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

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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.

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