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

Z. Gao (✉)
Department of Sociology and Anthropology, Simon Fraser University, Burnaby, BC, Canada

H. Minas (ed.), *Mental Health in China and the Chinese Diaspora: Historical and Cultural Perspectives*, International and Cultural Psychology,
https://doi.org/10.1007/978-3-030-65161-9_4

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.