti, & Rayhani, M. (2018). Analisis situasi kesehatan mental pada masyarakat di Indonesia dan strategi penanggulangannya. *Jurnal Ilmu Kesehatan Masyarakat, 9*(1), 1–10. https://doi.org/10.26553/jikm.2018.9.1.1-10.

Badan Penelitian dan Pengenbangan Kesehatan. (2019). *Laporan Nasional Riskesdas 2018*. Kementerian Kesehatan RI: Jakarta.

Blussé, L. (1986). *Strange company: Chinese settlers, mestizo women, and the Dutch in VOC Batavia*. Dordrecht: FORIS.

Budianta, M. (2011). *Malang mignon*: Cultural expressions of the Chinese, 1940–1960. In J. Lindsay & M. H. T. Liem (Eds.), *Heirs to world culture: Being Indonesian 1950–1965* (pp. 255–281). Leiden: KITLV Press.

Cary, P. (2015). *Orang Cina, bandar tol, candu, dan perang Jawa: Perubahan persepsi tentang Cina 1755–1825*. Depok: Komunitas Bambu.

Chen, X., Wang, P., Wegner, R., Gong, J., Fang, X., & Kaljee, L. (2015). Measuring social capital investment: Scale development and examination of links to social capital and perceived stress. *Social Indicators Research, 120*(3), 669–687.

Chirot, D., & Reid, A. (Eds.). (1997). *Essential outsiders: Chinese and Jews in the modern transformation of Southeast Asia and Central Europe*. Seattle: University of Washington Press.

Chong, W.-L. (2018). *Chinese Indonesians in post-Suharto Indonesia: Democratisation and ethnic minorities*. Hong Kong: Hong Kong University Press.

Cochrane, J. (2016, 4 Dec). Islamists march in Jakarta, demanding Christian governor be jailed. *New York Times*. Retrieved from https://www.nytimes.com/2016/11/05/world/asia/jakarta-protest-blasphemy-ahok-indonesia.html. Accessed 22 January 2019.

Cribb, R. (2019). Minorities in Indonesian history: From ambiguous advantage to cantonisation. In G. Fealy & R. Ricci (Eds.), *Contentious belonging: The place of minorities in Indonesia* (pp. 19–35). Singapore: ISEAS.

Daradjadi. (2013). *Geger pacinan 1740–1743: Persekutuan Tionghoa-Jawa melawan VOC*. Jakarta: Penerbit Buku KOMPAS.

Fasseur, C. (1994). Corner stone and stumbling block: Racial classification and the late colonial state in Indonesia. In R. Cribb (Ed.), *The late colonial state in Indonesia: Political and economic foundations of the Netherlands East Indies, 1880–1942* (pp. 31–56). Leiden: KITLV Press.

Gil-González, D., Vives-Cases, C., Borrell, C., Agudelo-Suárez, A. A., Davó-Blanes, M. C., Miralles, J., & Álvarez-Dardet, C. (2014). Racism, other discriminations and effects on health. *Journal of Immigrant Minority Health, 16*(2), 301–309.

Harris, R. B., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Effects of self-reported racial discrimination and deprivation on Maori health and inequalities in New Zealand: Cross-sectional study. *Lancet, 367*(9527), 2005–2009.

Harris, R. B., Stanley, J., & Cormack, D. M. (2018). Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data, Open access. *PLoS ONE, 13*(5), e0196476. https://doi.org/10.1371/journal.pone.0196476.

Hearman, V. (2018). Unmarked graves: Death and survival in the anti-Communist violence in East Java, Indonesia. Honolulu: University of Hawaii Press.

Heidhues, M. S. (1992). *Bangka tin and Mentok pepper: Chinese settlement on an Indonesian Island*. Singapore: ISEAS.

Heidhues, M. S. (2012). Anti-Chinese violence in Java during the Indonesian revolution, 1945–49. *Journal of Genocide Research, 14*(3–4), 381–401.

Heryanto, A. (1998). Ethnic identities and erasure: Chinese Indonesians in public culture. In J. S. Kahn (Ed.), *Southeast Asian identities: Culture and the politics of representation in Indonesia, Malaysia, Singapore, and Thailand* (pp. 95–114) Singapore: ISEAS.

Heryanto, A. (1999). Where communism never dies: Violence, trauma and narration in the last Cold War capitalist authoritarian state. *International Journal of Cultural Studies, 2*(2), 147–177.

Hoon, C.-Y. (2006). Assimilation, multiculturalism, hybridity: The dilemmas of the ethnic Chinese in post-Suharto Indonesia. *Asian Ethnicity, 7*(2), 149–166.

Hoon, C.-Y. (2008). *Chinese identity in post-Suharto Indonesia: Culture, politics and media*. Brighton: Sussex Academic Press.

Knörr, J. (2018). *Creole identity in postcolonial Indonesia*. New York: Berghahn.

Kwartanada, D. (2019). Dari 'pembawa sila' ke 'sumber inspirasi': Perubahan persepsi masyarakat Jawa atas perempuan Tionghoa pada awal abad xix-xx. In F. X. D. B. B. Hera (Ed.), *Urip iku urup: Untaian persembahan 70 tahun Profesor Peter Carey* (pp. 401–414). Jakarta: KOMPAS.

Melvin, J. (2018). *The army and the Indonesian genocide: Mechanics of mass murder*. New York: Routledge.

Pols, H. (2016). Quarantine in the Dutch East Indies. In A. Bashford (Ed.), *Quarantine: Local and global histories* (pp. 85–102). Basingstoke: Palgrave Macmillan.

Pols, H., Good, M.-J., & Good, B. (2019). Masa depan layanan kesehatan jiwa di Indonesia: Merealisasikan mimpi. In H. Pols, P. Setiawan, C. R. Marchira, E. S. T. Suci, Irmansyah, M.-J. D. Good, & B. Good (Eds.), *Jiwa sehat, negara kuat: Masa depan layanan kesehatan jiwa di Indonesia* (pp. xi–xxv). Jakarta: KOMPAS.

Purdey, J. (2003). Political change reopening the *asimilasi vs integrasi* debate: Ethnic Chinese identity in post-Suharto Indonesia. *Asian Ethnicity, 4*(3), 421–437.

Purdey, J. (2006). *Anti-Chinese violence in Indonesia 1996–1999*. Singapore: National University of Singapore Press.

Ramadhani, N. F. (2017, 17 Oct). Anies's 'pribumi' speech sparks debate, 'racist' comments on social media. *Jakarta Post*. Retrieved from https://www.thejakartapost.com/news/2017/10/17/aniess-pribumi-speech-sparks-debate-racist-comments-on-social-media.html. Accessed on 22 Jan 2018.

Reid, A. (1990). *Southeast Asia in the age of commerce, 1450–1680, Vol. I: The lands below the winds*. New Haven: Yale University Press.

Reid, A. (2009). Chinese as a Southeast Asian 'other'. In *Imperial alchemy: Nationalism and political identity in Southeast Asia* (pp. 49–80). Cambridge: Cambridge University Press.

Robinson, G. (2018). *The killing season: A history of the Indonesian Massacres, 1965–66*. Princeton: Princeton University Press.
Setijadi, C. (2019). Anti-Chinese sentiment and the 'return' of the *pribumi*. In G. Fealy & R. Ricci (Eds.), *Contentious belonging: The place of minorities in Indonesia* (pp. 194–211). Singapore: ISEAS.
Setiono, B. G. (2003). *Tionghoa dalam pusaran politik*. Jakarta: Elkasa.
Shiraishi, T. (1997). Anti-Sinicism in Java's New Order. In D. Chirot & A. Reid (Eds.), *Essential outsiders: Chinese and Jews in the modern transformation of Southeast Asia and Central Europe* (pp. 187–207). Seattle: University of Washington Press.
Stoler, A. L. (1985). *Capitalism and confrontation in Sumatra's plantation belt, 1870–1979*. Ann Arbor: University of Michigan Press.
Suryadinata, L. (1978). *Pribumi Indonesians, the Chinese minority and China: A study of perceptions and policies*. Kuala Lumpur: Heinemann.
Suryadinata, L. (1985). Government policies towards the Ethnic Chinese: A comparison between Indonesia and Malaysia. *Southeast Asian Journal of Social Science, 12*(2), 15–28.
Suryadinata, L. (2001). Chinese politics in post-Suharto Indonesia: Beyond the ethnic approach? *Asian Survey, 41*(3), 502–524.
Tajfel, H. (1978). *The social psychology of minorities*. London: Minority Rights Group.
Tan, M. G. (2008). *Etnis Tionghoa di Indonesia: Kumpulan tulisan*. Jakarta: Yayasan Obor Indonesia.
Turner, S. (2003). Setting the scene speaking out: Chinese Indonesians after Suharto. *Asian Ethnicity, 4*(3), 337–352.
Wijaya, C. A. (2017, 9 May). Ahok guilty of blasphemy, sentenced to two years. *Jakarta Post*. Retrieved from https://www.thejakartapost.com/news/2017/05/09/ahok-guilty-of-blasphemy-sentenced-to-two-years.html, accessed on 22 Jan 2019.
Willmott, D. E. (2009 [1961]). *The national status of the Chinese in Indonesia, 1900–1958*. Jakarta: Equinox.
Winarnita, M., Chan, C., & Butt, L. (2020). Narratives of exile twenty years on: Long-term impacts of Indonesia's 1998 violence on transnational Chinese-Indonesian women. *Identities: Global Studies in Culture and Power, 27*(2), 191–209.
Woolcock, M., & Narayan, D. (2000). Social capital: Implications for development theory, research, and policy. *World Bank Research Observer, 15*(2), 225–249.
Zhou, T. (2019). *Migration in the time of revolution: China, Indonesia, and the Cold War*. Ithaca: Cornell University Press.

Chapter 14
Social Boundaries and the Mental Health of the Lannang: Ethnic Chinese in the Philippines

Michael Lim Tan

Abstract I focus on the Lannang, the ethnic Chinese who first migrated from Fujian province to the Philippines in the early part of the nineteenth century, looking at cultural influences on interpersonal transactions and how these impact on mental health. In the context of relationships between the Lannang and Filipinos, one marked by periods of strong exclusion, if not outright anti-Chinese sentiments, I look at how social boundary making, maintenance, and modification become an important part of Lannang culture and mental health. I look into four core concepts of Lannang personhood – being Chinese, being male, being a filial person, and being a person with a sense of shame – and how these define the management of interpersonal transactions, revolving around boundaries of inclusion (Lannang) and exclusion (huan, foreigner). I also describe the impact of these concepts on mental health. I end with recommendations for improving mental health services, emphasizing language and rituals as providing emotional pathways for the reconfiguration of Lannang social boundaries.

Keywords Lannang · Mental health · Overseas Chinese · Social boundaries · Cultural pathways · Identity

Archaeological findings and Chinese history texts attest to contact between China and the islands of the Philippines from as early as the tenth century (Chu 2010:53), long before Spanish colonization.

There have been several waves of Chinese migration to the Philippines, with earlier ones leading to a complete integration of the Chinese, through intermarriage,

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into Philippine society. My focus will be the wave of the twentieth century, during the American colonial occupation. A US Chinese Exclusion Act passed in 1902 was applied to the Philippines because it was a US colony, restricting the number of migrations, but had an important exemption: merchants (Alejandrino 2015). This opened the doors, however limited, for migration so that by 1939, there were 117,000 ethnic Chinese enumerated in the national census, still less than 1% of a total Philippine population of 16 million (US Census Bureau 1941:3), but not a small number in absolute terms.

Today, the ethnic Chinese in the Philippines are still estimated to be not more than 2% of the total population (Wickberg 1998:187) but comprise the seventh largest overseas Chinese community in the world (Poston and Zhang this volume).

The ethnic Chinese migrants of the twentieth century came mainly from the southern Chinese province of Fujian and spoke Minnan (literally south of the Minnan river), also referred to as Hokkien, Amoy, Southern Fujian. The Minnan spoken in the Philippines is often referred to by the local Chinese as *Lannang Ue*, *Lannang* meaning "our people" and *Ue* meaning "language." More significantly, the term "Lannang" itself is widely used by the twentieth-century wave of ethnic Chinese in the Philippines to refer to themselves.

The main objective of my essay is to give the historical and cultural context to mental health among these Lannang, with a focus on how the diasporic experience maintains and modifies social boundaries, navigating Chinese and Filipino cultures in the definitions of self, class, gender, and social interactions.

The Lannang provide great potential for cross-cultural and diaspora studies in the way the community strongly identifies as Filipino (with terms like *Tsinoy* or Chinese-Filipino) but retains many Chinese traditions, including language, food, religion, and, important for this chapter, beliefs and practices around health and medicine. Contributing to this preservation of culture are Lannang institutions: business federations, banks, schools, hospitals, and even cemeteries.

Analytical Framework and Methodology

There is a stark absence of published articles on the mental health of the Lannang, which led me to first think of simply describing concepts and practices of the Lannang, but I wanted to avoid a culturalist approach that ends up exoticizing and decontextualizing the cultures we seek to understand.

Reading Kleinman and Lin (1981), I decided to look into cultural influences on the management of interpersonal and intercultural transactions and how such transactions affect mental health. For example, Kleinman and Lin, as well as other authors (e.g., Metzger 1981), explore Confucian concepts of selfhood and authority that are so central to Chinese culture and which impact on mental health.

I draw from Alexander (2003:5), who proposes a cultural sociology that looks into "interpreting collective meanings" and "tracing the moral textures and delicate emotional pathways by which individuals and groups come to be influenced by

them." I will do this cultural sociology by drawing on Chinese core concepts of personhood, relating these to emotional pathways marked by boundaries and borders (Lamont and Molnar 2002). I do this to underscore how the diasporic experience is more than a movement across geographic borders; instead, it is one that creates, maintains, and modifies social boundaries which in turn can impact on mental health in terms of well-being as well as risks and dysfunction.

These boundaries, I propose, come out of what Wickberg (1998) calls "oscillations of inclusion and exclusion" of the Chinese over several centuries – one which included massacres and expulsions during the Spanish colonial period. The discrimination has continued through the twentieth century and to the present. For example, acquisition of Philippine citizenship was a very difficult option for the Lannang until 1975 when President Ferdinand Marcos established ties with the People's Republic of China and saw the strategic value of allowing local Chinese to become Filipino citizens.

Certainly, at individual and community levels, there are many opportunities for more positive intercultural interactions and exchanges, which I describe in this chapter, particularly in the creation of emotional pathways and in the modification of boundaries.

I will present four core concepts of Lannang personhood: being Chinese, being male, being a filial person, and being a person with face (i.e., a sense of shame). I describe each of these concepts in terms of being and not-being, for example, being male as not being female. Not to act on the social imperatives of these concepts is to turn one's back on being Lannang, becoming *huan*, foreign, with its social consequences of social alienation, even excommunication.

I will also refer to the convergences and divergences in Filipino and Lannang values and social organization. For Filipino personality studies, I draw on Church (1986) and Melgar et al. (2018) for excellent summaries.

I end the chapter with recommendations for improving mental health services, emphasizing language and rituals as emotional pathways that figure prominently in the reconfiguration of Lannang social boundaries.

Reflecting my anthropology background, I will use an emic or "native/insider" perspective, writing as a third-generation Lannang, my grandparents on both my father's and mother's side having migrated from China to the Philippines early in the twentieth century.

I am aware of the dangers of generalizing about culture and must qualify that my observations in this chapter are meant to propose a possible research agenda that can further explore mental health among communities in diaspora.

Storytelling marks our diasporas, and I was fortunate I had a grandmother and a mother who were atypical in sharing their experiences, some very personal, with me despite my being male, allowing me to appreciate the gendered aspects of the Lannang diaspora.

I interviewed several Lannang from different generations, including three physicians, and have acknowledged some of them at the end of this chapter. It is revealing that some informants asked to remain anonymous because they did not want to be tagged as being critical of Lannang culture.

My Lannang informants helped me to identify the core personhood concepts and their impact on mental health. Standing out in their stories and in my memories of growing up Lannang were overarching themes of precarity and adversity. Some were very personal, as with my paternal grandmother's memories of her feet being bound as a child in the "lotus feet" tradition. The practice involves tightly binding a girl child's feet, cutting off blood circulation and preventing the feet from growing. Other stories involved collective memories of living in dangerous times: childhood in frontier areas as with my father in the southern Philippines, the Second World War, the uncertain post-war years, the unrest in the countryside from insurgencies and secessionist movements, martial law, and, in the 1990s, a wave of kidnappings and murders of Lannang. The country too is one of the most vulnerable for disasters, typhoons, floods, fires, and earthquakes are very much a part of collective memories and an overwhelming sense of life as being one of constant struggle against hardship.

A Linguistic Note

I give key concepts in Minnan and, when available, their Mandarin (also known as *Putonghua*, the national language of China) equivalents. The absence of a Mandarin equivalent means the term is distinct to Minnan. I also include the Chinese characters or script, which is shared across languages and dialects in China but with great variations in the exact characters that are used, complicated by the fact that Minnan does not traditionally have a written literature.

For the Mandarin I will use *pinyin*, which is a standardized Romanized system used throughout China. The situation is more difficult with Minnan with different orthographies that have been proposed. I use the one of Li and Li (2008), which is based on the International Phonetic Alphabet. I have omitted tonal marks because the Minnan dialect spoken in the Philippines has eight tones, compared to the already complicated four found in Mandarin. I also use Li and Li extensively because their dictionary is a compilation of Minnan terms that are not found in Mandarin.

Being Chinese: *tiong kok lang*

My father sat me down once, when I was a child, took an envelope he had just received in the mail and pointed out the return address to me. The envelope came from China, and the sender's address was written in this sequence: China, followed by the province, the city, and the street and number of the house.

It was my father's way of pointing out that in China, it is country that is central, as in the country's Chinese name: *zhongguo*. We were constantly reminded at home, in schools, that we were *tiong kok lang* (中国侬), which meant observing many

traditions from, in my father's words, "thousands of years of civilization." Being *tiong kok lang* also translated into pressures to excel in school and in the workplace because that was the way of the *tiong kok lang*, to work hard and to be better than others. Being *tiong kok lang* was also tied to other values such as thrift, which seemed to be so well internalized that Filipinos consider the overseas Chinese to be stingy.

Being *tiong kok lang* meant being "othered." While we talked of being Filipino-Chinese (or Chinese-Filipino), we were also constantly warned that we were only second-class citizens, never to be quite accepted. I learned, as a child, of the term *bai hua* (排华, *paihua* in Mandarin) which meant anti-Chinese sentiments. We were the *Intsik*, a term that was originally one of respect for elders but came to be adopted by Filipinos to use as an insult. The *Intsik* were there as easy prey from being taunted in the streets to being targeted for extortion by government workers. In the 1990s, there were numerous kidnappings for ransom of the Lannang throughout the country, and at its height in 1993, there was one month when kidnappings were being reported every other day. Most of the kidnappings were later exposed to have been masterminded by the military and the police. Teresita Ang-See, a Lannang community leader, estimates there were 140 fatalities among the victims, while others involved torture and rape (Ang-See 1997b; Delizo 2019).

The kidnappings stirred paranoia and panic among the Lannang, to the extent that some wealthier families sent their children overseas or would pack up and migrate as a family. The Lannang community lobbied with government, even rallying in the streets, leading to the creation of an anti-kidnapping task force with Lannang members. Kidnappings have decreased since then but continue, with mainland Chinese now the main target.

Chua (2002), a third-generation Lannang who spent part of her childhood in the Philippines and whose aunt was murdered in the Philippines, has written about the roots of ethnic tensions in various countries, with "ethnonationalism" as the response to "market-dominant minorities," the Lannang being that minority in the Philippines.

The memories of the kidnappings in the 1990s and early part of the twenty-first century remain. Recently when I invited a young Lannang businessman to a groundbreaking ceremony in our university, he smiled politely and said he was not sure if he was psychologically prepared to attend. He had not gone back to the university since 2003, when, as a student, he was nearly abducted by armed men right in front of his college.

Being Filial: *yuhaolang*

Confucian ideology emphasizes hierarchies governed by obedience, which is epitomized by the Lannang word *hao* (孝xiao Mandarin) or filial piety. One strives to be a *yu hao lang* (有孝侬), obedient and loyal to parents, which means a greater assurance that the elderly will be well cared for; in fact, it is considered a source of shame

to have to go to a home or a facility for the aged because it speaks of offspring who are not filial, *put hao* (不孝).

Hao is invoked to justify rigidity in social relations, the young having to give way to older people and women to men and, within families, even with sibling order. Absolute obedience may be required in some families, extending even to choices around career and marriage, and even where there is room for negotiation, this is fraught with tensions. Where the child makes a decision contrary to parental wishes, there may be strong guilt feelings. Unresolved disagreements, on the other hand, can turn into outright hostility and estrangement.

Hao amplifies unequal power relations, for example, younger daughters having to take on caregiver roles for the elderly instead of an elder brother or sister, with tremendous social costs in terms of giving up one's career and family life.

Hao also translates into a reproductive imperative: one must marry and produce children, preferably sons. Matchmaking continues, and people may be pressured into marrying, out of filial piety.

The diasporic experience in the Philippines has modified *hao* in that the filial piety obligation now includes mothers and other women elders in the clan. The Lannang have also adopted Filipino bilateral kinship, recognizing relatives on the paternal and maternal sides. These modified arrangements of a larger network have advantages (support and coping) as well as disadvantages (heavier responsibilities and obligations as well as a much more complicated decision-making system).

Being Male: *Tapolang*

Minnan has specific terms for male and female, not used in Mandarin. Men are *ta po lang* (丈夫侬) and women *tsa bo lang* (查某侬), with very strict differentiation when it comes to statuses and roles.

Child-rearing is characterized by many references to what is appropriate for males and females, from the color of clothing to the division of household duties. To deviate from these roles brings a sharp rebuke, for example, when a male behaves in a way that is considered gender-inappropriate. The boundaries can be rigid and comments cruel, Lannang fathers declaring girls are *bo lo ieng* (无路用, useless) and *tsa bo tsat* (查某贼, women thieves), because they marry out and take with them family resources as their dowry.

Lannang machismo may be aggravated by its reinforcement with the Latin variety found in mainstream Filipino society. An example comes with the *querida* (mistress) system among Filipino men, which converges with de facto polygamy among the Lannang following older Chinese traditions of a "big wife" and concubines. Although illegal under Philippine laws, both the *querida* system and Lannang concubinage are still socially accepted, even seen as a sign of both masculinity and social status, oblivious to the turbulent, even violent conflicts that can arise among co-wives and half-siblings in these relationships.

The diasporic experience has allowed Lannang women to carve out spheres of autonomy. Carino (2015) describes many of the changes among Lannang women who, with the benefit of higher education, found ways to become more independent, especially by becoming businesspeople themselves in the footsteps of their parents. I also find Lannang women who study in non-Chinese schools managing to retain a Lannang identity but with an ability to speak out when oppressed.

Lannang gay men are not as fortunate, Lannang machismo engendering a much more powerful combination of misogyny and homophobia, exemplified by the term *tsa bo tueh* (查某体), to be "like women" or effeminate (Li and Li 2008:147), used against gay men. For Lannang LGBT who cannot come out in the open, this can lead to a double life, including marrying for show and having extramarital affairs along one's sexual preference.

Being a Person with a Sense of Shame: *bin*

East Asian societies, including Chinese, tend to be shame-based, with a core concept of face or *bin* (面, Mandarin *mian*). To be shamed is to lose one's face, *bo bin chu* (没面子), or to be disgraced as in *sia pai* (泻败), a dramatic term that means a "torrent of defeat."

The shaming comes from an individual not living up to collective norms, some of which are moral (particularly sexual behavior), but applies as well to the failure to reach high standards in academics or even in wealth. To fail to meet expectations can elicit extreme shaming comments, like being called garbage or *pun soo* (粪扫, *fen sao* in Mandarin, which literally translates as swept manure).

The Lannang emphasis on face is reinforced by *hiya*, a Filipino term often translated as "shame" but which is more of a semantic complex that includes a sense of propriety, a keeping of one's place (*lugar*) in hierarchical relationships. *Hiya* and the Lannang notion of preserving face can be a double burden, applied to many different situations, from a perceived moral deficiency, as in being openly gay (read effeminate) to, simply, being poor, which might be seen too as not being hardworking, as is expected of a Lannang. While suicide rates in the Philippines are among the lowest in the world, explained by the strong stigma attached by Catholicism to suicide, its rates can be higher among the Lannang because of shame, as is described by Ang-See (1997a:30) for two Lannang suicides, a 15-year-old and a 60-year-old, both ashamed of their poverty. The role of clinical depression in suicides is another matter of discussion, but shame as a trigger factor should not be underestimated.

Being Lannang vs Being *huan*

Lannang as ethnicity integrates the core personhood concepts of being Chinese, male, filial, and having a sense of shame. Lannang is a collectively shared boundary, a definition of who belongs, and who does not, with complicated permutations.

To declare one is Lannang is an important mode for social disclosure. Even a simple encounter between storekeeper and a customer with the question "Lannang?" and an affirmative reply can mean lower prices. In hospitals and medical consultations, both patients and health professionals will ask each other "Lannang?", an affirmative answer leading to a linguistic shift which can lead to more candid and productive case histories.

Being Lannang, our people, requires an othering, which is encapsulated in the concept of *huan*. The Lannang refer to Filipinos as *huanna* (番仔) which, I was told in early adulthood, meant "barbarian," a term I began to avoid as part of political correctness.

Researching for this chapter, I was pleasantly surprised to find, in a Minnan dictionary (Li and Li 2008:31), a complete absence of "barbarian" in the definitions of *huan* and other words with *huan*. It turns out *huan* refers to a foreign provenance, thus, Arabic numerals, a Western-style building, and even Western cookies will be described as *huan*. Even overseas Chinese have been referred to as *huan ke* (番客) or *huan* visitors.

Huan therefore refers to difference, to foreign-ness. Significantly though, *huan* as a single word is also defined (Li and Li 2008:31) as "misbehaved, stubborn, and unreasonable." Important in relation to mental health, one can be described as *huan* because of improper behavior. A "Lannang" is expected to control one's emotions; therefore, to be short-tempered is to become *huan*. There is a striking similarity in this boundary-setting mechanism with the Filipino use of the term *salbahe* to mean socially deviant behavior, the word derived from the Spanish *salvaje*, which means savage (Alcantara 1999:189).

Lannang boundaries can be quite pervasive, excluding even other ethnic Chinese such as the Cantonese or more recent migrants from mainland Chinese. The most formidable of Lannang boundaries is the Great Wall, a term coined by younger Lannang to refer to the taboo on relationships and marriages between Lannang and non-Lannang and especially the *huan na*. Note the description of one Lannang woman of this Great Wall: "…a witty analogy for all the broken hearts, the ruined relationships, the you-and-me-against-the-world love stories brought about by this unforgiving rule" (Chua 2008). Unforgiving indeed, such relationships risking disinheritance. (See Pantajo-Manalac 2000:31–33 for the story of one Lannang woman who left the Philippines so she could escape this Great Wall.)

The discrimination extends to the children from such relationships or marriages, referred to as *tsut si a* (出世仔). An older term, *pua huan* (半番 Mandarin *ban fan*) or "half *huan*," captures, more powerfully, the perception that the offspring of a couple where one parent is not Lannang means a loss of the potential of being Lannang. *Tsut si a* I interviewed say they face the conundrum of being rejected for

not being Chinese enough, as well as not being Filipino enough, which can lead to either trying harder to be Lannang or actually becoming anti-Lannang.

Language and Mental Health

At the core of being Lannang is being able to speak *Lannang Ue*, "our people's language." Language becomes a sanctuary, allowing the Lannang to speak of feelings and emotions. I find it striking that Baytan's (2000) study of Lannang gay men found they preferred using Fukien (Minnan), almost an irony considering that was most probably also the language used to scold and ridicule them for being gay.

The Lannang use the generic term *sieng kieng bi* (神经病 *shen jing bing* in Mandarin) to refer to mental disease. In addition, the Lannang have adopted many Filipino generic terms for mental disorders, in particular the Filipino terms *buang*, *baliw*, and *loko-loko*, and English words like crazy and insane.

Terms for emotions are abundant and particular keywords should be studied. Reflecting the Lannang diasporic experience, one keyword is *ko* (苦) or hardship, with bitterness as a synonym. Extreme hardship is expressed as *ko si* (苦死) literally to die of hardship. *Ki ko* (气苦), on the other hand, is a combination of grief and indignation that turns bitter the vital life essence *qi*.

Kleinman (1986) and Lee (1996), among others, have written on how the Chinese tend to have more somatization of mental problems. This somatization certainly applies to the Lannang, and a linguistically competent psychologist or psychiatrist will need to understand the expressions around aches and pains, which can be similar to many other cultures, such as a headache being an expression of suffering from life's problems. In addition, there may be symbolic somatization, for example, the stomach, *pak* (腹*fu* in Mandarin), is often used to describe dysphoria, as with the expression *kui pak ke he*, the stomach filled with fire.

Somatization in the Lannang context may be due to the need to be strong, and stoic, especially among women, despite their often more difficult life circumstances. There is a Minnan term, *lun* (忍), which Li and Li (2008:80) define as "suppress, control," a term I heard very often especially from Lannang women, usually with sadness, as they talked about how they had to repress feelings of anger and resentment that come with enduring hardships, including a troubled or oppressive marriage. The term resonates with the Filipino *tiis*, to endure, again used much more by women. Significantly, the term is used as well in Mandarin, pronounced *ren*, to mean "to endure, to tolerate, to restrain oneself," and is considered a cardinal virtue in Confucianism.

I have referred to the fear the Lannang have from anti-Chinese sentiments; yet, I cannot remember hearing Minnan terms for fear. It took a poem by a Lannang, written in Filipino with references to *takot* (fear), *aalinlangan* (uncertainty), and *nangangamba* (anxiety), that reminded me we do use the Filipino, rather than Minnan, terms for this domain of emotions.

The Lannang community may need to question some of the Minnan terms we use. For example, the Lannang tend to be even more direct than non-Lannang

Filipinos when it comes to commenting about someone being thin or overweight. Paradoxically, such comments are intended to express concern, with an emphasis on the need to be heavier in weight as a sign of health. I have found such comments made for children, young adults, and the elderly.

Having cared for my parents for nearly a decade as they battled dementia, there were many occasions when they would tell me they had visitors who had commented they were looking "very thin," which would depress them, making them feel they were much weaker than they really were. Such comments can also be interpreted, by caregiving relatives, as suggesting neglect of their elderly and leading to a loss of face because it suggests a lack of filial piety.

Caring for the Lannang elderly demands even more linguistic competence because for many of them, Minnan remains the first language. This will include phasing out terms that have become dysfunctional, as with the Lannang term for dementia, *lau gong* (老戇), which means old and stupid. Another term is *lau huan tian* (老番癲 Mandarin *lao huan dian*), meaning "old and muddle-headed" (Li and Li 2008:70). Note that the term incorporates the word "*huan*," which I have discussed as the term distinguishing Lannang from "others." Other terms from Chinese remain unsatisfactory, like the Mandarin *shi zhi zheng* (失智症), which means loss of wisdom, or *chi dai* (痴呆), which can mean imbecility. I prefer using the English term "dementia," and then explain what it means, certainly not old and stupid.

Le and Multiple Cultural Pathways

Le (礼 li in Mandarin) is a Chinese keyword, referring to rituals, as well as to lifeways, and "etiquette, protocol, courtesy" (Li and Li 2008:71). The Chinese stress on *le* cuts across a continuum, from cursory politeness to obligations associated with filial piety.

Le as rituals are important in relation to health, the best example being an adherence to the *geh lai* (月里), a month-long observance after delivering a child. The *geh lai* will include non-bathing (although sponge baths are allowed) and the use of herbal preparations, as well as semi-isolation of mother and child. While tedious, the *geh lai* can become a time for the mother to rest.

The *geh lai* continues to be observed even by younger Lannang. I had a third-generation Lannang, in her 30s, who told me she and her friends observe the *geh lai* not only after births but also after miscarriages and gynecological procedures such as the removal of polyps, on the premise that any medical procedure involving the uterus is disruptive enough to need the *geh lai*, albeit with modifications such as a shorter length of observance and a combination of Chinese and Filipino medicinal plants.

Le is expressed too with gifts, *le but* (礼物 *li wu* in Mandarin), with medicines ranking high as an expression of *le*, especially for the elderly. Chinese medicines carry high prestige as gifts and are often referred to as *lannang yo* (*yo* 药), which are sometimes seen as superior to Western medicines, reflecting meanings of Lannang as ethnicity and exceptionalism, as well as social obligations and reciprocity.

The importance attached to medicines as social objects adds to its allure for mental health, offering comfort and internalizing the concern of the person giving the medicines as gifts. This however can be problematic, especially for Chinese medicines, because many Lannang do not read Chinese, presuming the medicines to be herbal when they may in fact contain Western drugs including antihistamines, antibiotics, analgesics, steroids, and even tranquillizers.

Le gives reassurance about life's important milestones, particularly end of life rituals with eclectic wakes and funerals and Buddhist monks sometimes chanting prayers right before a Catholic priest comes in for Mass, the modified rituals reflecting the bicultural Lannang's milieu for grief management (Dy 2015:148–151).

Lannang women are the gatekeepers for rituals and other forms of protocol, maintaining tradition but also being able to modify these practices. There is a Lannang expression that my mother frequently used to complain about excessive protocols, *u le bo te* (有 礼无体), which means all form but no substance (or, literally, no body), and she would either dispense with the observance or modify it. Simply uttering the expression was a way for her to reduce the stress that comes with cultural imperatives.

Paradoxically, the impetus to "preserve" Chinese and Lannang culture, coming especially from Lannang social scientists – historians, anthropologists, and psychologists in particular – may be an engine for change. There is, for example, renewed interest in teaching Confucianism in some of the Chinese schools, which might lead to variations in the reading and interpretation. Ang-See (1997c:10), one of the Lannang community leaders, is direct when she analyzes the cultural conflicts as being partly due to a "merchant culture" rather than "the traditional Confucian-based culture of China."

Change will be accelerated too as younger Lannang harness media to articulate their experiences and to reach out to fellow Lannang. A fortnightly publication appropriately named *Tulay* (Filipino for bridge), with articles in English, Chinese, and Filipino, describes itself as "a bridge of understanding between two cultures, a bridge of tolerance between two ages." Its content includes current events, as well as articles on Chinese and Lannang language and history and even a column on parenting.

Among younger Lannang, I find, too, that the adoption of an important Filipino value, *kapwa*, provides a way of dealing with the harsher imperatives of Lannang culture. *Kapwa* is difficult to translate but boils down to finding self in others (Enriquez 1978). It allows a balance between a more communal ethos and its strict requirements of conformity, with individual autonomy and agency. *Kapwa* is never essentialist but instead the product of social interactions called *pakikipagkapwa*, a constant relating of self to others. Here I find potentials in revisiting Lannang as an inclusive word. In Minnan there are two terms for "we": an exclusive *gun* (阮 and an inclusive *lan* (咱, which is used in Lannang. Lannang's borders may not be as rigid as it looks on the surface: one may be "genetically" Lannang but, not being able to speak Minnan, would not be considered as *jia Lannang* (real Lannang). Conversely, a *huan na* who takes effort to learn Minnan and adopt Lannang ways – as I have seen in many *huan na* men courting Lannang women – may be able to break down the Great Wall.

With young Lannang, the challenges to mental well-being may not be so much traditional Chinese culture, or of the influence of Filipino culture, or even of a bicultural Lannang. The tensions may in fact be between an expanded Lannang concept and a "Western" ethos especially around rights and entitlement.

The linkages between identity and mental health need to be further explored as they evolve today in different settings. I asked Lannang who have migrated to Canada for their views, and they vary, some retaining a sense of being Filipino, others of being Chinese, but, always, Canadian. They describe their identities in terms of food, language, or greeting people on the street, for example, "Are you Filipino?"

I referred to the importance of language in defining Lannang identity and have found this to be true too in discovering a sense of being Chinese in my trips to China. With frequent visits, I have come to be more comfortable with Mandarin, an indicator being an ability to express feelings, and to find shared identity, *kapwa*, among the Chinese, who always take delight in my being able to speak, write, and read in Chinese. My use of Chinese, I have realized, is often an invitation: Let me speak in Chinese so I can tell you what it means to be a *hua ren* (Chinese), Lannang, and a Filipino. It is in this spirit that I write this chapter.

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References

Alcantara, T. A. (1999). *Mga Hispanismo sa Filipino Batay sa Komunikasyong Pangmadla ng Filipinas: Pag-aaral Lingguwistiko*. Quezon City: University of the Philippines Sentro ng Wikang Filipino.

Alejandrino, C. (2015). A history of the 1902 Chinese Exclusion Act: American colonial transmission and deterioration of Filipino-Chinese relations. In R. Chu (Ed.), *More Tsinoy than we admit* (pp. 261–299). Quezon City: Vibal Foundation.

Alexander, J. C. (2003). *Meanings of life: A cultural sociology*. Oxford: Oxford University Press.

Ang-See, T. (1997a). Images of the Chinese in the Philippines. In T. Ang-See (Ed.), *Chinese in the Philippines* (Vol. I, pp. 28–49). Manila: Kaisa para sa Kaunlaran, Inc.

Ang-See, T. (1997b). On kidnapping, elections and the political position of the Chinese in the Philippines. In T. Ang-See (Ed.), *Chinese in the Philippines* (Vol. II, pp. 161–189). Manila: Kaisa para sa Kaunlaran, Inc.

Ang-See, T. (1997c). Cultural conflict and integration in the Philippines: The case of the ethnic Chinese minority. In T. Ang-See (Ed.), *Chinese in the Philippines* (Vol. II, pp. 1–23). Manila: Kaisa para sa Kaunlaran, Inc.

Baytan, R. (2000). Sexuality, ethnicity and language: Exploring Chinese Filipino male homosexual identity. *Culture, Health & Sexuality, 2*(4), 391–404.

Carino, T. C. (2015). Chinese women in Manila: Changing roles and perceptions. In R. Chu (Ed.), *More Tsinoy than we admit* (pp. 463–477). Quezon City: Vibal Publishing.

Chu, R. (2010). *Chinese and Chinese mestizos of Manila: Family, identity and culture*. Leiden Koninklijkw Veill and Mandaluyong: Anvil Publishing.

Chua, A. (2002). A world on the edge. *Wilson Quarterly*, Winter 2014. https://www.wilsonquarterly.com/quarterly/winter-2014-four-decades-of-classic-essays/a-world-on-the-edge/. Accessed September 5, 2019.

Chua, G. V. (2008, October 24). Pei pa koa: The ties that bind. *Philippine Star*. https://www.philstar.com:8080/young-star/409501/pei-pa-koa-ties-bind. Accessed October 14, 2019.

Church, A. T. (1986). *Filipino personality: A review of research and writings*. Manila: De la Salle University Press.

Delizo, M. J. (2019). *Kidnapping of Tsinoys gone, but vigilance continues*. https://news.abs-cbn.com/news/07/06/19/kidnapping-of-tsinoys-gone-but-community-remains-vigilant. Accessed September 26, 2019.

Dy, A. C. (2015). *Chinese Buddhism in Catholic Philippines: Syncretism as identity*. Mandaluyong City: Anvil Publishing. End-of-life rituals: orthodoxy and orthopraxy.

Enriquez, V. (1978). *Kapwa*: A core concept in Filipino social psychology. *Philippine Social Sciences and Humanities Review, 42*(1–4), 100–108.

Kleinman, A. (1986). *Social origins of distress and disease: Depression, neurasthenia and pain in modern China*. New Haven: Yale University Press.

Kleinman, A., & Lin, T.-Y. (1981). Introduction. In A. Kleinman & T.-Y. Lin (Eds.), *Normal and abnormal behavior in Chinese culture* (pp. xiii–xxiii). New York: Springer.

Lamont, M., & Molnar, V. (2002). The study of boundaries in the social sciences. *Annual Review of Sociology, 28*, 167–195.

Lee, S. (1996). Cultures in psychiatric nosology: The CCMD-2-R and the international classification of mental disorders. *Culture, Medicine and Psychiatry, 20*, 421–472.

Li, R., & Li, Z. (2008). *Minnan-English dictionary*. Hyattsville: Dunwoody Press.

Melgar, M. I., et al. (Eds.). (2018). *Beyond DSM: Casebook in abnormal psychology and mental health*. Quezon City: Ateneo de Manila University Press.

Metzger, T. A. (1981). Selfhood and authority in neo-confucian political culture. In *Normal and abnormal behavior in Chinese culture* (pp. 7–28). New York: Springer.

Pantajo-Manalac, T. (2000). *The Tsinoy parent*. Pasig City: Anvil.

Poston, D. L., & Zhang, H. (this volume). *The overseas Chinese communities in Southeast Asia and the Pacific*.

US Census Bureau. (1941). *Statistical Abstract of the United States*. https://www2.census.gov/prod2/statcomp/documents/1941-02.pdf. Accessed September 5, 2019.

Wickberg, E. (1998). The Philippines. In L. Pan (Ed.), *Encyclopedia of Chinese overseas* (pp. 187–199). Singapore: Chinese Heritage Center.

Chapter 15
Mental Health of Chinese in Canada

Zhipeng Gao

Abstract This chapter reviews the mental health of Chinese in Canada. Following an introduction to the historical and social contexts of Chinese immigrants in Canada, this chapter focuses on two major issues: the epidemiology and determinants of Chinese immigrants' mental health, and Chinese immigrants' utilization of mental health services. First, regarding epidemiology, Chinese immigrants overall report fewer occurances of mental problems than most other ethnic groups in Canada, and the determinants of their mental health center around resettlement issues including financial security, social relations, and acculturation. Each subgroup faces its own challenges: Females and elders have higher rates of depression; children's mental health is highly dependent on the family; and youths face the task of dealing with discrimination and ethnic/cultural identity. Next, this chapter suggests that Chinese immigrants are less likely to use mental health services due to a variety of reasons. They may understand mental illness from a spiritual or cultural perspective and, accordingly, deal with it through self-regulation or traditional Chinese medicine. The stigmatization of mental illness in Chinese culture, as well as Chinese immigrants' limited mental health literacy, low English proficiency, and lack of knowledge about Canadian health-care system are all barriers to accessing mental health services. At the end, this chapter reviews the current status of scholarly research on the mental health of Chinese immigrants in Canada and offers several suggestions.

Keywords Canada · Chinese immigrants · Epidemiology · Mental health

Historical and Social Contexts

In the middle of the nineteenth century, the first wave of Chinese migrants joined the labor force in the region of British Columbia in Canada, working at railways and mines. With the completion of the Canadian Pacific Railway, in 1885, Canada imposed a "head tax" to discourage Chinese workers and their family members

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from entering the country. Between 1923 and 1947, new Chinese immigrants were banned altogether. After World War II, the Canadian government gradually removed restrictions on immigration from China (Con et al. 1982). Before the 1960s, nearly all new arrivals in Canada came from Europe and the United States, but Chinese caught up rapidly in the following decades. At the turn of the new millennium, Hong Kong and mainland China supplied the greatest numbers of immigrants to Canada (Gushulak et al. 2011). According to the 2016 census, 1.8 million Canadian residents reported Chinese origin, surpassing the other two largest Asian ethnic populations, East Indians (1.4 million) and Filipino (0.8 million) (Statistics Canada 2017). The majority of Chinese immigrants live in several metropolitan areas including Vancouver, Toronto, and Montreal, a phenomenon which affects their living condition as well as their representation in scholarly literature (Guo and DeVoretz 2006).

In spite of the long history of Chinese migration to Canada, this chapter will focus on the recent decades, partly due to data availability and partly because the current immigrant population is the most relevant to policy and practical interventions. This chapter uses "Chinese" more as an ethnic/cultural than national concept; accordingly, the population it examines includes immigrants from mainland China, Hong Kong, Taiwan, as well as other locales where Chinese ancestry is found. Over time, Chinese immigrants arrived in Canada from different regions, with different characteristics, and under different immigrant categories (Guo and DeVoretz 2006; Li 2015). Notwithstanding the existence of refugees and undocumented migrants, the majority of Chinese immigrants came to Canada from middle-class or privileged social status. Having left their home country with good education and occupational skills, many Chinese immigrants find themselves facing various difficulties related to resettlement, employment, and acculturation. Downward mobility is usually to be expected (C. Chen et al. 2010; Tang et al. 2007). It is reported that it would take more than 20 years for Chinese immigrants to close the earning gaps with the general population (S. Wang and Lo 2005). Canada funds settlement services to help new immigrants with regard to issues such as employment, language, and housing, but these services are not without criticism (Li 2015; Rajkumar et al. 2012). Canada's official multiculturalism policy does not fully eradicate racism, although it appears that fewer Chinese immigrants (18%) than blacks (32%) and South Asians (21%) experience discrimination (L. Simich and Beiser 2011). All the above social, economic, and cultural factors exert impact on the mental health of Chinese immigrants in Canada. In the following sections, this chapter reviews, first, the epidemiology and determinants of Chinese immigrants' mental health and, second, Chinese immigrants' utilization of and barriers to mental health-care services.

General Epidemiology and Determinants of Mental Health

In Canada, Chinese immigrants report the weakest sense of belonging to the local community (M. Chiu et al. 2018). Chinese immigrants suffering psychological distress typically report somatic symptoms, impaired cognition and social functioning,

and loss of self-confidence (R. Lee et al. 2001). According to a study conducted on over 150,000 Chinese immigrants in British Columbia, between 1992 and 2001, 15% of the young immigrants and 25% of the older immigrants made at least one mental health visit to a medical practitioner (A. W. Chen et al. 2008). These rates can be seen through a comparative lens. East and South Asian immigrants in Canada are known for displaying lower rates of mental disorders than the white population (M. Chiu et al. 2018; Wu et al. 2003). Among the former group, Chinese are sometimes reported to have even lower prevalence of mental problems than the other Asian immigrants (Pahwa et al. 2012; Tiwari and Wang 2006). Canadian-born Chinese similarly display relatively low rates of mental illness (A. W. Chen et al. 2009). However, when it comes to self-rating, Chinese immigrants are most likely to report poor mental health (M. Chiu et al. 2018; Tiwari and Wang 2006). It is speculated that Chinese immigrants may have subthreshold mental disorders that do not meet the full diagnosis criteria (Tiwari and Wang 2006).

Causes of mental disorders among Chinese immigrants are predominantly social in origin. Centering around resettlement, determinants of mental health include economic uncertainty, acculturation-related stress, problems in familial and social relations, and discrimination (George et al. 2015; R. Lee et al. 2001). For example, more than half occupationally active new immigrants, including Chinese immigrants, are overqualified for their jobs in Canada, and these overqualified individuals are more likely to report deterioration in mental health (C. Chen et al. 2010). Chinese immigrants with less education are more likely to report mental distress, which pattern stands in contrast with that of South Asian immigrants (Pahwa et al. 2012). Social support and involvement in social activities appear to play a role in mental well-being (R. Lee et al. 2001; Pahwa et al. 2012). However, one finding suggests that social support has a weaker effect on Chinese Canadians in comparison with Arabic and West Asian Canadians (Wu et al. 2003). Cultural distance and cultural-linguistic barriers tend to be associated with poor mental health in all age and gender groups of the Chinese immigrant population (Beiser et al. 2010; Beiser et al. 2015; Lai 2004c). In spite of all these adverse factors, thanks to Canada's universal health coverage, medical expense rarely appears to be a concern to Chinese immigrants (Franks and Faux 1990).

Group-Specific Epidemiology and Determinants of Mental Health

The above findings depict common situations that Chinese immigrants in Canada are likely to encounter. However, it should be noted that Chinese immigrants are a highly heterogeneous group. An investigation into specific demographic features reveals much complexity, inconclusiveness, and potential conflicts in scholarly findings. For example, certain differences have been found among immigrants from mainland China and those from other Chinese regions (Beiser et al. 2010; Guo and DeVoretz 2006; Lai 2005), and female Chinese immigrants tend to face unique

challenges. The majority of evidence indicates that, among at least middle-aged and older Chinese immigrants, women are more likely than men to suffer from mental problems (Chow 2010; Franks and Faux 1990; Kuo et al. 2008; Lai 2000, 2004c). Chinese immigrant women's psychological distress is most often caused by employment and finance-related difficulties among other adverse factors (Tang et al. 2007).

Older Chinese Immigrants

Despite the fact that older Chinese Canadians often display good physical health, they have poorer mental health in comparison with the general elderly Canadian population (Lai 2004b, c, 2005). In a study based on seven major Canadian cities across provinces, nearly one-quarter of elderly Chinese participants reported having at least a mild level of depressive symptoms (Lai 2004c), and this rate is significantly higher than the 10% prevalence rate of depression among elderly Canadians in general (Lai 2000). It should be noted, however, that another longitudinal study did not replicate the contrast between elderly Chinese immigrants and Canadian-born elders (Pahwa et al. 2012). Depression among elderly Chinese immigrants is associated with the following characteristics: older age, shorter duration of residence in Canada, lower level of education, poor physical health, and lower income (Bagley 1993; Kuo et al. 2008; Lai 2000, 2004a, c, 2005; Lai et al. 2007).

Social support appears to protect the mental health of older Chinese immigrants. In addition to the benefit of community support outside the family (Lai 2004a), those living with family members – whether a spouse or children – tend to report better mental health (Bagley 1993; Chow 2010; Lai 2005; Lai et al. 2007). However, some research conducted on older Chinese Americans indicates more complex and even opposite phenomena (Mui and Kang 2006; Stokes et al. 2002). One possible explanation is that the mental health of older Chinese immigrants is affected by the quality of the parent-child relationship instead of the quantity of assistance they receive from their adult children (Kuo et al. 2008). In addition, one study suggests that the positive effect of marriage on mental health disappears after the control of cultural variables, indicating potential interactions between marriage and culture (Lai et al. 2007).

The role of cultural and religious beliefs remains unclear. Some research indicates that having Chinese religious belief is related to depression (Lai 2004c, 2005), but the opposite argument has also been made (L. Chiu et al. 2005). It remains a puzzle whether depression among older Chinese immigrants is predicted by a high identification with Chinese cultural values or by a low identification with Canadian cultural values (Kuo and Guan 2006; Lai 2004c). Whether Chinese health beliefs predict depression also remains controversial (Lai 2004c, 2005).

Children and Youth

Overall, Chinese immigrant children appear to have relatively good mental health, despite various difficulties involved in resettlement (Beiser et al. 2010). In school, China-born immigrant children display significant disadvantages compared to their Canadian-born Chinese counterparts regarding social competency and adjustment. Immigrant children perceive themselves more negatively in terms of their self-worth and feel lonelier and more socially dissatisfied. These problems can be explained in terms of limited English proficiency and cultural barriers (X. Chen and Tse 2010).

The mental health of children of Chinese origin is highly dependent on their families. Their mental health is predicted by universal factors that apply to all families, such as parental depression, parents' education, and family dysfunction, as well as by migration-specific factors, including region of emigration, resettlement stress, prejudice, and limited English fluency (Beiser et al. 2010, 2014). A surprising finding is that only children and children who experience separation from parents do not face increased mental health risks (Beiser et al. 2014). In Chinese immigrant families, mental health problems in parents and the use of harsh parenting approaches are associated with the children's emotional malfunctions (Beiser et al. 2014, 2015). A notable finding is that although poverty generally exposes children to mental health risks, Chinese immigrant children are rarely affected by their parents' financial difficulties (Beiser et al. 2010, 2014). It has been argued that the mental health of children in new immigrant families is protected by a view of poverty as a transient and inevitable part of the resettlement process so that it is not associated with stigma or future-oriented anxiety (Beiser et al. 2002, 2014).

When it comes to the mental health of the youth, discrimination is among the major risk factors (Hilario et al. 2015, 2018). It is suggested that adolescent immigrants from culturally distant backgrounds, including China, are more likely to experience discrimination than those from culturally closer backgrounds (Beiser et al. 2015). Among young Chinese immigrants, experience of discrimination is associated with stress symptoms. Unlike their male counterparts, females who experienced discrimination are more likely to display low self-esteem (Pak et al. 1991). It is also noteworthy that young Chinese immigrants' experience of discrimination is associated with positive attitudes toward their co-ethnic members (Pak et al. 1991). Meanwhile, ethnic identification is positively correlated with academic achievement and self-esteem and negatively correlated with symptoms of depression (Costigan et al. 2010). Thus, it is suggested that a strong sense of ethnic identity may function as a protective buffer against risks such as discrimination and poor achievement (Costigan et al. 2010).

With their cultural heritage, young Chinese immigrants display certain unique behavioral patterns. In comparison to white, Aboriginal, South Asian, and South East Asian youths, Chinese youths report the lowest lifetime prevalence of using cannabis, tobacco, alcohol, and club drugs, a phenomenon which may be explained by their conservative attitudes toward substance use, parental education, and peer group influence (Duff et al. 2011). While being less susceptible to substance abuse,

Chinese youths nonetheless have other problems. First-generation Chinese students display more social anxiety and impairment than the second-generation Chinese and European counterparts (Hsu and Alden 2008). On some occasions, the Chinese cultural heritage barely matters. One study that compares undergraduates of Chinese, European, and Indo-Asian origins finds no significant difference regarding their suicide ideation. Although individuals with stronger identification with their heritage culture are more likely to have suicidal thoughts, they do not necessarily make more suicidal plans or attempts (Kennedy et al. 2005).

Utilization of Mental Health-Care Service

As mentioned earlier, between 1992 and 2001, 15% of young Chinese immigrants and 25% of older Chinese immigrants made at least one mental health visit to a medical practitioner (A. W. Chen et al. 2008). Chinese immigrants received most mental health services from general practitioners, while fewer than 2% of them visited a psychiatrist (A. W. Chen et al. 2008). Chinese immigrants' utilization of mental health services is predicted by several factors. It has been reported that females are more likely than males to have received mental health services (A. W. Chen et al. 2008, 2010). However, there is also contradictory research indicating a lack of gender differentiation in the use of mental health service among Chinese immigrants (Tiwari and Wang 2008). Higher socioeconomic status of neighborhood is negatively correlated with mental health visits. English proficiency may be associated with higher rates of mental health visits, though the evidence is not conclusive (A. W. Chen et al. 2008, 2009). Further, mental health consultation increases substantially with the years since arrival in Canada and with the rate of general health visits (A. W. Chen et al. 2008). It is hypothesized that immigrants are exposed to heightened mental health risks not immediately after arrival but several years later. Also, after years of resettlement, immigrants attain improved language skills and health knowledge to be able to seek help (A. W. Chen et al. 2008). However, in another study conducted in the same province, the number of years in Canada was not found to be associated with the rate of mental health visits (A. W. Chen et al. 2009). Education appears to have little relationship with mental health service utilization (A. W. Chen et al. 2008; Lin et al. 1996). Due to contradictory evidence, it remains unclear whether being married increases the likelihood that Chinese immigrants pay mental health visits (A. W. Chen et al. 2008; Tiwari and Wang 2008).

In Canada, Chinese immigrants make less use of general health-care service than non-immigrants, and their low utilization rate is particularly pronounced when it comes to mental health issues (A. W. Chen and Kazanjian 2005). When services for all mental health conditions are considered, Chinese immigrants have lower rates of utilization than non-immigrants (rate ratios = 0.41–0.90) (A. W. Chen et al. 2010). South Asians are perhaps the only immigrant group with lower odds than Chinese immigrants of seeking mental treatment (Gadalla 2010; Tiwari and Wang 2008).

Among those self-reporting fair or poor mental health, only 19.8% Chinese, in comparison with 50.8% white individuals, seek help from a mental health professional (M. Chiu et al. 2018). Concerning severe mental illnesses, Chinese immigrants have lower rates of utilization than non-immigrants in visits to general practitioners, hospitalization, and psychiatric medication (rate ratios = 0.51–0.81). The only exception is regarding psychiatric visits – Chinese immigrants with severe mental illness are 1.36 times as likely as non-immigrants to make psychiatric visits (A. W. Chen et al. 2010).

Perhaps because of Chinese immigrants' reluctance in seeking mental health services, they are more likely, in comparison with the general Canadian population, to be involuntarily admitted for psychiatric examination and hospitalization, and when that occurs, they display more positive symptoms and aggressive behaviors (M. Chiu et al. 2016). It is clearly the case regarding first-generation Chinese students with social anxiety, who tend to avoid seeking treatment until their conditions become severe (Hsu and Alden 2008).

Barriers to Mental Health-Care Services

How to make sense of Chinese immigrants' low rate of mental health service utilization? As mentioned earlier, one potential reason lies in that Chinese immigrants have lower prevalence of mental disorders (A. W. Chen et al. 2009). There are several other possible factors that may reduce Chinese immigrants' mental health visits (A. W. Chen et al. 2009; Tieu and Konnert 2014). Seen from a cultural perspective, Chinese immigrants may have a different understanding of mental illness. Some of them emphasize individual qualities, such as personality, mental strength, and fortitude, in understanding mental illness (Simich et al. 2009). They may view symptoms of mental illness to be excessive reaction to life events and identify solutions in self-initiated emotional and behavioral regulation (R. N. Lee 1986). Some explain mental illness in religious or spiritual terms (L. Chiu et al. 2005; Lai and Chappell 2006). In addition, elderly Chinese immigrants have poor mental health literacy: A study shows that while 74.0% of Canadian-born elders correctly identify depression, only 11.3% elderly Chinese immigrants are able to do so (Tieu et al. 2010). Chinese immigrants may also lack the knowledge about what services are available (Lai and Chau 2007a).

It has also been suggested that Chinese immigrants may be averse to Western mental health services due to their cultural orientation (A. W. Chen et al. 2009). Chinese immigrants with mental illness are often sensitive about the stigma attached to it and would attempt to conceal their conditions (L. Chiu et al. 2005; R. Lee et al. 2001; Simich et al. 2009; Tieu and Konnert 2014). Some of them seek help from families and trusted persons before resorting to professionals (A. W. Chen et al. 2009; F. Chen et al. 2013). Chinese immigrants may prefer treating mental health problems with indigenous healing methods, such as traditional Chinese medicine (TCM), which see the mind and body as a dynamic whole (R. Lee et al. 2001).

About two-thirds of older Chinese immigrants use TCM in combination with Western health services, about half use Chinese herbs or herbal formulas, and about a third use Western health services only (Lai and Chappell 2006). Elderly Chinese immigrants who use TCM are more likely to have a mainland Chinese origin, a lower level of education, shorter residence in Canada, pain symptoms, and prior hospitalization, as well as live alone (Lai and Chappell 2006; Lai and Surood 2009; Tjam and Hirdes 2002). Despite their interest in TCM, Chinese immigrants have limited access to it because it is usually not covered by health insurance (R. Lee et al. 2001).

Even when Chinese immigrants view symptoms of mental illness in Western scientific terms, they may still face various cultural and linguistic barriers to seeking professional help (A. W. Chen et al. 2010; Lai and Chau 2007a; Simich et al. 2009; Stewart et al. 2011). These barriers stem partly from Chinese immigrants' low level of English proficiency and of Canadian cultural knowledge, and partly from the fact that mental health service agencies often lack Chinese-speaking professionals or interpreters (A. W. Chen et al. 2010). Ethnic, cultural, and language barriers often result in administrative problems in care delivery, cultural compatibility, personal attitudes, and circumstantial issues (Lai and Chau 2007b). There is little surprise that some Chinese immigrants consider health service providers to be culturally insensitive and prefer Chinese-speaking health professionals (Chappell and Lai 1998; Lai and Chau 2007a; L. Wang et al. 2008).

Conclusion

This chapter provides a general introduction to the mental health of Chinese immigrants in Canada, including the historical and social contexts of Chinese immigrants, the epidemiology and determinants of their mental health, as well as their utilization of and barriers to mental health services. Chinese immigrants overall have lower rates of mental problems than the general Canadian population despite various difficulties involved in their resettlement, which center around financial security, social relations, and acculturation. Meanwhile, each subgroup faces its own challenges: Females and elders are more likely to experience mental disorders, children's mental health is highly dependent on the family, and youths face the task of dealing with discrimination and ethnic/cultural identity. In addition, this chapter discusses Chinese immigrants' lower rates of use of mental health services than most other ethnic groups. A variety of reasons underlie their low utilization rate. They may understand the nature of mental illness from Chinese spiritual or cultural perspectives and, accordingly, deal with mental health problems through self-regulation or traditional Chinese medicine. The stigmatization of mental illness in Chinese culture, as well as Chinese immigrants' limited mental health literacy, English proficiency, and knowledge about Canadian health-care system all constitute barriers to mental health service.

Reports on the mental health status of Chinese immigrants in Canada must be viewed with circumspection. With its geographical scope, ethnic diversity, social inequality, rapidly changing economy, and political divisions, China supplies to Canada highly heterogeneous migrants (Guo and DeVoretz 2006; S. Wang and Lo 2005). The very "Chinese" label is problematically generalizing. In large-scale quantitative research, the application of administrative data, which depends on residents' participation in census and registration in the health-care system, tends to omit more marginalized immigrants. Locally based research initiatives cluster around several metropolitan areas and thus exclude Chinese immigrants in other regions who may face different resettlement challenges (Hansson et al. 2012; Stafford et al. 2011). Qualitative research reveals further complexity in which mental health research is enmeshed: such as that verbal responses to research questions are dependent on one's employment, length of residence, and cultural background (Franks and Faux 1990; Simich et al. 2009). In addition, certain findings remain inconclusive or controversial, and many have not been replicated (Hansson et al. 2012). Furthermore, it should be noted that by synthesizing research findings based on different periods, locations, data sets, and methods, this review inevitably entails a certain degree of de-contextualized generalization. Readers of this chapter are encouraged to trace original research articles with the references provided.

Finally, this chapter makes a few observations and suggestions regarding scholarly approaches to the mental health of Chinese immigrants in Canada. It would be reductionistic to establish any simple correlation between immigrants' mental health with their country of origin. By moving away from attributing characteristics to a certain ethnic group, many researchers have increased exploration into how social context matters in immigrants' mental health. For example, one study shows that when the percentage of immigrants increases in a given region, the rate of depression among immigrants decreases (Stafford et al. 2011). Contrary evidence is however found that children in the multicultural Toronto demonstrate greater mental health risk than those in cities with less immigrant density, such as Edmonton, Calgary, Winnipeg, and Montreal, a curious finding that calls for further contextualized analysis of local history and policy (Beiser et al. 2010). Against essentializing approaches, researchers call for more future studies of specific cultural factors, resettlement contingencies, post-migration social environment, and access to health care (Beiser et al. 2014; Guruge and Butt 2015; Hilario et al. 2018). There is a continuing need for flexible, individualized approaches to immigrants' psychological well-being (Franks and Faux 1990).

References

Bagley, C. R. (1993). Mental health and social adjustment of elderly Chinese immigrants in Canada. *Canada's Mental Health, 41*(3), 6–10.

Beiser, M., Hou, F., Hyman, I., & Tousignant, M. (2002). Poverty, family process, and the mental health of immigrant children in Canada. *American Journal of Public Health, 92*(2), 220–227.

Beiser, M., Hamilton, H., Rummens, J. A., Oxman-Martinez, J., Ogilvie, L., Humphrey, C., & Armstrong, R. (2010). Predictors of emotional problems and physical aggression among children of Hong Kong Chinese, Mainland Chinese and Filipino immigrants to Canada. *Social Psychiatry and Psychiatric Epidemiology, 45*(10), 1011–1021.

Beiser, M., Goodwill, A. M., Albanese, P., McShane, K., & Nowakowski, M. (2014). Predictors of immigrant children's mental health in Canada: Selection, settlement contingencies, culture, or all of the above? *Social Psychiatry and Psychiatric Epidemiology, 49*(5), 743–756.

Beiser, M., Puente-Duran, S., & Hou, F. (2015). Cultural distance and emotional problems among immigrant and refugee youth in Canada: Findings from the New Canadian Child and Youth Study (NCCYS). *International Journal of Intercultural Relations, 49*, 33–45.

Chappell, N. L., & Lai, D. (1998). Health care service use by Chinese seniors in British Columbia, Canada. *Journal of Cross-Cultural Gerontology, 13*(1), 21–37.

Chen, A. W., & Kazanjian, A. (2005). Rate of mental health service utilization by Chinese immigrants in British Columbia. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique, 96*, 49–51.

Chen, X., & Tse, H. C.-H. (2010). Social and psychological adjustment of Chinese Canadian children. *International Journal of Behavioral Development, 34*(4), 330–338.

Chen, A. W., Kazanjian, A., & Wong, H. (2008). Determinants of mental health consultations among recent Chinese immigrants in British Columbia, Canada: Implications for mental health risk and access to services. *Journal of Immigrant and Minority Health, 10*(6), 529–540.

Chen, A. W., Kazanjian, A., & Wong, H. (2009). Why do Chinese Canadians not consult mental health services: Health status, language or culture? *Transcultural Psychiatry, 46*(4), 623–641.

Chen, A. W., Kazanjian, A., Wong, H., & Goldner, E. M. (2010). Mental health service use by Chinese immigrants with severe and persistent mental illness. *The Canadian Journal of Psychiatry, 55*(1), 35–42.

Chen, C., Smith, P., & Mustard, C. (2010). The prevalence of over-qualification and its association with health status among occupationally active new immigrants to Canada. *International Journal of Environmental Research and Public Health, 15*(6), 601–619.

Chen, F., Lai, G. Y.-C., & Yang, L. (2013). Mental illness disclosure in Chinese immigrant communities. *Journal of Counseling Psychology, 60*(3), 379.

Chiu, L., Morrow, M., Ganesan, S., & Clark, N. (2005). Spirituality and treatment choices by South and East Asian women with serious mental illness. *Transcultural Psychiatry, 42*(4), 630–656.

Chiu, M., Lebenbaum, M., Newman, A. M., Zaheer, J., & Kurdyak, P. (2016). Ethnic differences in mental illness severity: A population-based study of Chinese and South Asian patients in Ontario, Canada. *The Journal of Clinical Psychiatry, 77*(9), e1108–e1116.

Chiu, M., Amartey, A., Wang, X., & Kurdyak, P. (2018). Ethnic differences in mental health status and service utilization: A population-based study in Ontario, Canada. *The Canadian Journal of Psychiatry, 63*(7), 481–491. Retrieved from https://doi-org.ezproxy.library.yorku.ca/10.1177/0706743717741061.

Chow, H. P. (2010). Growing old in Canada: Physical and psychological well-being among elderly Chinese immigrants. *Ethnicity & Health, 15*(1), 61–72.

Con, H., Con, R. J., Johnson, G., Wickberg, E., & Willmott, W. E. (1982). *From China to Canada: A history of the Chinese communities in Canada*. (E. Wickberg, Ed.). Toronto: McClelland and Stewart.

Costigan, C. L., Koryzma, C. M., Hua, J. M., & Chance, L. J. (2010). Ethnic identity, achievement, and psychological adjustment: Examining risk and resilience among youth from immigrant Chinese families in Canada. *Cultural Diversity and Ethnic Minority Psychology, 16*(2), 264.

Duff, C., Puri, A. K., & Chow, C. (2011). Ethno-cultural differences in the use of alcohol and other drugs: Evidence from the Vancouver youth drug reporting system. *Journal of Ethnicity in Substance Abuse, 10*(1), 2–23.

Franks, F., & Faux, S. A. (1990). Depression, stress, mastery, and social resources in four ethnocultural women's groups. *Research in Nursing & Health, 13*(5), 283–292.

Gadalla, T. M. (2010). Ethnicity and seeking treatment for depression: A Canadian national study. *Canadian Ethnic Studies, 41*(3), 233–245.

George, U., Thomson, M., Chaze, F., & Guruge, S. (2015). Immigrant mental health, a public health issue: Looking back and moving forward. *International Journal of Environmental Research and Public Health, 12*(10), 13624–13648.

Guo, S., & DeVoretz, D. J. (2006). The changing face of Chinese immigrants in Canada. *Journal of International Migration and Integration/Revue de l'integration et de La Migration Internationale, 7*(3), 275–300.

Guruge, S., & Butt, H. (2015). A scoping review of mental health issues and concerns among immigrant and refugee youth in Canada: Looking back, moving forward. *Canadian Journal of Public Health, 106*(2), 72–78.

Gushulak, B. D., Pottie, K., Roberts, J. H., Torres, S., & DesMeules, M. (2011). Migration and health in Canada: Health in the global village. *CMAJ, 183*(12), E952–E958.

Hansson, E. K., Tuck, A., Lurie, S., & McKenzie, K. (2012). Rates of mental illness and suicidality in immigrant, refugee, ethnocultural, and racialized groups in Canada: A review of the literature. *The Canadian Journal of Psychiatry, 57*(2), 111–121.

Hilario, C. T., Oliffe, J. L., Wong, J. P.-H., Browne, A. J., & Johnson, J. L. (2015). Migration and young people's mental health in Canada: A scoping review. *Journal of Mental Health, 24*(6), 414–422.

Hilario, C. T., Oliffe, J. L., Wong, J. P., Browne, A. J., & Johnson, J. L. (2018). "Just as Canadian as anyone else"? Experiences of second-class citizenship and the mental health of young immigrant and refugee men in Canada. *American Journal of Men's Health, 12*(2), 210–220.

Hsu, L., & Alden, L. E. (2008). Cultural influences on willingness to seek treatment for social anxiety in Chinese-and European-heritage students. *Cultural Diversity and Ethnic Minority Psychology, 14*(3), 215.

Kennedy, M. A., Parhar, K. K., Samra, J., & Gorzalka, B. (2005). Suicide ideation in different generations of immigrants. *The Canadian Journal of Psychiatry, 50*(6), 353–356.

Kuo, B. C., & Guan, J. (2006). Sociocultural predictors of depression for Chinese immigrant elderly in Canada: Acculturation, relationship with adult children, social support, and perceived services barriers. In D. Zinga (Ed.), *Navigating multiculturalism: Negotiating change* (pp. 373–392). Newcastle upon Tyne: Cambridge Scholars Publishing.

Kuo, B. C., Chong, V., & Joseph, J. (2008). Depression and its psychosocial correlates among older Asian immigrants in North America: A critical review of two decades' research. *Journal of Aging and Health, 20*(6), 615–652.

Lai, D. W. (2000). Prevalence of depression among the elderly Chinese in Canada. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique, 91*(1), 64–66.

Lai, D. W. (2004a). Depression among elderly Chinese-Canadian immigrants from Mainland China. *Chinese Medical Journal, 117*(5), 677–683.

Lai, D. W. (2004b). Health status of older Chinese in Canada: Findings from the SF-36 health survey. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique, 95*, 193–197.

Lai, D. W. (2004c). Impact of culture on depressive symptoms of elderly Chinese immigrants. *The Canadian Journal of Psychiatry, 49*(12), 820–827.

Lai, D. W. (2005). Prevalence and correlates of depressive symptoms in older Taiwanese immigrants in Canada. *Journal of the Chinese Medical Association, 68*(3), 118–125.

Lai, D. W., & Chappell, N. (2006). Use of traditional Chinese medicine by older Chinese immigrants in Canada. *Family Practice, 24*(1), 56–64.

Lai, D. W., & Chau, S. B. (2007a). Effects of service barriers on health status of older Chinese immigrants in Canada. *Social Work, 52*(3), 261–269.

Lai, D. W., & Chau, S. B. (2007b). Predictors of health service barriers for older Chinese immigrants in Canada. *Health & Social Work, 32*(1), 57–65.

Lai, D. W., & Surood, S. (2009). Chinese health beliefs of older Chinese in Canada. *Journal of Aging and Health, 21*(1), 38–62.

Lai, D. W., Tsang, K. T., Chappell, N., Lai, D. C., & Chau, S. B. (2007). Relationships between culture and health status: A multi-site study of the older Chinese in Canada. *Canadian Journal on Aging/La Revue Canadienne Du Vieillissement, 26*(3), 171–183.

Lee, R. N. (1986). The Chinese perception of mental illness in the Canadian mosaic. *Canada's Mental Health, 34*(4), 2–4.

Lee, R., Rodin, G., Devins, G., & Weiss, M. G. (2001). Illness experience, meaning and help-seeking among Chinese immigrants in Canada with chronic fatigue and weakness. *Anthropology & Medicine, 8*(1), 89–107.

Li, J. (2015). Chinese immigrants in Canada: Profiles, challenges, and social services. In K. L. Chan (Ed.), *Chinese migration and families-at-risk* (pp. 141–164). Newcastle upon Tyne: Cambridge Scholars Publishing.

Lin, E., Goering, P., Offord, D. R., Campbell, D., & Boyle, M. H. (1996). The use of mental health services in Ontario: Epidemiologic findings. *The Canadian Journal of Psychiatry, 41*(9), 572–577.

Mui, A. C., & Kang, S.-Y. (2006). Acculturation stress and depression among Asian immigrant elders. *Social Work, 51*(3), 243–255.

Pahwa, P., Karunanayake, C. P., McCrosky, J., & Thorpe, L. (2012). Longitudinal trends in mental health among ethnic groups in Canada. *Chronic Diseases & Injuries in Canada, 32*(3), 164–176.

Pak, A. W.-P., Dion, K. L., & Dion, K. K. (1991). Social-psychological correlates of experienced discrimination: Test of the double jeopardy hypothesis. *International Journal of Intercultural Relations, 15*(2), 243–253.

Rajkumar, D., Berkowitz, L., Vosko, L. F., Preston, V., & Latham, R. (2012). At the temporary-permanent divide: How Canada produces temporariness and makes citizens through its security, work, and settlement policies. *Citizenship Studies, 16*(3–4), 483–510.

Simich, L., & Beiser, M. (2011). Immigrant and refugee mental health in Canada: Lessons and prospects. In D. Bhugra & S. Gupta (Eds.), *Migration and mental health* (pp. 323–336). Cambridge: Cambridge University Press.

Simich, L., Maiter, S., Moorlag, E., & Ochocka, J. (2009). Taking culture seriously: Ethnolinguistic community perspectives on mental health. *Psychiatric Rehabilitation Journal, 32*(3), 208–214.

Stafford, M., Newbold, B. K., & Ross, N. A. (2011). Psychological distress among immigrants and visible minorities in Canada: A contextual analysis. *International Journal of Social Psychiatry, 57*(4), 428–441.

Statistics Canada. (2017). *Ethnic and cultural origins of Canadians: Portrait of a rich heritage*. Ottawa: Statistics Canada. Retrieved from https://www12.statcan.gc.ca/census-recensement/2016/as-sa/98-200-x/2016016/98-200-x2016016-eng.pdf.

Stewart, M., Shizha, E., Makwarimba, E., Spitzer, D., Khalema, E. N., & Nsaliwa, C. D. (2011). Challenges and barriers to services for immigrant seniors in Canada: "You are among others but you feel alone". *International Journal of Migration, Health and Social Care, 7*(1), 16–32.

Stokes, S. C., Thompson, L. W., Murphy, S., & Gallagher-Thompson, D. (2002). Screening for depression in immigrant Chinese-American elders: Results of a pilot study. *Journal of Gerontological Social Work, 36*(1–2), 27–44.

Tang, T. N., Oatley, K., & Toner, B. B. (2007). Impact of life events and difficulties on the mental health of Chinese immigrant women. *Journal of Immigrant and Minority Health, 9*(4), 281–290.

Tieu, Y., & Konnert, C. A. (2014). Mental health help-seeking attitudes, utilization, and intentions among older Chinese immigrants in Canada. *Aging & Mental Health, 18*(2), 140–147.

Tieu, Y., Konnert, C., & Wang, J. (2010). Depression literacy among older Chinese immigrants in Canada: A comparison with a population-based survey. *International Psychogeriatrics, 22*(8), 1318–1326.

Tiwari, S. K., & Wang, J. (2006). The epidemiology of mental and substance use-related disorders among White, Chinese, and other Asian populations in Canada. *The Canadian Journal of Psychiatry, 51*(14), 904–912.

Tiwari, S. K., & Wang, J. (2008). Ethnic differences in mental health service use among White, Chinese, South Asian and South East Asian populations living in Canada. *Social Psychiatry and Psychiatric Epidemiology, 43*(11), 866.

Tjam, E. Y., & Hirdes, J. P. (2002). Health, psycho-social and cultural determinants of medication use by Chinese-Canadian older persons. *Canadian Journal on Aging/La Revue Canadienne Du Vieillissement, 21*(1), 63–73.

Wang, S., & Lo, L. (2005). Chinese immigrants in Canada: Their changing composition and economic performance. *International Migration, 43*(3), 35–71.

Wang, L., Rosenberg, M., & Lo, L. (2008). Ethnicity and utilization of family physicians: A case study of Mainland Chinese immigrants in Toronto, Canada. *Social Science & Medicine, 67*(9), 1410–1422.

Wu, Z., Noh, S., Kaspar, V., & Schimmele, C. M. (2003). Race, ethnicity, and depression in Canadian society. *Journal of Health and Social Behavior, 44*, 426–441.

Chapter 16
Mental Health of Chinese Immigrants in Australia

Harry Minas

Abstract The Chinese are among the earliest immigrants to Australia, with substantial numbers coming from the middle of the nineteenth century, fully half a century before Federation of the states to form the Commonwealth of Australia. The White Australia Policy, established immediately after Federation in 1901 specifically to prevent migration from China, was not dismantled until 1972, when Australia was among the first Western nations to recognise the People's Republic of China. Since that time, large-scale migration from China has recommenced, and the Chinese are now the fastest growing immigrant community in Australia. Substantial differences between the culture that Chinese immigrants bring with them and the dominant Australian culture contribute to risks for development of mental disorder, as a result of the challenges associated with settlement in a new country and culture. While there have been no adequate epidemiological studies of mental disorders in Australia's Chinese communities, it is probably the case that the overall prevalence of mental disorders is not substantially different to that in the overall Australian population and in other immigrant communities. Despite this, Chinese immigrants with mental disorder substantially underutilise public mental health services, largely as a result of the lack of culturally appropriate, acceptable and effective mental health services. In recent years, the political and economic tensions between Western countries – primarily the United States – and China have become prominent also in Australia, with the possibility that these may be undermining Chinese immigrants' sense of security and wellbeing.

Keywords Chinese immigrants · Mental health · Mental health services · Acculturation · Culture and psychopathology · Politics, migration and mental health

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Chinese Migration to Australia

The Chinese diaspora – people of Chinese origin who are resident outside the People's Republic of China – constitutes a population of almost 50 million, with people of Chinese descent and Chinese migrants in almost every country in the world. Almost 30 million people of Chinese origin are in Asia, with the largest numbers in Indonesia (8.4 million), Thailand (7.0 million) and Malaysia (6.6 million) (Ch 11, Poston and Zhang).

While the Chinese have been settling in Southeast Asia since the Han Dynasty (second century AD) (Suryadinata 2004), migration to Australia commenced in the mid-nineteenth century, initially consisting of people fleeing civil unrest, floods and famine in southern China and subsequently in response to the discovery of gold. By 1861, the Chinese community made up nearly 7% of the Victorian population (Museum of Victoria). Although some who came to work on the goldfields left, many remained, settling into multiple occupations and establishing many Chinese religious and cultural organisations. The influx of Chinese in the mid-nineteenth century prompted the imposition of a poll tax (Yong and Vosslamber 2018), a precursor to the White Australia Policy, and multiple other forms of racial discrimination. Despite these measures, there has been a small but significant and continuing Chinese presence in Australia since the 1850s. The Immigration Restriction Act, passed in 1901, soon after federation, was aimed primarily at stopping Chinese migration and prevented further immigration from Asia.

Prior to the 1970s, there was a small, widely dispersed Chinese population in Australia. Immigration of Chinese re-commenced in the early 1970s after adoption of non-discriminatory immigration policy by the Whitlam government. This was mostly from Southeast Asian countries such as Malaysia (which became one of the top ten sources of migration in the 1970s) and subsequently from Taiwan, Hong Kong, Vietnam and China. By 1986, there were a dozen countries from which 100 or more Chinese immigrants came. While some Chinese came as refugees, e.g. from Vietnam in the late 1970s and into the 1980s, and as family reunion migrants, increasingly Chinese immigrants have come as professionals and business migrants and as overseas students who have settled in Australia following completion of their studies.

The China-born population rapidly increased as a result of the granting of asylum and permanent residency to thousands of Chinese students and their dependents who were in Australia at the time of the 1989 Tiananmen Square (or June 4th) Incident (Banham 2003). In the past two decades, the rate of growth of immigration from China to Australia is faster than for any other immigrant group (Fig. 16.1). At the time of the 2016 Census, the overseas-born constituted 28% of the Australian population. China-born immigrants were the third largest immigrant group, the number having more than doubled – growing at 8% per year – in the previous 10 years. Figure 16.1 shows that 37.4% of all China-born residents in Australia in 2016 arrived in the previous 5 years (2011–2016), while the corresponding figure for all overseas-born was 21.5%. The large proportion of recently arrived immigrants among the Chinese presents particular challenges for mental health services.

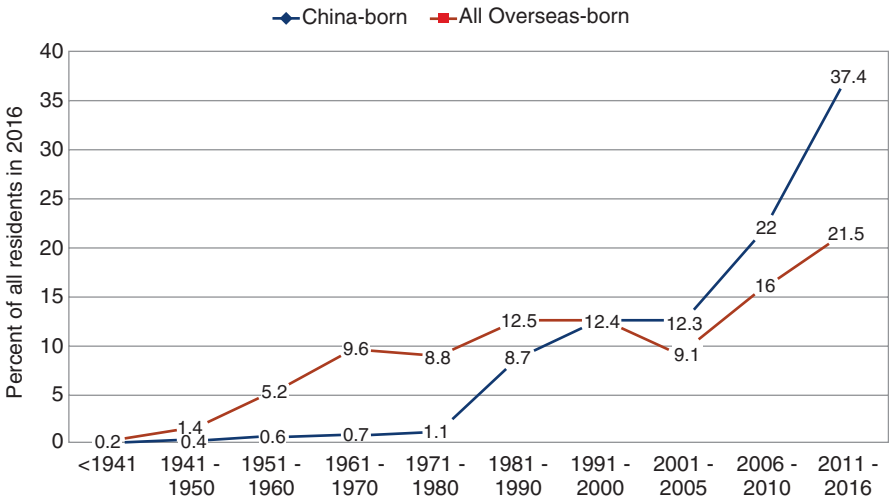

Fig. 16.1 Overseas-born residents in Australia in 2016 by year of immigration to Australia. (Source: Australian Bureau of Statistics Census 2016. Figures are percent of total China-born and all overseas-born populations in Australia in 2016 by year of arrival)

While the median age of the longer-established immigrant communities has continued to increase, the median age of Chinese immigrants has dropped from 38.7 years in 2006 to 34.7 years in 2016 (Australian Bureau of Statistics 2017a). The proportion of Chinese immigrants aged 65 years and over (9.2%) is less than half that in all overseas-born immigrants (19.9%) and substantially lower than that in the Australia-born population (13.5%). However, among Australia-born persons of Chinese ancestry, the proportion of elderly persons is substantially higher than among China-born immigrants, so mental health problems of old age are a significant issue among Chinese Australians.

In 2016, the top five languages spoken by persons at home were English (72.7%), Mandarin (2.5%), Arabic (1.4%), Cantonese (1.2%) and Vietnamese (1.2%) (Australian Bureau of Statistics 2017b). The proportion of China-born immigrants who speak English "not well" or "not at all" is substantially higher (31.0%) than that in all overseas-born immigrants (10.5%). This is a result of the relative recency of arrival of China-born immigrants and of the fact that Chinese immigrants place high value on maintenance of cultural traditions and language, as indicated by the fact that only 26% of China-born immigrants speak "English only", whereas 41.9% of all overseas-born speak "English only".

China-born and all overseas-born have greater proportions of persons with a bachelor degree or other tertiary-level qualification than the Australia-born and higher proportions of high school completion. Despite these higher levels of educational attainment, China-born immigrants have significantly lower levels of personal, family and household income than both the all overseas-born and Australia-born groups.

Chinese and Australian Culture

Over several decades, Hofstede and his colleagues (Hofstede Insights 2018) have developed a global database of national cultural values that is widely used in business and in research studies of culture. Figure 16.2 shows the different patterns of scores on the cultural values dimensions from surveys conducted in China and Australia.

While both China and Australia encompass considerable cultural diversity, and there are very substantial individual differences in cultural values, there are some broad cultural differences between China and Australia at national levels. Of course it should not be assumed that these "national" values are relevant to any particular individual of Chinese origin. However, these group differences constitute important cultural background information and, for mental health professionals, a starting point for an exploration of cultural factors that may be relevant in understanding mental health problems and in framing a helping strategy for a particular individual of Chinese origin with mental health problems.

Also, the pattern of scores from mainland China and from Chinese respondents in other regions and countries from which Australia's Chinese immigrants

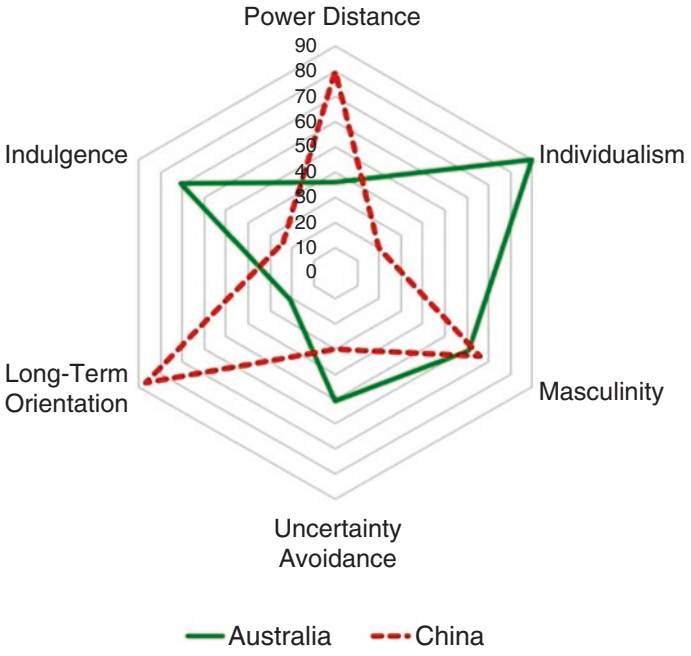

Fig. 16.2 Comparison of China and Australia on Hofstede's national cultural values dimensions. (Data source: Hofstede Insights 2018)

come – e.g. Hong Kong, Taiwan, Singapore, Malaysia, Vietnam and others – is likely to be significantly different, as would be the scores of Chinese immigrants in Australia.

The most well-known of the differences in values are in individualism, high in Australians and low in Chinese, and power distance, high in Chinese and low in Australians. Less well-known but just as important are the large differences between the two cultures in long-term orientation and indulgence. The smaller but significant difference between the two cultures in uncertainty avoidance also carries some explanatory power. An understanding of these values is important in designing and delivering appropriate mental health services, and their possible relevance in a specific clinical situation of a particular individual with mental illness and her/his family should be considered by the clinician.

As well as values differences between Chinese and Western societies, such as Australia, there are both close similarities and also considerable differences in core values among Chinese societies in different countries. Figure 16.3 shows the cultural values profiles of China, Hong Kong, Singapore and Taiwan.

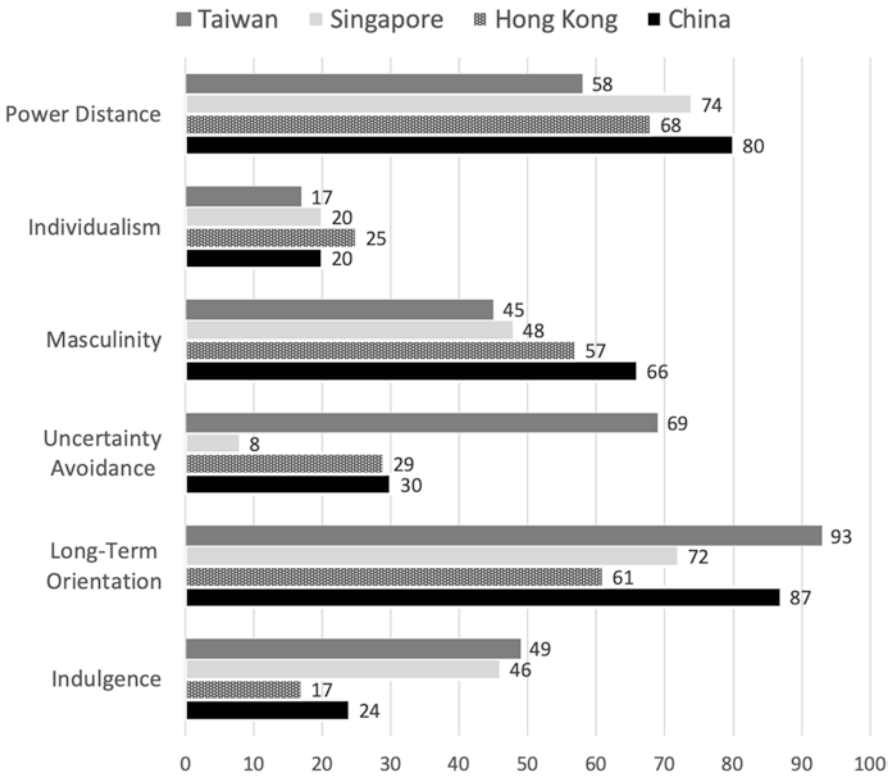

Fig. 16.3 Comparison of Chinese societies on Hofstede's national cultural values dimensions. (Data source: Hofstede Insights 2018)

Acculturation

As immigrants arrive in a new society and culture, they are faced with challenges concerning the extent to which they maintain their own cultural attitudes, beliefs and practices and the extent to which they incorporate aspects of the host culture into their lives. The process of cultural transformation is referred to as acculturation. Dominant acculturation strategies include assimilation, where the individual renounces the culture of origin and adopts the host culture; integration, where the individual maintains her/his own cultural identity while also being an active and capable participant in the host culture; separation, where the individual strongly maintains the culture of origin and rejects the host culture; and marginalisation, where the individual neither values nor fully accepts or participates in the culture of origin or the host culture (Berry et al. 1989; Berry 2001) The extent and pace of acculturation are influenced by many factors, including age on arrival in the new country, the cultural distance between the culture of origin and the host society, the size and level of geographic concentration or dispersal of immigrant communities of origin and the existence and influence in the host country of immigrant community institutions such as schools (such as the Chinese schools system in Malaysia (Chap. 12, Ting et al.), religious organisations, language of origin media and business and professional and employment opportunities. In large immigrant communities, it is possible for those who wish to do so to be completely immersed in culture of origin employment and leisure using the primary language. Just as important as cultural characteristics and issues within the immigrant population are the attitudes of the host population to the immigrant community, the nature and extent of denigration of and discrimination against particular immigrant groups, government policies concerning cultural maintenance and very many other factors.

The Australian policy of inclusive multiculturalism explicitly supports the *integration* form of acculturation by promoting the learning of English and understanding of and respect for Australian laws and culture while at the same time supporting the maintenance of the culture of origin, including language and cultural practices. The dominant mode of acculturation of Chinese immigrants in Australia is integration – maintenance of language of origin and important aspects of Chinese culture while adoption of important Australian cultural values and being fluent in English.

Level and type of acculturation have been shown to be associated with health status and with level of access to health services. For example, adoption of Australian diet and lifestyle is associated with increased cardiovascular disease risk factors, such as hypertension and diabetes, among Chinese immigrants in Australia (Jin et al. 2017). Low levels of acculturation are frequently associated with persistence of traditional conceptions of mental health and illness, high levels of mental illness-related stigma and limited knowledge of, and access to, mental health services, all frequently observed in Chinese immigrant communities.

Culture and Psychopathology

A recent overview of culture and psychopathology (Kirmayer and Ryder 2016) summarises progress that has been made in improving our understanding of the ways in which social and cultural contexts shape illness onset, experience, course and outcome by influencing developmental processes, exposure and response to social adversity and risk of specific forms of psychopathology. Cross-national epidemiological, clinical and anthropological studies over many decades have made clear the wide variations across cultures in prevalence and expression of specific mental disorders, and in cultural understandings, explanations and social responses to mental illness. The most common mental disorders, depression and anxiety, also display great variability across cultures in the ways in which disorders are experienced and expressed, and in social (including health system) responses that are intended to support the individual's recovery, and enhance interpersonal and social functioning (Minas et al. 2007a).

There are substantial differences across cultures in the experience and expression of mental disorders. For example, Parker et al. have suggested that the existing evidence supports the commonly held view that the Chinese are more likely than Australians to deny depression or to express it through somatic symptoms (Parker et al. 2001a, b). However, cultural changes in China in recent decades (Chap. 5, Huang) and among Chinese immigrants in Australia appear to have resulted in significant changes in both the experience and expression of depression. In a study of the impact of acculturation on depressive experiences of Chinese patients in Sydney, Parker et al. (2005) found that both the low rates of reported depression and the phenomenon of somatisation in Chinese people are likely to be influenced principally by cultural factors. These differences in experience and expression of illness can be a source of difficulty for mental health professionals. New Zealand Lifeline counsellors providing services to Chinese immigrants (Dong 2016) were less comfortable and confident when callers focused on physical problems, a particularly common issue in Chinese immigrants who are more likely to express mental disorders through somatic symptoms.

Anxiety, depression and somatoform disorders (a group of psychological disorders resulting in experience of physical symptoms that are not produced by physical pathology) account for a large proportion of all problems seen in general practice in Australia. Under-diagnosis of mental disorder is thought to be a particularly significant problem in persons who do not speak English and in immigrants from Asia (Tang et al. 2009), including immigrants from China, particularly among patients who present with somatic symptoms of mental disorders. A study of Chinese patients attending a general practice in New South Wales found that, while only 12% of subjects reported ever having depression or anxiety, between one-third and one-half of the subjects scored in the probable depression range. The authors suggested the need for specific exploration for symptoms of depression and anxiety, with the possible use of screening instruments. Chan and Parker (2004) also suggest that more direct and sensitive questioning regarding psychological symptoms in Chinese patients may be needed to "unveil the true nature of the distress" and to arrive at a correct diagnosis.

Prevalence of Mental Disorders

Despite the progress in understanding of culture and mental health referred to above, there is still considerable uncertainty about whether variations that have been observed in prevalence of specific disorders represent real differences in prevalence or are due to problems with conceptualisation and measurement across countries and cultures. Unfortunately, these issues have not been studied in a sufficient number of different national contexts and across enough immigrant and minority ethnic groups to enable a full understanding of the origins of such differences (Minas et al. 2013). There are, for example, no studies of prevalence of mental disorders in Chinese Australians.

Reliable estimates of population prevalence of different types of mental disorder in populations of interest are required before anything useful can be said about the scale of mental health problems in specific populations, whether attempts to improve population mental health are effective and are a good investment, or whether differences in observed patterns of mental health service utilisation between different population subgroups are due to differences in rates of mental disorder in those subgroups or to other factors, such as obstacles to service access. A lack of prevalence information results in poorly informed mental health policy and service design and delivery. This is currently the situation in Australia in relation to most immigrant communities, including the Chinese community (Minas et al. 2013).

Mental Health Determinants

A key goal of population health research is to understand the determinants of health and illness – both risk and protective factors – and to develop effective health promotion, illness prevention and early intervention and effective treatment and psychosocial support service programs (Cohen and Minas 2010).

Several factors have been identified as potentially important risk or protective factors for mental illness among immigrant groups in Australia and are likely to be relevant to Chinese immigrants. Factors found to be associated with increased risk of mental disorder among immigrants include limited English proficiency (Alizadeh-Khoei et al. 2011); "marginalised" cultural identity (Sawrikar and Hunt 2005); loss of close family ties (Thompson et al. 2002); lack of opportunity to make effective use of occupational skills (Reid 2012); and the many stresses associated with migration and adjustment to a new country (Krupinski 1984). Protective factors include religious belief and observance, younger age at migration, better proficiency in the language of the host country, a higher sense of personal control, stronger social support and higher self-efficacy (Leung 2002; Connor 2012). A survey of 1139 immigrant and refugee people in two rural and two metropolitan areas in Victoria focused on their experiences of racism and its association with psychological distress (VicHealth 2007). Approximately two-thirds of participants had experienced racism

in the previous 12 months and reported that this had adversely affected their mental health. The extent of experiences of racism was positively correlated with level of psychological distress.

The distribution of these factors across immigrant populations and their importance and impact in different immigrant populations are not well understood. Existing findings are mostly from a very small number of studies with only a very few immigrant groups. Such findings as we have must be regarded as provisional.

Suicide and Self-Harm

Risk of suicidal behaviour among immigrants is influenced by experiences in the country of origin (Kliewer 1991), living circumstances (Kliewer 1991; Morrell et al. 1999), low socio-economic status (Taylor et al. 1998) in the host country, and many other factors. Strong family ties, religious adherence and maintenance of traditional values may lead to lower suicide rates in immigrants (Burvill et al. 1983).

Suicide rates for China and Australia are close to the regional average of the countries of the Western Pacific region, which is 10.8 per 100,000 population, while there is a fourfold difference in suicide rates from the country in the Western Pacific Region with the lowest rate (Philippines) to that with the highest (South Korea). Aside from this wide difference in national rates, there are wide variations in suicide rates among population subgroups within countries (e.g. by age, gender, ethnocultural and socio-economic groups, rural and urban regions, etc.) (Kliewer 1991; Taylor et al. 1998; Morrell et al. 1999; Ide et al. 2012). Among persons aged 65 years and over, immigrants from non-English-speaking background countries have substantially higher rates of suicide. This difference appears to be particularly prominent in immigrants from Northeast Asia. It is not known whether this specifically applies in the Chinese Australian population.

Whereas suicide is substantially more common among males than among females in most countries, China has consistently had a high female suicide rate, particularly in rural regions, and particularly for suicide by pesticide ingestion, although this has been substantially reduced in recent years by improved regulation of pesticide storage and use in rural areas. Rates of suicide of immigrants in Australia are more similar to rates in countries of origin than with the overall Australian suicide rates, but there is convergence in the rates to those in the host country with increased length of stay. Among Chinese in Australia, female suicide rates are half those of male rates, a pattern more like the Australian pattern than that in China (Table 16.1). It is worth noting from Table 16.1 that there is also variation among Chinese immigrants in Australia who come from Mainland China, Hong Kong and Singapore, highlighting the fact of diversity among Chinese immigrants from different countries.

Although the World Health Organization has defined deliberate self-harm as a behaviour that is intended to cause self-harm but without suicide intent and having a nonfatal outcome, deliberate self-harm, or parasuicide, or attempted suicide, is the

Table 16.1 Suicide rates per 100,000 by country of birth and sex in Australia during 2001–2006 compared with suicide rates of COB

Males			Females		
Country of birth	ASR in Australia 15+?[a]	ASR in COB[b]	Country of birth	ASR in Australia 15+	ASR in COB
Australia	22.8	–	Australia	5.8	–
China	10.7	13.0	China	5.5	14.8
Singapore	9.6	13.7	Singapore	np	6.7
Hong Kong	5.7	22.0	Hong Kong	3.4	13.1

Source: Ide et al. (2012)

[a]Age-standardised suicide rates of persons aged 15+ years by country of birth and sex in Australia was sourced from the Australian Institute of Health and Welfare, National Mortality Database

[b]Age standardised to the World Standard Population

clearest predictor of future self-harm and of suicide, with around a quarter of those completing suicide having previously engaged in deliberate self-harm (Wong et al. 2010; Heerde et al. 2015). Deliberate self-harm, which occurs substantially more frequently among females than among males (Heerde et al. 2015), often occurs in the context of wide-ranging problems in adolescents' lives, common features of which are high levels of depression symptoms (Wan et al. 2011), antisocial and other forms of personality disorder and alcohol use. The high rates of suicidal thoughts among Chinese in Malaysia are thought to be related to the political and socioeconomic context of Chinese communities in that country (Chap. 11, Ting et al).

McDonald and Steel (1997) found wide variation in rates of hospital attendance due to self-harm across country-of-birth groups. The rates for males born in China or Hong Kong were among the lowest for all country-of-birth groups. The rates for females born in China or Hong Kong were significantly lower than for those born in Australia. It is not known whether the lower rates of hospital attendance are due to lower population rates of self-harm or due to lower likelihood of presentation to a health service.

Help-Seeking

A number of studies have explored explanatory models of mental health and illness in individual immigrant and refugee groups in Australia and their influence on help-seeking (Cheng, 1985; Hsiao et al. 2006a; Hsiao et al. 2006b; Klimidis et al. 2007; Lenzi et al. 2012; Minas et al. 2007b). Although the findings of these studies are of considerable theoretical value, there have been few systematic attempts to explore the practical significance of the findings – to inform clinical practice, community engagement and use of health services, mental health service design or mental health policy.

A majority of persons with mental disorder in Australia, and throughout the world, do not seek and do not receive any help from mental health professionals and mental health services. In Australia, at the beginning of this century, only 35% of the Australian general population with a mental disorder in a 12-month period sought help from health services (Andrews et al. 2001). In immigrant communities, particularly the Chinese community, the proportion of persons with mental disorder who receive mental health services is much lower than is the case for the Australia-born.

Anxiety disorders and major depressive disorders are the most commonly occurring mental disorders in all adult populations, including in Australia (Andrews et al. 2001). This is true in China as it is in all other countries (Baxter et al. 2016) and in immigrant populations (Stuart et al. 1998; Minas et al. 2008). They are associated with substantial disabilities. Rates of access to public mental health services by immigrants of non-English-speaking background in Australia have been consistently low for several decades (Stuart et al. 1998; Klimidis et al. 1999a, b; Minas et al. 2008, 2013; Stolk et al. 2008).

Within Chinese immigrant populations, cultural factors that have been identified as barriers to seeking help from mental health services (Blignault et al. 2008) are generally based in Chinese traditions of Confucianism, Taoism and Buddhism. Acculturation, ethnic identity and English proficiency are known to influence attitudes towards seeking professional mental health services.

Pathways to Care

A New South Wales study of pathways to first contact with specialist mental health care by Australian-born and Vietnamese-, Chinese- and Arabic-speaking patients making their first lifetime contact with mental health services (Steel et al. 2006) found that an average of three professional consultations was made prior to first contact with public mental health services. Family physicians occupied the key role in the help-seeking pathway with 53% of patients consulting a general practitioner. Many of the findings of this study, particularly the centrality of general practitioners in pathways to mental health care, have been confirmed by subsequent studies of pathways to care shown by Chinese immigrants.

It should be pointed out, however, that these results are applicable only to persons with mental disorder that did eventually make contact with a specialist mental health services. They tell us nothing about persons from immigrant communities with a mental disorder who either choose not to make contact with mental health services or, for whatever reason and regardless of the severity of their mental disorder, do not come into contact with mental health services.

An Australian study of Chinese- and English-speaking persons who undertook an Internet-delivered cognitive behavioural therapy (iCBT) for depression (Choi et al. 2015) showed that the Chinese-speaking participants had significantly milder depressive symptoms and were less likely to have previously sought professional

help compared to the English-speaking participants. The Chinese-speaking participants were more likely to seek iCBT due to lack of knowledge about face-to-face treatment, while the English-speaking participants were more likely to report not benefiting from standard mental health services.

Mental Health Service Utilisation

The likelihood of receiving treatment for mental disorder has been shown to be influenced by immigrants' country of birth (Burvill et al. 1982; Stuart et al. 1998), and in general, immigrants are under-represented in the populations who utilise mental health service in Australia (Hassett and George 2002; Boufous et al. 2005; Wagner et al. 2006). The key barriers identified are stigma and shame associated with mental illnesses (Wynaden et al. 2005; Youssef and Deane 2006; Drummond et al. 2011), limited knowledge of services, communication difficulties, confidentiality concerns, lack of trust in service providers, service constraints and discrimination (Youssef and Deane 2006; Blignault et al. 2008). A pattern of under-utilisation of mental health services by particular groups may point to systematic inadequacies in service systems, important questions concerning the need for service reform, community attitudes towards and beliefs about mental illness and psychiatric treatment, barriers to service access, difficulties in diagnosis and racism.

In studies of public mental health service utilisation by immigrant communities in Victoria in 1995/1996 and 2004/2005 (Klimidis et al. 1999a, b; Stolk et al. 2008), China-born persons had among the lowest rates of utilisation of both hospital services and specialist community mental health services. China-born persons were also more likely to be admitted as involuntary patients, to have a diagnosis of psychotic disorder and to spend more days in hospital than the Australia-born and most other non-English-speaking country-born persons. In 1997 McDonald and Steel reported very similar findings from New South Wales (McDonald and Steel 1997). China-born patients in New South Wales had among the lowest rates of admission to hospital for psychiatric disorder and use of community-based mental health services.

A recent, unpublished, analysis of data from the National Hospital Morbidity Database on all mental health-related hospital admissions in 2013/2014 included data from a total of 260,158 admissions to Australian hospitals. Table 16.2 is a summary of main findings for China-born, all non-English-speaking country-born and the Australia-born. It can be seen that over a period of more than 20 years, China-born persons continue to have extremely low rates of mental health service utilisation and continue to have longer hospital admissions and be more likely to be admitted involuntarily than the Australia-born and most other non-English-speaking country-born persons.

Chinese Australians, particularly those who are more recently arrived, have low English proficiency and are older, experience multiple barriers to access to effective mental health services (Stolk et al. 2008; Colucci et al. 2013; Minas 2017). These

Table 16.2 Admissions to Australian hospitals in the 2013/2014 financial year

Country of birth	Mean admission rate per 10,000 population	Proportion involuntary admissions (%)	Proportion of admissions with psychotic disorder (%)	Mean duration of admission (days)
Australia	133.0	15.6	14.6	6.7
All non-English-speaking country-born	71.4	23.5	21.6	8.6
China-born	21.6	35.0	27.7	9.9

Source: Minas and Hall (unpublished)

barriers include the stigma of mental illness, concerns about confidentiality, lack of knowledge about mental health services and how to gain access to them, perceived and actual discrimination within the general community and among service providers, and problems with communication. Also important is the unavailability of professionals who speak the necessary community languages and who are familiar with the cultures of immigrant communities (Blignault et al. 2008) and a widespread lack of knowledge among health professionals and health service managers of the particular needs and preferences of particular immigrant communities (Colucci et al. 2013; Minas et al. 2013). Such barriers can only be eradicated through adequate information on the particular issues facing immigrant communities and by involving these communities in the design, delivery and evaluation of mental health services (Minas et al. 2013).

Although Australia's National Mental Health Strategy and successive national and state and territory mental health plans have emphasised a focus on quality, effectiveness and cultural appropriateness of services, and a major national effort has been made on continuously measuring the quality of outcomes for service users (Burgess et al. 2012), the evaluation of outcomes has not included analysis of relative outcomes for immigrant groups. As a result of the systematic failure to collect relevant demographic data as part of the national mental health outcomes data collection there is no useful information concerning outcomes for immigrant and refugee clients of mental health services (Minas et al. 2013).

As mentioned above, the Chinese community has been in Australia for a long time. The high value placed on education within the Chinese immigrant community means that Chinese in Australia are significantly better educated than the Australia-born population. In addition, the Australian immigration program is such that a substantial proportion of immigration places within the annual quota is reserved for skilled immigrants, so among the large number of recent Chinese immigrants, there are many who have professional qualifications, skills and experience. All of these factors result in substantial resources within the Australian Chinese communities, including physicians and other health professionals, Chinese social assistance organisations of many kinds throughout the country and a vibrant Chinese language media. The existence of these community resources may at least partly explain the very low rates of utilisation of public mental health services by Chinese in Australia.

Politics, Migration and Mental Health

Politics have always been important in Chinese migration to Australia, and Chinese migration has had, and continues to have, substantial impacts on Australian politics. For example, the transparently racist White Australia Policy was a direct response to Chinese migration in the nineteenth century and was virtually the first act of the national parliament following the creation of the Australian nation through Federation in 1901. This immigration policy was not finally dismantled until the early 1970s, following which, Australia was one of the first Western countries to recognise, and to establish diplomatic relations with, the People's Republic of China. Over subsequent decades, relations between the two countries have become increasingly close, despite major political and cultural differences. China is now Australia's largest trading partner, and Australian prosperity has become increasingly dependent on this trade with China. Australia is the second most favoured destination, after the USA, of Chinese international students (Minas 2020).

However, with China's rapidly developing economic and military might, and its increasingly confident and assertive posture in the region and globally, the relationship between Australia and China has become increasingly frosty. There are frequent expressions of concern in the West, including Australia, and among China's Asian neighbours, about China's approach and intentions in the South China Sea, the implementation of the Belt and Road Initiative and, for Australia, China's increasing influence among the small island nations of the Pacific. In this context Australia is engaged in a delicate positioning between its close alliance with and security dependence on the USA and its economic dependence on its trade with China. A constant stream of negative stories in the Australian media about possible Chinese influence on various aspects of Australian life, and about possible security threats from China, is having at least an unsettling impact on Chinese immigrants and international students in Australia and may be undermining these groups' sense of security and mental health and wellbeing.

Conclusion

Cultural considerations are relevant to all aspects of mental health and mental illness and mental health service design and delivery. Mental health professionals should have a high level of competence in incorporating cultural assessments into their understanding of the problems that their clients present and in crafting approaches to the solution of those problems. Because cultural maintenance in Chinese communities is strong, mental health professionals should have a good deal of knowledge about the more traditional Chinese understandings of mental health and illness, family structures and dynamics, and preferences concerning solutions to mental health problems. Unfortunately, this is not the current reality. There are few appropriate training programs, and neither mental health policy nor arrangements

that regulate mental health practice require the acquisition of such knowledge and skills.

The level of knowledge and the attitudes that different members of the Chinese Australian community have about mental health and illness, and their preferences concerning helping responses, are largely influenced by their age and previous experience when they migrated to Australia and were confronted with a different set of values and attitudes to those in their home country, their level of education and where that education was gained and many other factors.

In general, the level of knowledge and attitudes of the broad Australian community about the common mental disorders, depression and anxiety has changed greatly in the past few decades, as a product of active community education and information campaigns that have had a significant impact. There is less ignorance and less stigma, although there is still more than enough of both. There have also been significant changes in China as the massive economic and cultural transition has gathered pace over the past two or three decades, particularly in the large urban centres. People who migrated from China not long after the cultural revolution, when there was no mental illness but only wrong political thought in (China Chap. 4, Gao) will clearly have different understanding and attitudes to those who migrated in the past 10 years (Chap. 10, Yang).

In seeking to understand the thinking, practices and preferences of Chinese Australians concerning mental health and illness, and to inform helping approaches, mental health professionals would benefit from at least some knowledge of mental health in China and the massive changes that have occurred in China in recent decades and how these changes have influenced knowledge, attitudes and beliefs about mental illness, while traditional Chinese thinking, practices and values persist to varying extents.

Before ending this discussion of the mental health of Chinese immigrants in Australia, it is important to comment briefly on the range, quality and contemporary relevance of the Australian research on mental health of Chinese communities that is presented in this chapter.

A key point to highlight is that Australian research on mental health and illness in Chinese communities mostly consists of small-scale studies on small samples that are not representative of the entire Chinese-Australian population. An additional issue is that the Chinese-Australian population is diverse in terms of country of birth, primary language and period of arrival in Australia. When Chinese migration to Australia re-commenced in the 1970s, most people came from Hong Kong and Southeast Asian countries with large Chinese populations, including Malaysia, Singapore and Vietnam. As Chinese migration gathered pace in the past few decades, the main source of Chinese immigrants has been mainland China. The histories, experiences and cultural influences in the source countries for Chinese migration have been very different, although there is in all a strong core of Chinese traditional values. As a result, studies carried out in the 1980s and 1990s and studies carried out more recently have actually been focused on significantly different populations. Virtually no studies have been replicated at different historical periods, in different components of the Chinese-Australian community or in different states and territories.

Therefore, what we know about mental health in Australia's Chinese communities is partial and fragmented, and frequently informed by inconsistent research findings. This mirrors the situation of all migration mental health research in Australia (Minas et al. 2007a, 2013) and in other countries of settlement and imposes limits on the usefulness of the research for the purpose of understanding the determinants, onset, course and outcome of mental disorders in specific immigrant communities, and for the purpose of informing service design and delivery and professional practice.

Along with the British, the Chinese are among the earliest immigrants to Australia, with substantial numbers coming from the middle of the nineteenth century. After a long interregnum, from the beginning of the White Australia policy after Federation in 1901 until the early 1970s when this loathsome policy was fully discarded, the pace of Chinese immigration has again accelerated. They are the fastest growing immigrant group in Australia. In many ways, Australia's communities of Chinese origin are similar to other large immigrant communities; in other ways, they are quite different. Like other immigrant communities, there are important differences with the Australia-born, and there is considerable internal diversity within Australia's population of Chinese origin. The lesson of this for mental health policymakers, service planners and clinicians is that along with a general commitment to respond to Australia's cultural diversity, there is also a need for specific knowledge about particular communities.

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References

Alizadeh-Khoei, M., Mathews, R. M., & Hossain, S. Z. (2011). The role of acculturation in health status and utilization of health services among the Iranian elderly in metropolitan Sydney. *Journal of Cross-Cultural Gerontology, 26*(4), 397–405.

Andrews, G., Henderson, S., & Hall, W. (2001). Prevalence, comorbidity, disability and service utilisation – Overview of the Australian National Mental Health Survey. *British Journal of Psychiatry, 178*, 145–153.

Australian Bureau of Statistics. (2017a). *Over 28 per cent of Australians born overseas*. From http://www.abs.gov.au/ausstats/abs@.nsf/lookup/3412.0Media%20Release12015-16.

Australian Bureau of Statistics. (2017b). *Census reveals a fast changing, culturally diverse nation*. From http://www.abs.gov.au/ausstats/abs@.nsf/lookup/Media%20Release3.

Banham, C. (2003, December 26). *Children of the revolution*. From http://www.smh.com.au/articles/2003/12/25/1072308628745.html.

Baxter, A. J., Charlson, F. J., Cheng, H. G., Shidhaye, R., Ferrari, A. J., & Whiteford, H. A. (2016). Prevalence of mental, neurological, and substance use disorders in China and India: A systematic analysis. *The Lancet Psychiatry, 3*(9), 832–841.

Berry, J. W. (2001). A psychology of immigration. *Journal of Social Issues, 57*(3), 615–631.

Berry, J. W., Kim, U., Power, S., Young, M., & Bujaki, M. (1989). Acculturation Attitudes in Plural Societies. *Applied Psychology: An International Review/Psychologie Appliquee: Revue Internationale, 38*(2), 185–206.

Blignault, I., Ponzio, V., Rong, Y., & Eisenbruch, M. (2008). A qualitative study of barriers to mental health services utilisation among migrants from mainland China in south-east Sydney. *The International Journal of Social Psychiatry, 54*(2), 180–190.

Boufous, S., Silove, D., Bauman, A., & Steel, Z. (2005). Disability and health service utilization associated with psychological distress: The influence of ethnicity. *Mental Health Services Research, 7*(3), 171–179.

Burgess, P., Coombs, T., Clarke, A., Dickson, R., & Pirkis, J. (2012). Achievements in mental health outcome measurement in Australia: Reflections on progress made by the Australian Mental Health Outcomes and Classification Network (AMHOCN). *International Journal of Mental Health Systems, 6*(1), 4.

Burvill, P. W., Reymond, J., Stampfer, H., & Carlson, J. (1982). Relationship between country of birth and psychiatric admissions in Western Australia. *Acta Psychiatrica Scandinavica, 66*(4), 322–335.

Burvill, P. W., Armstrong, B. K., & Carlson, D. J. (1983). Attempted suicide and immigration in Perth, Western Australia, 1969-1978. *Acta Psychiatrica Scandinavica, 68*(2), 89–99.

Chan, B., & Parker, G. (2004). Some recommendations to assess depression in Chinese people in Australasia. *Australian and New Zealand Journal of Psychiatry, 38*, 141–147.

Cheng, S. K. K. (1985). Cultural explanation of a psychosis in a Chinese woman living in Australia. *Australian and New Zealand Journal of Psychiatry, 19*(2), 190–194.

Choi, I., Andrews, G., Sharpe, L., & Hunt, C. (2015). Help-seeking characteristics of Chinese- and English-speaking Australians accessing Internet-delivered cognitive behavioural therapy for depression. *Social Psychiatry & Psychiatric Epidemiology, 50*(1), 89–97.

Cohen, A., & Minas, H. (2010). Mental health etiology: Social determinants. In V. Patel, A. Woodward, V. Feigin, S. R. Quah, & K. Heggenhougen (Eds.), *Mental and neurological public health: A global perspective* (pp. 107–117). Waltham: Academic Press.

Colucci, E., Chopra, P., McDonough, S., Kouzma, N., & Minas, H. (2013). Improving cultural responsiveness in mental health services: Development of a consensus around the role of cultural portfolio holders. *International Journal of Culture and Mental Health, 7*(3), 339–355.

Connor, P. (2012). Balm for the soul: Immigrant religion and emotional well-being. *International Migration, 50*(2), 130–157.

Dong, C. (2016). The uses of mental health telephone counselling services for Chinese speaking people in New Zealand- demographics, presenting problems, outcome and evaluation of the calls. *New Zealand Medical Journal, 129*, 68–77.

Drummond, P. D., Mizan, A., Brocx, K., & Wright, B. (2011). Barriers to accessing health care services for West African refugee women living in Western Australia. *Health Care for Women International, 32*(3), 206–224.

Hassett, A., & George, K. (2002). Access to a community aged psychiatry service by elderly from non-English-speaking backgrounds. *International Journal of Geriatric Psychiatry, 17*(7), 623–628.

Heerde, J. A., Toumbourou, J. W., Hemphill, S. A., Herrenkohl, T. I., Patton, G. C., & Catalano, R. F. (2015). Incidence and course of adolescent deliberate self-harm in Victoria, Australia, and Washington State. *The Journal of Adolescent Health, 57*(5), 537–544.

Hofstede Insights. (2018). *The 6 dimensions of national culture*. Retrieved 28 Dec 2018, from https://www.hofstede-insights.com/models/national-culture/.

Hsiao, F. H., Klimidis, S., Minas, H., & Tan, E. S. (2006a). Cultural attribution of mental health suffering in Chinese societies: The views of Chinese patients with mental illness and their caregivers. *Journal of Clinical Nursing, 15*(8), 998–1006.

Hsiao, F. H., Klimidis, S., Minas, H. I., & Tan, E. S. (2006b). Folk concepts of mental disorders among Chinese-Australian patients and their caregivers. *Journal of Advanced Nursing, 55*(1), 58–67.

Huang, H.-Y. (2020). Psychiatry and mental health in post-reform China. In H. Minas (Ed.), *Mental health in China and the Chinese diaspora: Historical and cultural perspectives*. New York: Springer.

Ide, N., Kolves, K., Cassaniti, M., & De Leo, D. (2012). Suicide of first-generation immigrants in Australia, 1974-2006. *Social Psychiatry and Psychiatric Epidemiology, 47*(12), 1917–1927.

Jin, K., Gullick, J., Neubeck, L., Koo, F., & Ding, D. (2017). Acculturation is associated with higher prevalence of cardiovascular disease risk-factors among Chinese immigrants in Australia: Evidence from a large population-based cohort. *European Journal of Preventive Cardiology, 24*(18), 2000–2008.

Kirmayer, L. J., & Ryder, A. G. (2016). Culture and psychopathology. *Current Opinion in Psychology, 8*, 143–148.

Kliewer, E. (1991). Immigrant suicide in Australia, Canada, England and Wales, and the United States. *Journal of the Australian Population Association, 8*(2), 111–128.

Klimidis, S., Lewis, J., Miletic, T., McKenzie, S., Stolk, Y., & Minas, H. (1999a). *Mental health service use by ethnic communities in Victoria: Part I, Descriptive report*. Melbourne, Victorian Transcultural Psychiatry Unit.

Klimidis, S., Lewis, J., Miletic, T., McKenzie, S., Stolk, Y., & Minas, H. (1999b). *Mental health service use by ethnic communities in Victoria: Part II, Statistical tables*. Melbourne, Victorian Transcultural Psychiatry Unit.

Klimidis, S., Hsiao, F. H., & Minas, I. H. (2007). Chinese-Australians' knowledge of depression and schizophrenia in the context of their under-utilization of mental health care: An analysis of labelling. *International Journal of Social Psychiatry, 53*(5), 464–478.

Krupinski, J. (1984). Changing patterns of migration to Australia and their influence on the health of migrants. *Social Science and Medicine, 18*(11), 927–937.

Lenzi, M., Colucci, E., & Minas, H. (2012). Suicide, Culture, and Society from a Cross-National Perspective. *Cross-Cultural Research, 46*(1), 50–71.

Leung, C. (2002). Factors related to the mental health of elderly Chinese immigrants in Australia. *Australian Journal of Primary Health, 8*(2), 48–53.

McDonald, B., & Steel, Z. (1997). *Immigrants and mental health: An epidemiological analysis*. Sydney: Transcultural Mental Health Centre.

Minas, H. (2017). Developing effective mental health services for multicultural societies. In D. Bhugra & K. Bhui (Eds.), *Textbook of cultural psychiatry*. Cambridge: Cambridge University Press.

Minas, H. (2020). Mental health of Chinese international students. In H. Minas (Ed.), *Mental health in China and the Chinese diaspora: Historical and cultural perspectives*. New York: Springer.

Minas, H., & Hall, T. (unpublished). *Public inpatient mental health service use by culturally and linguistically diverse populations in Australia*.

Minas, H., Klimidis, S., & Kokanovic, R. (2007a). Depression in multicultural Australia: Policies, research and services. *Australia and New Zealand Health Policy, 4*, 16.

Minas, H., Klimidis, S., & Tuncer, C. (2007b). Illness causal beliefs in Turkish immigrants. *BMC Psychiatry*, 7.

Minas, H., Klimidis, S., Ranieri, N., & Stuart, G. W. (2008). Relative prevalence of psychological morbidity in older immigrants. *International Journal of Culture and Mental Health, 1*(1), 58–72.

Minas, H., Kakuma, R., Too, L. S., Vayani, H., Orapeleng, S., Prasad-Ildes, R., Turner, G., Procter, N., & Oehm, D. (2013). Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion. *International Journal of Mental Health Systems, 7*(1), 23.

Morrell, S., Taylor, R., Slaytor, E., & Ford, P. (1999). Urban and rural suicide differentials in migrants and the Australian-born, New South Wales, Australia 1985-1994. *Social Science & Medicine, 49*(1), 81–91.

Museum of Victoria. *History of immigration from China*. From https://museumsvictoria.com.au/origins/history.aspx?pid=9.

Parker, G., Cheah, Y.-C., & Roy, K. (2001a). Do the Chinese somatize depression? A cross-cultural study. *Social Psychiatry and Psychiatric Epidemiology, 36*, 287–293.

Parker, G., Gladstone, G., & Chee, K. (2001b). Depression in the Planet's Largest Ethnic Group: The Chinese. *American Journal of Psychiatry, 158*, 857–864.

Parker, G., Chan, B., Tully, L., & Eisenbruch, M. (2005). Depression in the Chinese: the impact of acculturation. *Psychological Medicine, 35*(10), 1475–1483.

Reid, A. (2012). Under-use of migrants' employment skills linked to poorer mental health. *Australian and New Zealand Journal of Public Health, 36*(2), 120–125.

Sawrikar, P., & Hunt, C. J. (2005). The relationship between mental health, cultural identity and cultural values in non-English speaking background (NESB) Australian adolescents. *Behaviour Change, 22*(2), 97–113.

Steel, Z., McDonald, R., Silove, D., Bauman, A., Sandford, P., Herron, J., & Minas, I. H. (2006). Pathways to the first contact with specialist mental health care. *Australian and New Zealand Journal of Psychiatry, 40*, 347–354.

Stolk, Y., Minas, H., & Klimidis, S. (2008). *Access to mental health services in Victoria: A focus on ethnic communities*. Melbourne: Victorian Transcultural Psychiatry Unit.

Stuart, G. W., Klimidis, S., & Minas, I. H. (1998). The treated prevalence of mental disorder amongst immigrants and the Australian-born: Community and primary-care rates. *The International Journal of Social Psychiatry, 44*(1), 22–34.

Suryadinata, L. (2004). Chinese migration and adaptation in Southeast Asia: The last half-century. In A. Ananta & E. N. Arifin (Eds.), *International migration in Southeast Asia*. Singapore: Institute of Southeast Asian Studies.

Tang, G. W.-G., Dennis, S., Comino, E., & Zwar, N. (2009). Anxiety and depression in Chinese patients attending an Australian GP clinic. *Australian Family Physician, 38*(7), 552–555.

Taylor, R., Morrell, S., Slaytor, E., & Ford, P. (1998). Suicide in urban New South Wales, Australia 1985-1994: Socio-economic and migrant interactions. *Social Science & Medicine, 47*(11), 1677–1686.

Thompson, S., Manderson, L., Woelz-Stirling, N., Cahill, A., & Kelaher, M. (2002). The social and cultural context of the mental health of Filipinas in Queensland. *Australian and New Zealand Journal of Psychiatry, 36*(5), 681–687.

VicHealth. (2007). *Mental health impacts of racial discrimination in Victorian culturally and linguistically diverse communities – Experiences of Racism survey – A summary*. Melbourne: Victorian Health Promotion Foundation.

Wagner, R., Manicavasagar, V., Silove, D., Marnane, C., & Tran, V. T. (2006). Characteristics of Vietnamese patients attending an anxiety clinic in Australia and perceptions of the wider Vietnamese community about anxiety. *Transcultural Psychiatry, 43*(2), 259–274.

Wan, Y. H., Hu, C. L., Hao, J. H., Sun, Y., & Tao, F. B. (2011). Deliberate self-harm behaviors in Chinese adolescents and young adults. *European Child & Adolescent Psychiatry, 20*(10), 517–525.

Wong, H. M., Leung, H. C. M., Chow, L. Y., Kam, W. K., & Tang, A. K. L. (2010). Prevalence of borderline personality disorder and its clinical correlates in Chinese patients with recent deliberate self-harm. *Journal of Personality Disorders, 24*(6), 800–811.

Wynaden, D., Chapman, R., Orb, A., McGowan, S., Zeeman, Z., & Yeak, S. (2005). Factors that influence Asian communities' access to mental health care. *International Journal of Mental Health Nursing, 14*(2), 88–95.

Yong, S., & Vosslamber, R. (2018). Race and tax policy: The case of the Chinese poll tax. *Journal of Australian Taxation, 20*, 147–164.

Youssef, J., & Deane, F. P. (2006). Factors influencing mental-health help-seeking in Arabic-speaking communities in Sydney, Australia. *Mental Health, Religion and Culture, 9*(1), 43–66.

Zhang, H., & Poston, D. L. (2019). The overseas Chinese communities in Southeast Asia and the Pacific. In H. Minas (Ed.), *Mental health in China and the Chinese diaspora: Historical and cultural perspectives*. New York: Springer.

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