

Introduction

This book offers an ethnographic account of emotion-related disorders as they are understood, experienced, and treated in the clinics of Chinese medicine or *zhongyi* 中医 in contemporary China. Central to this enquiry is a *zhongyi* category of illness, *qingzhi bing* 情志病 or *qingzhi lei jibing* 情志类疾病 (emotion-related disorders),¹ attributable to disordered emotions and treatable with ordinary Chinese medical therapies. What needs to be emphasized from the very beginning is that *qingzhi bing* is not a direct translation of the Western psychiatric concept of “emotional disorder” or “mental disorder.” Not a strictly defined discrete illness entity in a biomedical sense, the *zhongyi* construct is used somewhat loosely to include a group of illness patterns, originating from “internal damages attributable to excessive emotions” (*qingzhi neishang* 情志内伤) and marked with certain configurations of physical, emotional, and behavioral symptoms. While to group disorders predominantly involving emotions and thoughts under the heading of *qingzhi* is nothing modern,² the meaning of *qingzhi* disorders encountered in today’s *zhongyi* clinics reflects ongoing social and political dynamics in contemporary Chinese society and changes in the profession of Chinese medicine itself through decades of the state-sponsored *zhongyi* modernization under the guidance of science. Biomedical terminology and technology are commonly present in contemporary *zhongyi* practices, yet the way in which a *qingzhi* disorder is conceptualized, experienced, diagnosed, and treated remains remarkably “Chinese.” It is not “culturally bound,” but certainly “permeated with culture.”³

THEORETICAL ORIENTATIONS

It is quite common for a medical anthropologist to imagine culture as a shared, unified set of beliefs and values that produce, cause, or govern and thus explain illness and health behaviors. The earlier studies of “culture-bound syndromes” exemplifies this approach, in which culture is seen as playing either a “pathogenic” or “pathoplastic” role in the manifestation of syndromes, such as *amok* and

latab in Southeast Asia.⁴ Most cross-cultural studies of psychiatric disorders in Chinese society also problematize the connections between cultural institutions and universal psychiatric disorders. The emphasis on harmonious family and interpersonal relationships is identified as the main factor that influences mental health in Chinese society.⁵ Arthur Kleinman's anthropological study of neurasthenia and depression in Chinese society is also typical. Traditional cultural values and norms are said to lead Chinese to suppress distressing emotions and somatize social and psychological problems, thus transforming a universal disease of depression into a culturally particular illness—neurasthenia.⁶

This "culture versus a universal disease" approach is problematic in several ways. First, local knowledge is measured against the Western conceptual categories understood as normative and universal; the difference is perceived as deviant from the norm and then explained by referring to local cultural beliefs and practices. Sometimes, the argument can go the other way around. A harmonious and therapeutic traditional culture is presented in contrast to disintegrated, alienating, and pathogenic modern society.⁷ Either reflects the same orientalist imagination that constructs a cultural other "in terms of specifically Western discursive categories."⁸ Second, as shown in recent medical anthropological studies, illness behavior and health-seeking strategies are complicated processes that respond to a complex of personal, social, and material exigencies and involve negotiating among diversified perspectives and resources available to patients and their families. To assume that people make rational decisions simply based on what they believe and explain the complexity of health and illness in terms of a few oversimplified cultural rules and beliefs offers an impoverished understanding of both culture and medicine.

My ethnographic account of emotion-related disorders in the context of Chinese medicine is informed by three different theoretical perspectives.

My approach to the Chinese experience of emotions and illness is inspired by the recent anthropological discourse of embodiment that locates culture in "the lived body" of everyday practice and directs analytical attention to the experiential aspect of culture in everyday life.⁹ Culture is not simply understood in symbolic or structural terms as representations or abstract structures detached from bodily performance and presence.¹⁰ Ethnographic writing has shown increased interest in "embodied culture." In her ethnography *Training the Body for China*, Brownell makes a compelling argument that "an ethnography account that overlooks the body omits the center of human experience."¹¹ Increasingly, medical anthropologists focus on "lived body" as a way to think and talk about illness and distress as they are experienced and to produce "experience-near" ethnographic accounts of suffering. Jenkins and Valient analyze the narratives of Salvadoran women to show *el calor* (heat) as a culturally specific body experience that is "existentially isomorphic with anger and fear."¹² Ots offers a semantic and phenomenological analysis of some of the most common symptoms presented in *zhongyi* clinics and explores the meanings of bodily perceptions both in *zhongyi* discourse and in patients' presentations. He

suggests that the Chinese experience of body and emotion provides insight into the correspondence of emotions and bodily manifestations in emotion-affected disorders, and that bodily organs or emotional metaphors in Chinese medicine, such as “the angry liver,” “the anxious heart,” and “the melancholy spleen,” “may serve as evidence for the role of the body in generating culture.”¹³

Desjarlais, in an ethnography based on his field experience among the Yolmo of Nepal, proposes an analytical approach that attends to the “surface imagery, felt quality, and embodied values intrinsic to moments of illness and healing.”¹⁴ In my writing of *qingzhi* disorders, I pay similar attention to felt quality of culture that informs and gives styles and meaning to Chinese experience of pain and malaise. By attending to aesthetics of body-person (*shenti* 身体) that ordinary Chinese are tacitly oriented to in their everyday lives, my study explores the interplay among the bodily sensibilities, *zhongyi* constructions, and local social processes and gives a sense as to how it might “feel” for someone suffering a *qingzhi* disorder and the feeling of the heart-emotion (*xinqing* 心情) blocked from flowing and extending freely.

My research also draws extensively from current language theories that give primacy to language use in its social context. As Good and Good argue, any approach to studying illness and medicine, especially cross-culturally, has to address meaning and thus is embedded in a particular theory of language.¹⁵ Ethnomedical research based on “emic” studies of folk nosologies¹⁶ and combining “emic” categories with “etic” measures of biosciences¹⁷ is grounded in the conventional theory of meaning¹⁸ that links a word to an object or a concept. The medical discourse is therefore seen as establishing connections between a patient’s pathological condition and a particular disease category. Accordingly, the meaning of a folk illness can be uncovered through a series of mappings, such as mapping “emic” symptom expressions onto the indigenous categories of illnesses, then onto the underlying physiological process, and finally onto the “etic” diagnostic entities of scientific medicine.¹⁹ This referential approach to meaning and its application for cross-cultural comparisons have been faulted for its serious limitations in accounting for meanings in particular sociocultural contexts. As noted by many medical anthropologists, illness realities are never merely reflections of human biology but are socioculturally constituted and therefore need a different articulation of meaning.

Byron Good, in his study of “heart distress” in a small town in Iran, systematically records the domains of meaning associated with core symbols and symptoms in medical lexicon and reveals a configuration of meanings that associate old age, sorrow and sadness, ritual mourning, poverty, worries and anxiety, blood problems, and so on. He argues that “such a syndrome is not merely a reflection of symptoms linked with each other in natural reality, but a set of experiences associated through networks of meaning and social interaction in a society.”²⁰ This conception of medical language directs research attention to the creative use of medical discourse in articulating experience of social distress and in negotiating meanings of suffering. Adding a critical dimension to this

meaning-centered approach, some medical anthropologists argue that cultural analysis of illness and medicine have to take into consideration sociopolitical dimensions of power, interest, and resistance.²¹ For these medical anthropologists, healing is also an ideological practice, and medicine can be analyzed as part of the social order, which also engages itself in the process of objectification and mystification of social facts, specifically, the process of medicalization of social problems and political oppression.²² In her analysis of the disorder of nervosa among impoverished shantytown dwellers in northeast Brazil, Scheper-Hughes points to multiple meanings associated with the illness, such as a refusal of “demeaning and debilitating labor” and a response to violence and tragedy in everyday life.²³ Similarly, Kleinman & Kleinman analyze illness narratives of Chinese patients suffering chronic pains and emotional disorders to show the connection between physical complaints and political violence, personal or collective demoralization and delegitimization.²⁴

My own research is aligned with the above outlined meaning-centered enterprise of medical anthropology but goes beyond the symbolic and semiotic dimensions of meaning by including interactive aspects of actual clinical encounters. If it is agreed that talking is an act that is socially effective, the interactive dimensions of social discourse—how a person presents and evaluates his/her own experience and how he/she is interpreted, understood, and responded to by others—offers a practical and useful way for understanding local experience in everyday life. Various medical discourse analyses, for example, demonstrate that a close examination of “talk” could be an effective tool to explore how illness realities are actually constructed and social roles and relations are enacted through clinical interactions.²⁵ Taking *zhongyi* clinical encounters as real-time sociolinguistic events, my ethnographic research incorporates microanalytical concepts and methods developed by various discourse analysis scholars²⁶ in examining interactive exchanges between doctors and patients during the routine clinical process of “looking at illness” (*kanbing* 看病) to trace and demonstrate how and at what point various clinical decisions were made and therapeutic transformations achieved. From this perspective, culture is examined as local processes and resources that members are oriented to from different subject positioning and that are evoked by the members in everyday social interactions to negotiate with and make sense of one another. It is in this mundane practice that culture is confirmed, contested, destabilized, and transformed.

Finally, contemporary *zhongyi* scholar-physicians see their profession as built upon “a unique body of medical theories” (*dute de yixue lilun tixi* 独特的医学理论体系) that is deeply rooted in “ancient [*gudai* 古代] Chinese people’s scientific practice and philosophical thinking.” In other words, Chinese medicine not only is grounded in collectively accumulated practical experience (*jin-yan* 经验) but also owes as much to particular ways of thinking and theorizing. Classic Chinese philosophy and medical reasoning employ the same language, such as *yin-yang* and *wuxing* 五行 (five transformative phases) interactions and correlations as well as *qi* 气 (vital energy) transformations. This language evokes

a world of transformation, in which myriad things and events are constantly in motion and extension and changes are seen as resulting from inherent complementary and contradictory *yin-yang* dynamics rather than resorting to any transcendental power or force essential in the Western intellectual traditions.²⁷ This particular way of philosophizing and theorizing is very much present in contemporary *zhongyi* texts and clinical reasoning under the name of rephrased “simple materialism and dialectic thinking” (*pusu weiwuzhuyi he bianzhengfa sixiang* 朴素唯物主义和辩证法思想). Any interpretation of Chinese medicine then has to be aware of the fundamental difference of the intellectual environment that has bred and nourished Chinese medicine and to be informed by classic Chinese cosmological assumptions distinctive from those underlying modern scientific thinking.²⁸

It is this enriched meaning-centered interpretive approach combining analysis of local, interactive, and embodied meanings with a sensitivity to the epistemology and with a “civilization awareness”²⁹ that provides the general conceptual and methodological orientations of this book. It explores how indigenous Chinese medical concepts and knowledge related to *qingzhi* and its disorders are constructed, explained, and embodied in everyday *zhongyi* clinical practices and experiences. It also examines the interactive dimensions of medical and social discourse of *qingzhi* illnesses and analyzes how the *zhongyi* discourse links the illness construction to expressed and tacit cultural orientations, and how this indigenous illness category that recognizes simultaneously bodily, mental-emotional, and social experience in the illness provides meaningful forms of suffering for Chinese patients. Although I do not resort to reductive, objective, and standardized categories of comparison, I nevertheless see my study as comparative. For the ethnographic work to grasp the meaning of the “lived” life of a people and to convey it effectively to a reader who is linguistically and culturally alien to that people, the comparativeness must be already immanent in the ethnographic translation itself.

TOPIC ORIENTATIONS

Does Chinese medicine treat disordered emotions or emotional distresses? Contemporary *zhongyi* physicians seem unequivocal about Chinese medicine’s role in treating disordered emotions. They insist that *zhongyi* has always paid considerable attention to emotional or psychosocial aspects in illness and health, and they could cite numerous examples from *zhongyi* classics to support this claim.³⁰ My own observations in Beijing confirmed that Chinese patients do habitually seek help in *zhongyi* clinics for what, in the West, might be considered psychological distress or a psychiatric disorder.³¹ Typically, patients present their complaints in “bodily language,”³² yet without denying affectivity as a source of their suffering. They take herbal remedies or other “traditional” forms of treatment³³ and claim to feel much better (*haoduo le* 好多了). Both patients and doctors of Chinese medicine with whom I interacted in Beijing insisted

that *zhongyi* enjoys a special efficacy with such “functional disorders” (*gongneng xing jibing* 功能性疾病), while *xiyi* 西医 (literally, “Western medicine,” referring to the biomedicine practiced in modern China) shows no effective means in treating such illnesses.

Yet, the question remains a problematic issue for anthropologists and scholars of Chinese medicine. For some, the topic is a slippery terrain that is better to be circumvented. The underlying concern is that Chinese medicine does not presuppose a dualistic separation of mind and body, nor does it typically make a categorical distinction between psychological and physical disorders,³⁴ therefore any discussion of *zhongyi* focusing on emotion inevitably makes modern clinical psychology or psychiatric medicine a comparative reference, thus imposing on Chinese medicine the structure of the Western biomedical model that typically views diseases as having a separate ontology as if they are either “in the body” or “in the mind.”³⁵

This is a legitimate concern. The ordinary Chinese terms for body, mind, and emotion do not evoke a simple divide between the physical and the psychological. *Shenti*, a word with a connotation of “person” and “self,” is much more active and intentional than body, which etymologically is in English a physical “container” devoid of the mind.³⁶ *Shenti* is both physical and extraphysical, capable of feeling, perceiving, creating, and resonating or embodying changes and transformations in the social world as well as in the natural world. It is the world: at the same time, emotive, moral, aesthetic, and visceral. Neither is *jingshen* 精神³⁷ an equivalent to soul or spirit in English. It does not imply a disembodied mentality or a higher order of existence. In fact, *jingshen*, the combination of two characters of *jing* 精 (concentrated basis of vitality) and *shen* 神 (vitality as manifested through functional activities of mind and body), suggests a dynamic and inseparable relationship in the lived world of mind-body. Similarly, *xin* 心 is both heart and mind; *qingzhi* is also a process both mindful and visceral. These are not considered as essentially different kinds of existence³⁸ but different in functions or manifestations that are temporal and contingent.

In other words, the domains of body, mind, and emotion are mutually penetrating and activating. Such correlativity is embodied in the most mundane levels of everyday life, in the patterns and rhythms of work, exercising, eating, sleeping, and becoming ill and being healed. Apparently, Chinese medicine heals *qingzhi* disorders in a world that is not consistent with the epistemological structure of the Western biomedical model of knowing and practice.³⁹ Its practical logic involves a language of “bodies” in dynamic process and constant transformation and a language of relations. The *zhongyi* language of *yin-yang*, *jing* (concentrated basis for vitality), *qi* (vital energy), *shen* (vitality), *zangfu* 脏腑 (the visceral systems), *jingluo* 经络 (meridian tracts), has its roots in a distinctive cultural tradition and a unique history and evokes a different sense and experience of order and disorder. Its cultural and therapeutic efficacy evolves through a process of attuning (*tiao* 调), which in different clinical contexts is demonstrated as the actions of reordering (*li* 理), unblocking and freeing

(*tong* 通), calming and neutralizing (*ping* 平), harmonizing and mediating (*he* 和) releasing and dissolving (*jie* 解), and so on.

Therefore, language itself becomes problematic and a subject of focus for this book. It seeks to understand *qingzhi* disorders as they are treated in the clinics of a *zhongyi* hospital on its own terms. In the words of my *zhongyi* teacher in Beijing, that means not to use a Western scientific way of thinking (*siwei fangshi* 思维方式) to frame *zhongyi* theory and practice but to understand how it really works within the relations between its own theory and practice (*zishen lilun he shijian de guanxi* 自身理论和实践的关系). The primary concern is not only to translate the relevant terms and concepts but also to make sense of a distinctive embodied experience of being ill and being healed.

For many scholars engaged in cross-culture psychiatric studies in Chinese society, *zhongyi*, because it does not recognize the separation of the mental from the physical, not only does not offer a legitimate way to treat an emotional distress but also exerts a negative cultural influence on developing a modern mental health care system for China.⁴⁰ Previous cross-cultural psychiatric and medical anthropological research on emotional distress and disorders was mostly carried out in the Western psychiatric context in Chinese society using biomedical models as the standard for comparative investigations.⁴¹ Studies of this paradigm, in general, fail to assign any significant meaning to Chinese medicine in treating emotion-related disorders. They tend to interpret the way Chinese present, experience, and seek help for emotion-related disorders in terms of cultural beliefs and norms that emphasize somatic experience, “cognitive coping strategies” that patients and families employ to cope with highly stigmatized dysphoric affects, or simply cognitive and linguistic deficiency in expressing feelings.⁴² In short, it is conceptualized as “somatization,”⁴³ a cultural process that transforms “an essential psychological event into a secondary somatic expression.”⁴⁴

Somatization has been seen as “a basic feature of the construction of illness in Chinese culture”⁴⁵ and for some time was alleged to be a “culture-specific trait typical of the Chinese people.”⁴⁶ *Zhongyi* language is said to lack explicit terms for the description of emotional states and contributes to the somatization of affective illness among Chinese.⁴⁷ Tseng, too, argues that the characteristics of Chinese medicine, such as emphasis of visceral organs and the concepts of “exhaustion,” “weakness,” and “emptiness,” strongly influence Chinese psychiatric patients.⁴⁸

This book shares the cross-cultural psychiatric interest in emotion-related disorders in Chinese society; however, my research is of a different type. It is situated in a context of Chinese medicine, in which the basic psychiatric conception of “mental” versus “physical,” “emotion” versus “cognitive,” or “illness entity” versus “illness behavior” is questionable. I question applicability of the concept of somatization in Chinese experience. In fact, Chinese psychiatrists in actual clinical settings have no difficulty making connections between bodily and emotional changes as Chinese medical doctors habitually do. They agree

that symptom expression, be it somatic or psychological, depends on how the individual experiences these changes at the specific moment and that Chinese patients do not limit their complaints to a somatic mode but present psychological and emotional symptoms too.⁴⁹ I also question the soundness of any national or community-based mental health policy and service in China that excludes *zhongyi* from playing an active role despite the fact that Chinese people routinely utilize *zhongyi* themselves in their fight against the illnesses allegedly emotional or mental according to the biomedical model.⁵⁰

My study lies outside the paradigm of cross-culture psychiatry and asks different questions. *Zhongyi* doctors in the past and present do not have to resort to the underlying assumption of modern psychiatry—the dichotomy of mind and body—in order to understand and treat the disorders that predominantly involve emotions and thoughts. This does not mean that *zhongyi* clinicians have been unable to see the distinctions,⁵¹ but rather their epistemological and professional “bias” emphasizes interconnections among emotions, thoughts, and various visceral systems. These underlying connections are actively explored by them as sources for fighting illnesses, physical as well as emotional. To *zhongyi* clinicians, disordered emotions or thoughts can have physiological consequences and vice versa, and a clinical intervention may start from either end or both. Then the questions are Does *zhongyi*’s distinctive approach to disordered emotions and thoughts have any therapeutic value in contemporary China? If the answer is yes, how does it actually work clinically today? Can *zhongyi* be incorporated as effective resources into the national and community programs and services to improve mental health care for Chinese people? There is an applied dimension implied in this book. It shows that *zhongyi* has a unique role to play in its care for the emotionally ill and that social and mental health facilities can benefit from *zhongyi*’s participation.

In my study, *qingzhi* disorder is seen as a *zhongyi* construct, complete and valid in itself, not a culturally mediated version of a “real” psychiatric disease. It is an ethnographic research without psychobiological measurements. Throughout the book, *qingzhi* disorder remains a Chinese experience: a meaningful form of suffering for those who seek to balance and to put back in order their upset world of *shenti* (body-person). Surely it is possible to compare *qingzhi* disorder with relevant psychiatric constructs of depression or anxiety, yet it requires a different type of research that goes beyond the frame and the scope of this book.

This book is not meant to offer a comprehensive account of the practice of Chinese medicine in contemporary China. Yet it is helpful to situate my own ethnographic investigation of *qingzhi* disorders in relation to some of the recent anthropological studies of Chinese medicine in contemporary China.

In the early 80s, Judith Farquhar spent eighteen months studying and conducting participant observation at the Guangzhou College of Traditional Chinese Medicine. Her book *Knowing Practice: The Clinical Encounter of Chinese Medicine* (1994) is based primarily on this experience. In the book, Farquhar

discusses in great detail the process of “looking at illness” (*kanbing* 看病) in *zhongyi* clinical encounters and the practical logic of this process, which a *zhongyi* practitioner has to follow in order to effect healing. My study is indebted to her insights in clinical encounters of Chinese medicine, and I benefit from her discussions on the epistemological incompatibility between the biomedical sciences and Chinese medicine.

A number of factors set my study apart from hers. Farquhar makes extensive use of *zhongyi* textbooks and published cases for her analysis. My own study focuses mostly on the actual clinical work with all of its interactive implications. Second, the process of *kanbing* is understood as the process of doctor and patient looking at illness together. Farquhar’s analysis is more directed to the professional point of view, that is, what a doctor needs to know in order to effect a cure. My study that takes a face-to-face interaction as a strategic site for understanding the clinical process presents both the professional and the patient’s perceptions and shows the role that the patient plays in both the diagnosis and the healing. Finally, my focus is on *qingzhi* disorders where affective factors in Chinese medicine have received an ultimate attention, while in Farquhar’s study, affectivity is not a topic of concern.

Any writing of Chinese medicine in contemporary China will inevitably confront the issue of plurality. Diversity is observable at every level of Chinese medical discourse and practice. The heterogeneity of Chinese medicine in the past and present has been widely described and commented on by scholars mostly in the West.⁵² Chinese sources tend to take *zhongyi* pluralities for granted and see little need for further justification, whereas unity or uniformity is seen as something that needs to be established. Scholar-physicians of different schools in the past found their identity by tracing their professional genealogies to *Huangdi Neijing* 黄帝内经 (Yellow Emperor’s Inner Classics), *Shanghan Lun* 伤寒论 (Discussions of Cold Damage), and other canonical texts, and to great masters in the history of Chinese medicine. For contemporary *zhongyi* scholars, there is not only a need to show continuity of their profession from the past but also a pressure to demonstrate its alignment with modern science. Interestingly, while the process of standardization (*guifanhua* 规范化) or systemization (*xitonghua* 系统化) based on biomedical models has significantly transformed the face of *zhongyi* organization and practice, original styles, personal experience, and individual virtuosity are continuously valued in the profession and deliberately sought by patients. In a sense, the participation of biomedicine adds more dimensions to the existing pluralities of Chinese medicine.⁵³

Scholars of Chinese medicine in the West, from a different background in which existence of the objective truth is presupposed, are more likely to feel a compelling need to explain and justify diversity in Chinese medicine. In Elisabeth Hsu’s ethnography, *The Transmission of Chinese Medicine*, the plurality is embedded in the transmission of knowledge in contemporary Chinese medicine. She shows that medical knowledge acquired through different modes

of transmission and within different social relationships is understood and “known” differently. She describes three different modes of knowledge transmission in correspondence with three distinctive social settings, namely, the transmission of “secret knowledge” within a master-disciple relationship, “the personal transmission of knowledge” between a mentor and a follower characteristic of classical scholarship, and “the standardized mode of transmission” in the context of modern classroom learning.⁵⁴ Volker Scheid takes plurality and diversity as the main thesis of his book, *Chinese Medicine in Contemporary China: Plurality and Synthesis*, which examines “a plurality of agencies and processes involved in the shaping of contemporary Chinese medicine,” including politicians and state, patients and physicians, classical scholarship and modern health care systems, institutions, networks, and training of *zhongyi* physicians.⁵⁵ In my own ethnography, plurality is not a topic but a context. I take Scheid’s conclusion that plurality is “an intrinsic aspect of contemporary Chinese medicine”⁵⁶ as a starting point and explore how multiple perspectives and sources of knowledge play out in an actual clinical process. In this sense, my case studies of *qingzhi* disorders should be read as an analysis of a microprocess of a local synthesis rather than as an attempt to provide a complete or comprehensive presentation of how *qingzhi* disorders are diagnosed and treated generally in clinics of Chinese medicine.

ETHNOGRAPHIC SETTINGS

After being away from China for about four years, I went back to Beijing in January 1994 to conduct a twelve-month fieldstudy for my ethnographic study on emotion-related disorders in the clinics of Chinese medicine, on which this book is based. However, my research for the book has continued beyond the original fieldwork through correspondence and interactions with *zhongyi* professionals and scholars both in and outside China, as well as subsequent visits to the original field sites and through reading the published literature on Chinese medicine.

For this anthropological research, I relied heavily on participant observation as well as semistructured and unstructured interviews with patients, doctors, and ordinary Chinese citizens, whom I came to know by different means and at different times. My own personal background as a Chinese native who grew up and was educated in China permitted me ready access to the Chinese cultural resources and social networks, which were very much needed in doing such research. Needless to say, however, the way I formulated my theoretical positions and interpreted the empirical data and the way in which I actually went about doing my interviews and observations bore the cultural and experiential marks of me as a Western trained native anthropologist.

My fieldwork took me to various hospitals and clinics of Chinese medicine in Beijing, but the major part of the clinical observation was carried out in one of the affiliated hospitals of the Beijing Academy of Chinese Medicine. The

hospital was built in the mid-1950s. Over the decades, it has been expanded and developed into one of the largest *zhongyi* hospitals as well as a major clinical research and teaching center for Chinese medicine in the Beijing area. Many physicians who work in the hospital divide their time among clinical work, research, and teaching. Clearly my ethnographic account of clinical encounters reflects the practice of this elite and professionalized Chinese medicine, which, as an integrated part of the national health care system, is sanctioned and closely supervised by the state.

The organization and management of the hospital resembles, in every important way, a modern biomedical hospital in Beijing. It consists of 24 clinical departments (*ke-shi* 科室), including *qigong* 气功 (breathing exercises for improving health or curing disease) and *zhenjiu* 针灸 (acupuncture and moxibustion) clinics that are not common divisions in most biomedical hospitals in China, and 13 labs and research departments of medical sciences and technology, which centrally reflect the policy of “using modern science and technology to conduct scientific research of traditional Chinese medicine.”⁵⁷ I chose Shenjing Ke 神经科 (Clinic of Neuropathic Disorders) as the primary site for my clinical observations.⁵⁸ Like many other structural categories in a modern *zhongyi* hospital, the name of Shenjing Ke itself came from the biomedical model in an attempt to establish greater authority in the culture of modern science. The reason I chose Shenjing Ke as the base of my research is mainly because it has a large concentration of patients with *qingzhi* disorders. When referring to an illness, ordinary Chinese do not typically make distinctions between “of nerves” (*shenjing* 神经) and “of mind or spirit” (*jingshen* 精神). Chinese use “neurological disorder” (*shenjing bing* 神经病) casually to mean “mental illness” (*jingshen bing* 精神病). The doctors I worked with in this particular clinic estimated that about 75 % of their patients who came to seek medical help suffered a *qingzhi* related disorder. In addition, the director of the clinic is recognized as an expert in treating such disorders, especially, stagnation syndrome (*yuzheng* 郁证), in which I was particularly interested.

I was introduced to the head of the clinic, who is a senior doctor known for his efficacy in treating *qingzhi* disorders, through a mutual friend. At our first meeting, he emphasized that *zhongyi* and *xiyi* (Western biomedicine) are of two different “ways of thinking” (*siwei fangshi* 思维方式) and that I should be cautious not to interpret *zhongyi* simply in terms of Western scientific categories and language. According to him, a good understanding of *zhongyi* requires a completely different language, and it takes time to slowly “understand through direct experience” (*tihui* 体会) *zhongyi* theories and practices. I could not agree more with this advice. A good rapport between the senior doctor and me started from this straightforward conversation. I was later given permission to do participant observations in his clinic. In an anthropological expression, I was “adopted” into the community by assuming a student role. The doctor took it to be his responsibility to see that I really understood Chinese medical concepts and clinical actions so that I would not misrepresent Chinese medicine in

my research. I followed the doctor in his clinic for about ten months like one of his student doctors, though I did not wear their uniform. As a result, I became familiar with his colleagues working in the same consulting room, his graduate students, and some of his patients. Most of all, I gained considerable *tibui* of Chinese medicine. Toward the end of my fieldwork, my doctor friends told me that I used their language and asked “correct” questions, and they joked that I could even open a clinic of Chinese medicine myself some day.

During my clinical observations, I recorded more than four hundred cases. The procedure was to sit beside the doctor, take notes, and later with the participants’ permission to record clinical interactions. I was encouraged to move along with the clinical process, when appropriate, to feel a patient’s pulse, look at his/her tongue, and ask questions. Sometimes, the doctor would directly put me on the spot by suggesting that a patient talk with me, and he introduced me as an anthropologist doing a research project on emotion-related disorders. Only a few patients actually agreed to sit down for an interview. Most patients would simply decline the invitation citing various reasons. Most of my interviews of patients were semistructured and took place outside the clinical room. The questions centered on the informants’ illness history and experience as well as their *zhongyi* knowledge. The purpose of my questions was to understand a patient perspective on his or her illness and the role of emotion in his or her illness experience and also to record patients’ narratives regarding how they coped with and accounted for or made sense of their sufferings, and why they chose to see a *zhongyi* doctor. My one disappointment was that I was not able to build up a closer rapport and have more in-depth interviews with the patients. Conducting an interview with a patient proved to be challenging and, sometimes, frustrating. Partly this was due to the clinical settings of my research. Patients came to the clinic for treatment because they were suffering. They had little time or interest in talking to a stranger, much less talking about their personal lives beyond their immediate concerns of their illnesses. I also felt little justified to probe into a patient’s personal life. In fact, *zhongyi* doctors are very subtle when coming to sensitive personal questions. I was told that a doctor should not probe into anything that a patient was deliberately avoiding talking about, because that could only add stress and anxiety to the patient and interfere with the efficacy of the therapy. This is especially a concern with patients who suffer from a *qingzhi* disorder. However, I was able to carry out lengthy and in-depth interviews with the patients whom I happened to know well and friends and relatives who suffered emotion-related disorders and sought Chinese medical treatment.

My experience with doctors was quite different. I saw them several times a week and had lunch with them at the hospital’s cafeteria. They were interested in my experiences in the United States. My interaction with them was informal and relaxed. Unstructured interviews were carried out with them whenever it was convenient. These interviews covered broad medical, social, cultural, and political topics, as well as personal experiences.⁵⁹

My participant observation also went beyond the major field site. Directly under the Ministry of Health, this hospital closely reflects the official policies to promote *zhongyi* to a modern scientific realm and to explore ways to combine Western and Chinese medicines. In terms of funding and other forms of government support, it has advantages over many other smaller hospitals. My experience in other Chinese medical institutions that are less prestigious provided a comparative perspective.

Coming back to the much changed neighborhood in the Haidian district where I used to live, I was impressed by the number of *zhongyi* clinics in the neighborhood. Within the area where I live, there were two *zhongyi* outpatient clinics with a Chinese pharmacy attached, a small *zhongyi* hospital, a *zhongyi* clinic within a community hospital, and a new *zhongyi* consulting room added to a health clinic. I frequented these smaller Chinese medical institutions, especially the small *zhongyi* hospital, which lay hidden in a small lane behind tall buildings. The hospital specialized in treating chronic and difficult diseases (*manxing yinan bingzheng* 慢性疑难病证) by combining Chinese and Western medicines (*zhong-xi yi jiehe* 中西医结合). I was surprised to find a *Jingshen Ke* 精神科 (mental health clinic) in this small hospital, which was not a common division in *zhongyi* hospitals. From the information provided in the various posters, pictures, and banners in this location, I recognized quite a few names of famous senior doctors (*laozhongyi* 老中医) and professors, who were invited to work part time there, while keeping their permanent positions in other hospitals and research or teaching institutes. Their presence made this small hospital popular. Some of my interviews with patients were carried out in this small hospital.

The economic reforms that gained momentum in the 1980s and the movement toward the free market system have changed the face of *zhongyi* practice in an important way. The new economic policies have encouraged the flow of *zhongyi* knowledge and practitioners from the large state institutions to smaller community clinics and private hospitals.⁶⁰ Not only do well-established senior doctors run their own private clinics, but the young graduates of *zhongyi* colleges and universities may also engage in sideline businesses.⁶¹ Between large state-sponsored institutions and smaller or privately owned practices, there is no strict boundary but a constant flow of knowledge and resources.

During my residency in Beijing, I stayed in a community where my parents lived and where families had known one another for a long time and shared many social occasions. In this community I was a true participant in every sense, visiting my neighbors, helping out and being helped, listening to gossip in the mail room, and talking to people while taking a walk in the neighborhood parks. Not only did I observe daily social and emotional interactions and actual management of emotional crisis and illnesses, but I was also sometimes part of that process. Former classmates, friends, and relatives were also valuable resources for my research. I was given access to their medical records and prescriptions and was allowed to accompany them to see a doctor. With them, I

carried out lengthy and in-depth interviews regarding their personal and emotional experience. I understood them and shared many of their worries, anxieties, confusions, and hopes.

THE FRAMEWORK OF THE BOOK

In this introduction, I have outlined some theoretical and conceptual considerations that are central to a cultural understanding of *qingzhi* disorders in contemporary practice of Chinese medicine and introduced the ethnographic subjects and settings. I situate my research in the anthropological discourse of body, emotion, illness, and medicine. I show how my study is related to and different from other relevant studies theoretically and empirically. Chapter 2 discusses the continuity and modern transformation of Chinese medicine. One purpose of this chapter is to historicize the form of *zhongyi* practice in contemporary China. It explores how the manifold historical events and forces since the late nineteenth century have been at work in shaping the traditional indigenous “*yi* (medicine)” into present day cosmopolitan *zhongyi*. This chapter also seeks to ground “modern” *zhongyi* in an epistemological tradition that approaches knowledge, theory, and practice differently from that of the modern Western science and that gives Chinese medicine a sense of continuity from its distant and recent past. Chapter 3 explores the Chinese world of body-person (*shenti*), through the analysis of cultural semantics and aesthetics of *shenti* embodied in the way Chinese talk about their body and experience the “loss of balance” (*shitiao* 失调) or “being in discord” (*weibe* 违和). I show that the way Chinese patients experience *qingzhi* disorders and the Chinese medical therapeutic process in healing them are profoundly embedded in the cultural sensibilities and the meanings of body, person, and society. In other words, the cultural aesthetics and values persistent in Chinese society are embodied and are thus particularly visible when the body-person is in “dis-ease.” Chapter 4, focusing specifically on the Chinese concept of “*qingzhi*” (emotion-mind), explores the sociocultural and ethnomedical contexts where *qingzhi* and disordered *qingzhi* are formulated, talked about, and experienced. Chapters 5 and 6 examine the meaning and the categorization of *qingzhi* disorders in relation to the *zhongyi* clinical process of “differentiation of syndromes and determination of therapies” (*bianzheng lunzhi* 辨证论治). Chapter 7 offers a close examination of an actual face-to-face clinical interaction, which shows how the syndrome of a particular *qingzhi* disorder is defined through ordinary clinical work and how the process of *tiao* (attuning) works to transform the patient’s experience. Finally, Chapter 7 offers some general conclusions based on previous analysis and discussions. It is evident that *qingzhi* disorders—illnesses resulted from disordered emotions and social difficulties—in contemporary Chinese medicine offer a meaningful form and a viable language for Chinese patients to make sense of their sufferings and a practicable regimen to manage a lived body that falls out of order.

Throughout the book, Chinese medicine is used interchangeably with *zhongyi* to refer to the professional Chinese medicine practiced in contemporary China and its classic form of scholarly medicine, from which the present day *zhongyi* has evolved and transformed. Accordingly, *xiyi* and Western medicine, its direct translation, are also used interchangeably to refer to the form of biomedicine practiced in modern China. Translation of Chinese medical terminology proves to be a difficult task. My translation does not follow one single source. Instead, I consulted various sources⁶² and decided on the ones I feel best reflect my understanding of the terms in the context. In other words, the translation itself may not be mine, but the choice is. Some Chinese terms are used untranslated, such as *qi* and *yin-yang*, which have been largely accepted as English words. For other commonly used terms that appear repeatedly in this book and of which no simple English translation is sufficient to capture an array of meanings, such as *qingzhi*, I tend to use the original Chinese term in *pinyin* transcript, which is supplemented with a suggested English translation at least when it appears for the first time in the chapter. Chinese characters of the term are also provided at least once in a chapter. I appreciate the challenge that this makes for non-Chinese readers, but I feel that it was important to include Chinese characters for those readers who read Chinese and depend on characters for specific meanings and sources of the terms.