

BIOPOLITICAL PATERNALISM AND ITS MATERNAL SUPPLEMENTS: Kinship Correlates of Community Mental Health Governance in China

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In November 2010, the *New York Times* published an article on the inadequacies of mental health treatment in China. It vividly described the “dearth of care” in the Chinese household:

Left to their own devices, some relatives resort to heartbreaking solutions. In 2007, He Jiyue, a government psychiatrist, discovered a 46-year-old man locked behind a metal door in a stinking room in a rural Hebei Province home. The man was mentally ill, his aged parents told Dr. He. They had locked him up after he attacked his uncle.

That was 28 years earlier. The man, a high school graduate, could no longer speak. “I said to the parents: ‘How could you do this to somebody?’” Dr. He recalled. They replied, “We had no choice.”

In the past three years, Chinese mental health workers have rescued 339 other people whose relatives were too poor, ignorant or ashamed to seek treatment. Some, shackled in outdoor sheds, were “treated just like animals,” said Dr. Liu Jin, of the Peking University Mental Health Institute. (LaFraniere 2010)

This tragic image of home confinement has been repeatedly invoked in both international and domestic media reports as the primary justification for an ambitious government-sponsored program, Unlock Action (*Jiesuo Xingdong*), that sought to eradicate the home confinement of seriously mentally ill patients.¹ The action led to a broader national community mental health program—the 686 Program—established by the Ministry of Health in 2004 and promoted in full force since 2010. Aimed at building a nationwide mental health infrastructure that extends beyond psychiatric hospitals and reaches patients living at home, the 686 Program trains general practitioners and nurses to visit patients regularly, monitor their symptoms and risks of violence, and offer them necessary treatment. Why is the establishment of community mental health services in China hinged on this image of mental health workers as heroic rescuers against ignorant family members? Why and how do some family members engage in home confinement and other practices denounced by the state?

KINSHIP CORRELATES OF CHINA'S COMMUNITY GOVERNANCE

From 2008 to 2014, I conducted thirty-two months of fieldwork on how families in China were involved in the lives of people diagnosed with serious mental illnesses (SMIs)—schizophrenia, bipolar disorder, or other disorders with predominant psychotic features—and how medical and legal institutions shaped those involvements. As part of this fieldwork, I interviewed national and local leaders of the 686 Program, reviewed archival and media sources about it, observed workshops that trained practitioners and family caregivers, shadowed practitioner visits to more than eighty households with SMI patients,² and independently interviewed many more patients and caregivers, mostly in a city in South China that I call Nanhua.³

Drawing on these data, this article examines the discourse and practice of community mental health in China, especially how it conceptualizes, mobilizes, and molds the family in relation to questions of care, risk management, and coercion. More broadly, this examination illuminates the interplay of the family and state power in contemporary China, including how the state deploys ideas of, and practices from, the family for its projects of governance, and how these projects in turn reshape family relations. As [Susan McKinnon and Fenella Cannell \(2013, 24\)](#) suggest, state power has “kinship correlates”—that is, “cultural understandings [and practices] about kinship, marriage, family, and relatedness [that] organize, inform, and naturalize what will count as the nation and citizenship.” Other scholars

have argued that kinship and gender should be analyzed together, since gender helps articulate systems of meaning and models of inequality in and beyond the household (Yanagisako and Collier 1987). Note that gender means not only socially constituted roles performed by different groups of people but also symbolic representations of masculine, feminine, or other qualities invoked by normative concepts and reinforced by social institutions, even when they are not exclusively tied to a particular group (Scott 1999). For instance, men can act maternally, a situation demonstrated in the evidence I present here. The present study thus also attends to how kinship correlates of state power become mediated by historically situated ideas and practices of gender.

In China, the ideology of state Confucianism, dominant for most of the imperial era, saw the family and the state as constructed on the same patriarchal principles. Like the father ruling the son, the emperor was to rule his subjects; motherly figures, meanwhile, were to provide compassion and nurturing (Hsu 1971; Wolf 1972). The Maoist regime downplayed the family, organizing people into collectives such as work units and rural communes. Meanwhile, following the Confucian legacy of paternalism, it fashioned itself as a parent state that safeguarded people's lives and livelihoods (Walder 1988), and it encouraged people to develop a direct paternal identification with the leader (Steinmüller 2015). During the market reform period that began in the late 1970s, political and popular discourses turned away from collectivization to cherish individualization. Families have again become a key social unit, this time to produce individual subjects and to protect them from fierce market competition and the retreat of public welfare. Scholars have noted that this "neo-familism" (Yan 2018) continues to reinforce male dominance, casting women as natural and primary caretakers (Harrell and Santos 2017). By examining how the 686 Program invokes and interacts with the family in the care of SMI patients, this article further explores how the family figures in state governance, especially how this process invokes both gendered notions of power and gendered practices of relation. As we shall see, historical legacies of paternal authority and maternal compassion continue to influence contemporary Chinese state governance, though with changing discursive and institutional conditions.

With the demise of work units in the 1990s, and the rising wealth disparity, social unrest, and public health crises of the new millennium, the Chinese state needed to find a new axis around which to organize and order the social. Loosely referring to various place-based or group-based networks of people, the notion of *community* provided a mechanism for this reorganization by dispersing the sites and proliferating the agents of governance, thereby reaching deep into everyday life

(Bray 2006; Zhang 2012; Tomba 2014). Community governance sees its subjects no longer as “the people”—a unified proletariat citizenry of the socialist state—but as “the population,” that is, a multiplicity of individuals who exist biologically and who need to be regulated to achieve an “optimal public” (Cho 2013). For instance, the community mental health program seeks to manage the risk of violence that SMI patients pose to the public. As such, community governance in China constitutes a form of biopolitics (Foucault 2009).

According to Michel Foucault (2009, 105), when population and security replaced sovereignty as the new focus of Euro-American governments in the eighteenth century, the family changed “from being a model to being a privileged instrument for the government” (also see Donzelot 1979). Anthropologists have also examined how families become entangled in biopolitics in other contexts (e.g., Biehl 2005; Cohen 1998). Building on these insights, this study explores how the family may work as a model, an instrument, and/or a product of the biopolitics of community governance. Indeed, as the Chinese state seeks to outsource the task of managing the population through community governance, the family becomes an effective site to which it can turn. For one, since the family can be seen either as a pristine private realm or as a basic social institution, its flexible positioning enables “the continual definition and redefinition of what is within the competence of the state and what is not” (Foucault 1991, 103). For another, community governance often entails various constructs of the subject and uses various techniques of power, ranging from expecting self-responsible individuals to manage themselves to disciplining intractable ones through coercive and carceral means (Rose 1996). As community agents and experts teach family members to interact with one another in specific ways, as they publicize certain family practices while keeping others private, they are reshaping the image and reality of the state in relation to its citizens. Moreover, as an idea and practice of difference, gender proves critical to revealing how the state draws flexible boundaries and negotiates intricate modalities of governance through the family.

My fieldwork shows that in China, the 686 Program constantly struggles between care, management, and coercion in its governance of people with serious mental illnesses. Two gendered kinship correlates stand in tension here. By exposing and intervening into home confinement as well as providing basic biomedical services to the general patient population, the program presents the state as a father caring for its vulnerable children. Meanwhile, the program portrays these same vulnerable patients as carriers of medical and security risks and demands that family members manage them. It equates care with risk management, defines

both biomedically, and assumes that caregivers can smoothly enact their familial paternalistic power to command patients' compliance. It is this interplay between the state's invocation of the paternalistic tradition to construct new public responsibilities for population management and its simultaneous privatization of that management through outsourcing care to families that I call "biopolitical paternalism." It marks the first kinship correlate of community mental health, and in the following I will demonstrate its workings in the 686 Program's history, discourse, and practice. I will then turn to the second kinship correlate—that is, the ways in which families supplement the program's biopolitical paternalism through compassionate practices coded as maternal and carried out mostly by women, practices that reveal the limits of medicalized care and the hidden edge of psychiatric coercion. By discovering and disentangling the dual kinship correlates at work, we can gain a fuller and more transformative understanding of community governance in contemporary China and beyond.

WHEN COMMUNITY MENTAL HEALTH MEETS FAMILIES: The Emergence of Biopolitical Paternalism

The Iron Cage and the Father State

During the Maoist era, mental health—like most other health-care services—was eclectic, inexpensive, and focused on primary care. Besides hospital psychiatrists and patients' families, many other local agents were also involved in the care of patients, and the goal was to return them quickly to revolutionary society (Kao 1979). With the introduction of market reforms in the 1980s, primary health-care services gradually collapsed. The limited state investments in health largely went into building big tertiary hospitals, which in turn charged clients exorbitant fees. As psychiatry became predominantly biomedical and pharmaceutical, it came to see patients with SMIs as carriers of chronic pathologies needing perpetual care *and* management. With the retreat of public welfare, the task of illness management disproportionately fell onto patients' family members. They either looked after patients at home or paid to have patients hospitalized, often involuntarily (Phillips 1998). In recent years, as human rights activists vigorously criticized the prevalence of involuntary hospitalization in China, psychiatrists have defended the practice as a manifestation of "state paternalism" (*guojia fuquan*), literally the power of the state to act as a father. According to this idea, although committing patients to an institution against their will might seem coercive, it actually demonstrated care for patients because they had no insight into their

own condition (Z. Ma 2014). This idea of state paternalism thus defined people's well-being biomedically as symptom control and elimination while requiring the state only to endorse, but not actually perform, the paternalistic responsibilities to help patients achieve this state of well-being.

Meanwhile, many psychiatrists whom I interviewed expressed frustration with the concentration of mental health care in a limited number of institutions, because they saw most patients' families as having little knowledge of or access to them. This went against the mission of mental health-care professionals to "serve the people"—a mission especially cherished by senior practitioners trained before the market reform. A golden opportunity for change emerged in the wake of the SARS epidemic in 2003. The inability of hospitals and health departments to handle the outbreak, resulting in lost lives, wealth, and public trust, made clear to the state that public health was crucial for maintaining its priorities of social stability and market productivity. Since then, the government has poured much money into constructing a public health system (Mason 2016). After a decade of development, this system now consists of a network of community health stations staffed by general practitioners and nurses who are subsidized by municipal governments to provide basic public health services. However, the state's renewed interest in public health was initially limited to preventing and controlling infectious diseases. How, then, could psychiatry share the spotlight and insert itself into this new wave of development?

My analysis of media reports and policy documents shows that psychiatrists and allied policy makers turned to the sensationalist image of home confinement, of the kind presented in the *New York Times* article quoted at the beginning of this essay.⁴ Such reports depict a crisis of care in which patients are treated like animals—wounded, disoriented, smelly, and filthy. Note that many of these reports do not portray confined patients simply as victims of family maltreatment. Rather, they emphasize the violence and disruption that those patients inflict on others because of their mental illness: they have allegedly beaten up their family members, damaged property, harassed neighbors and villagers, and even killed people (Cao 2013). As the *New York Times* article explains, family members often "had no choice" but to resort to home confinement, because they are "too poor, ignorant or ashamed to seek treatment." In other words, even though these reports depict home confinement as pure coercion, they see it as an ultimately understandable response to patient violence and to families' lack of access to health care.

Psychiatrists and allied policy makers have used the tragic image of home confinement to call for more government investments in mental health. In re-

sponse, the state has found a perfect opportunity to performatively demonstrate care for its citizens and to address the public outcry against the retreat of welfare and market deprivation. In the mid-2000s, under the banner of Unlock Action, many local governments sent psychiatrists and officials out into communities to find patients confined at home. The patients were freed from the homemade locks, chains, or cages, sent to the psychiatric hospital for treatment, and ideally returned home having recovered. Estimates suggest that the Unlock Action reached thousands of patients nationwide (Guan et al. 2015).

In reports of home confinement, as we can see in figures 1 and 2, the family member involved in confining the patient is often an old and weak parent, living with tears and a broken heart. In contrast, state agents leading the unlocking efforts are typically senior male doctors who bring patients from an animal state back to humanity by wielding the miraculous power of biomedicine. In figure 3, for example, against the background of a decrepit room and a rusty cage, the doctor appears bright and clean, like a beam of light that dispels darkness. His tall but slightly bent body, his smiling face, and the hand gesture accompanying his self-introduction suggest his authority, expertise, and kindness. On seeing him, the patient, who it must be assumed has been abject and disoriented, appears immediately lucid and attentive. If the patient resists the unlocking effort, as seen in figure 4, then doctors can easily overpower him and take him out of his chaotic lifeworld.⁵ In addition, psychiatric treatment is reported to restore the confined patients' capacity to recognize and relate to their family members—for example, by enabling a long-mute patient to greet his mother again (Jinan Shengkang Hospital n.d.). In all these accounts, psychiatrists—and the state they represent—appear to embody and enact a set of paternalistic power, knowledge, authority, and care to bring order to the patient and the family.



Figure 1. A forty-year-old patient restrained with chains by her mother for twenty-three years. Photo by Zhibing Zhong. <http://health.sohu.com/20110825/n352889530.shtml>.



Figure 2. A father showing the wounds on a tree his son inflicted with a knife during a psychotic episode. Since then he has confined his son at home.

Photo by Beijing News. <http://health.sohu.com/20130711/n381262203.shtml>.



Figure 3. A patient who has lived in a cage for ten years is rescued by hospital psychiatrists.

Photo by Beijing News. <http://health.sohu.com/20130711/n381262203.shtml>.

At the same time, the emphasis on the past or potential violence of the mentally ill patient in the image of home confinement posits SMIs as urgent a threat to public safety as infectious diseases. This has helped to insert mental health into the country's growing public health apparatus. Moreover, since the late 1990s, with



Figure 4. Doctors carry an unchained patient to the hospital while he is kicking and screaming. Photo by Qilu Net. <http://yx.iqilu.com/2016/0623/2862679.shtml#10>.

the rise of socioeconomic inequalities and popular unrest, the Chinese state has shown an increasing obsession with monitoring and eliminating any actual or potential threat to its governance and to general social stability. It has thus come to spend the largest proportion of its budget on “stability-maintenance” (*weiwen*) work (Lee and Zhang 2013). Several leading psychiatrists told me that the violent aspect of mental illnesses had to be highlighted to gain resources from the stability-maintenance apparatus. The image of home confinement provides a potent discursive tool for this purpose. In turn, managing the risk of patient violence has preoccupied the design and operations of community mental health.

Constructing the Paternal Family

The Unlock Action spurred a broader community mental health program in China. In 2004, the Ministry of Health established the National Hospital-Community Integrative Treatment and Management Program for SMIs, also known as the 686 Program, because it was initially funded by RMB 6.86 million (about USD 1 million) in state revenue. The 686 Program’s main goals, as stated by its leaders, are “to establish an effective mechanism to comprehensively prevent and control the violent behavior of patients with SMIs; to enhance the treatment rate and reduce the violence rate; to disseminate knowledge of mental illness prevention and treatment; and to spread the knowledge of systematic treatment of SMIs” (H. Ma

et al. 2011, 726). In other words, the program connects the prevention and treatment of SMIs to the management of patient violence. Note that the program is not aimed at ending or reducing psychiatric institutionalization, as community mental health programs in Euro-American countries were historically, but at strengthening institutions and connecting them to community treatment. Thanks to psychiatrists' successful strategy of linking patient management to stability maintenance, government support for the program has steadily increased, and especially since 2010, the program has been rolled out across the country aggressively. Most urban and rural communities now have primary care physicians or nurses working as community mental health practitioners (CMHPs) to manage patients.

Before the advent of the 686 Program, the state only endorsed and enabled the family's paternalistic practices such as involuntary hospitalization chiefly to promote the biomedically defined well-being of individual patients. In the face of the severe lack and disparity of mental health care, the 686 Program fashioned itself as the father state directly caring for individuals in dire need and restoring proper familial authority. Indeed, although the sweeping scale of Unlock Action has abated, the program still requires CMHPs to watch for cases in which caregivers "lock up or chain" patients "for non-medical purposes," to report these occurrences, and to stop them by sending the patient for free hospital treatment (Ministry of Health of the People's Republic of China 2012). After the Unlock Action, the program has expanded its focus to the general SMI patient population, providing them with services such as free basic psychopharmaceuticals and physical checkups.⁶ Community mental health practitioners have the task of connecting patients to these services by organizing community clinics with hospital psychiatrists and conducting routine home visits themselves.

Meanwhile, as government support makes the 686 Program increasingly preoccupied with patient violence, the state now also expects and demands that families act paternalistically for the biopolitical task of population management, for the state's security interests. This task of population management is first put on CMHPs. Many of them have said that no matter how hard they work, they would be held accountable—such as failing their yearly evaluation—if one patient they manage wound up doing something publicly violent (J. Zhu et al. 2018). However, even with increased government support, the country faces a severe shortage of CMHPs, so that one practitioner has to oversee as many as a few hundred patients. Under these circumstances, the 686 Program has come to outsource its care and management tasks back to family members, albeit now with professional state supervision. In Nanhua, for instance, CMHPs typically ask patients' family

members—not the patients themselves—to visit community clinics to receive the medications, so that they can supervise patients' medication intake at home. In their routine home visits, CMHPs usually ask family members about the recent state of a patient's conditions, medication compliance, and social functioning. They also solicit family members' reports on a patient's recent acts of aggression or violence, in particular those acts committed outside the home. As home visits come to an end, CMHPs usually exhort family members to closely watch over patients, lest they make any trouble outside. As the pressure of risk management is passed down from the state to CMHPs and then to families, the 686 Program configures family members as *private* agents to manage patients' illness and prevent them from harming the *public*.

The 686 program sees family members as key to patient management because they can supposedly use their intimate authority, knowledge, and attention to guide patients through medical treatment. As a CMHP told me, "I really like those family members who can urge patients to take the meds and supervise the process. If something happens, they will increase the dosage [based on their own experience or psychiatrists' advice]. Then when the patients get better, they will decrease the dosage." Comments like this are fairly common in CMHPs' public discussions about, and education of, family members. They imagine patients as submissive, easily influenced by their family members. Family members, in turn, are thought to be invested in managing patients solely by psychiatric means, through a supposedly open, if hierarchical, relationship, with no coercion or deception on the part of caregivers needed or warranted. If patients are unwilling to abide by the (medically informed) familial authority, especially when this may lead to illness relapse or a heightened risk of violence, then family members are encouraged to send the patients to the psychiatric hospital. As such, the family is supposed to act like the paternalistic state and be articulated with its paternalistic institutions.

COVERT MEDICATION AS MATERNAL SUPPLEMENTS

As we have seen, biopolitical paternalism defines care biomedically, emphasizing it for the purpose of managing patients' risk of violence, and it expects family members—be they men or women—to perform these tasks in an authoritative but open fashion. In reality, women are usually the ones who stay at home to look after patients, because their jobs often earn less and seem more dispensable. In some cases, especially when patients have no other relatives, men—typically elderly fathers—may also become primary caregivers, although people would see their high involvement in care as uncommon and characterize them as "being a

father *and* mother” for patients. As these female, or elderly, caregivers are themselves vulnerable, they cannot always count on patients submitting to being managed. Instead, they often have to resort to covert and seemingly coercive tactics denounced by the program discourse, such as secretly administering medicines to patients (hereafter “covert medication”) or confining patients at home. Interestingly, CMHPs often acquiesce to these practices when they visit patients’ homes.

This section and the next will examine these covert and apparently coercive family practices in relation to state agents’ reactions. I suggest that these practices allow caregivers not only to act on the state’s mandate to manage patients’ risk of violence from a position of vulnerability but also to compassionately prioritize the preservation of patients’ well-being, especially their non-medical desires and lifeworlds. Drawing on Jacques Derrida’s (1997) idea of supplementation, which entails both accretion and substitution, I argue that these family practices supplement the work of biopolitical paternalism in community mental health: on the one hand, they contribute to the mission of patient management, allowing it to work to the fullest extent (Derrida 1997, 144), beyond existing institutional confines and beyond the limited resources available in community mental health. On the other hand, these practices—especially the everyday labor provided mostly by women, the compassion for suffering they show, and the diverse forms of well-being they enable—offer a maternal alternative to the ideals and demands of biopolitical paternalism. The practical and ontological challenges that these practices pose to biopolitical paternalism render them as a “subaltern instance” (Derrida 1997, 145) publicly denounced by the community mental health program even as it privately relies on them. These covert, seemingly coercive, and ultimately compassionate practices by caregivers constitute what I call “maternal supplements” to biopolitical paternalism. The structure of community governance reduces them to the supplemental, but their supplemental status in no way renders them insignificant. On the contrary, only by grasping the workings of the supplemental can one understand how the primary, that is, biopolitical paternalism, functions.

A case example illustrates how covert medication works as a maternal supplement. One day in 2014, the CMHP Dr. Xu and I visited the home of a fifty-year-old female patient, Jing. She was napping in her bedroom while her eighty-year-old mother received us. Dr. Xu asked to check the medications Jing was taking, so the mother went to her own room and fetched a small bottle of perphenazine. Every day during the past ten years, she told us in a hushed voice, she had mixed thirty milligrams of perphenazine with some heparinica, ground it up, and dissolved the powder into Jing’s milk. “I have no choice. My daughter doesn’t think she is men-

tally ill, and she refuses to take any pills. Whenever I ask her to, she just gets mad at me.” Like Jing’s mother, the majority of caregivers do not hold as much authority as the community mental health discourse assumes they do or as is needed to win over the “noncompliant” patients. When trying to persuade patients to take medications, they often get stuck in trivial, painful, and futile arguments with them. Despite these difficulties, caregivers often feel the need to use medications to handle the disruptions that mental illness brings to everyday life, such as Jing’s frequent wanderings and occasional yelling at strangers. They are also faced with the pressure—constantly reinforced by CMHPs—to minimize the risks the patients pose to others. Covert medication thus provides a way for these vulnerable caregivers to manage patients while circumventing resistance, protecting themselves, and easing family relations.

As these female (or elderly) caregivers closely look after patients every day, they are intimately exposed to patients’ suffering, desires, and hopes, including those that seem strange from a medical perspective. Covert medication thus also offers caregivers a way to show compassion for patients and protect their alternative lifeworlds. In Jing’s case, her mother told me that she had been diagnosed with schizophrenia in early adulthood. Thinking that love would calm her down, the mother arranged a marriage for her with a large dowry. Unfortunately, her husband turned out to be after the money, and he treated her coldly, especially after learning about her diagnosis. Soon after she gave birth to a son, he divorced her and took custody of the child. Since then, Jing had been going to her ex-husband’s home every day, trying to catch a glimpse of her son, but he did not want to be associated with his “crazy” mother. Jing’s mother found it understandable for Jing to fiercely resist psychiatric treatment, to hold onto the image—and the self-understanding—of a normal and capable mother. “I can’t confront her with her illness,” Jing’s mother told me, “otherwise it will break her heart.”

To simultaneously manage patients and engage compassionately with them, caregivers have to tinker with how to hide the pills in a way similar to the everyday experimentations that parents—especially mothers—of children with other disabilities lovingly conduct (Silverman 2011). It is not rare for these experimentations to fumble, to come short of meeting the psychiatric standards. In Jing’s case, her psychiatrist had only prescribed her twenty milligrams of perphenazine a day. Her mother had decided to put in more, in case she did not finish all the milk. As time went on, Jing’s blood pressure rose to dangerously high levels, probably as a result of the long-term overuse of antipsychotics. In some other cases, caregivers do not have the opportunity to hide the pills in food or drinks every day, and fluc-

tuations in medication intake may worsen patients' symptoms. Patients may also suspect or even find out what caregivers are doing and then lose trust in them, refusing altogether any food or drink they provide.

Given these compromising qualities, CMHPs *publicly* denounce covert medication. *Privately*, however, CMHPs often acquiesce to this practice and help caregivers with it. They may provide caregivers with pills, cooperate with them in front of patients, and even quietly suggest better ways to hide the pills. In Jing's case, as soon as her mother finished showing us the pill bottle and put it away, Jing emerged from her bedroom. We all greeted her warmly. Dr. Xu, known to her simply as a community doctor, did not utter a single word about mental illness. Instead, having gathered from previous visits that she admitted having hypertension, the doctor asked her about its symptoms, such as mood swings, dizziness, and sleep problems. She slowly answered the questions with slightly slurred speech. The doctor then told her not to go out so often lest she should fall in a faint, and he invited her to the community health station for a checkup. She nodded. As Dr. Xu later told me, the questions and the checkup could reveal not only Jing's hypertension but also her schizophrenic symptoms and the effects of antipsychotics. At the checkup, Dr. Xu might also be able to prescribe her some antihypertensives, which would then serve as a cover-up for any other pills that she might see her mother handling in the future. Jing's mother immediately recognized the doctor's intention. She beamed on hearing his suggestion to Jing and thanked him profusely for his care.

In this way, just as the family's concerns for the patient's well-being, kin relations, and the household's social standing make it complicit in the state's demands for biomedicalized patient management, so the state's requirements for patient management make the CMHPs complicit in the family's compassionate practices that nurture their loved ones' non-medical desires. The concept of supplementation reveals the mutual dependence between the agenda of management in biopolitical paternalism and the practice of compassion in maternal labor. It also reveals the hierarchy and tension between them: while the discourse of community mental health, operating on the vision of biopolitical paternalism, openly criticizes caregivers' practice of covert medication for its secretive and compromising qualities, caregivers quietly push back on having to shoulder the supplemental labor alone when the state turns away. Their appreciation for CMHPs' understanding of, cooperation with, and advice for them shows how much they long for the state's recognition and assistance.

THE “PROBLEM” OF HOME CONFINEMENT

Compared to covert medication, home confinement is decried by the discourse of the 686 Program in even stronger terms. After all, its *coercive* appearance contradicts the program’s vision of *caring* for the patient—and the public—through pharmaceuticalized risk management, and the confined patient’s reportedly abject, animal-like state constitutes the polar opposite of the program’s ideal of a dignified human. Examining the actual practice of home confinement and the response to it by CMHPs can shed light on the subject, relation, and technique of governance at stake in community mental health, as articulated in biopolitical paternalism and its maternal supplements.

“How Could the Madman Not Be Locked Up?”

My first encounter with home confinement occurred in the summer of 2011. One day, I followed the CMHP Dr. Gao on his home visits to some urbanizing villages on the edges of Nanhua. Driving through rows of glamorous European-style townhouses, we came to Uncle Long’s rundown neighborhood. Uncle Long, an eighty-one-year-old man, greeted us warmly and led us to the place where Ah Niu, his mentally ill son, lived. “Just a glance is OK,” said Dr. Gao, indicating his familiarity with Ah Niu’s condition. Ah Niu lodged in a single-room bungalow, its door locked from the outside, with thick iron bars on the only window and no light within. Ah Niu stood inside, topless and disheveled. Smiling, he greeted Dr. Gao with a “hi.” The doctor approached him, gave him a cigarette, and immediately drew back a few feet before asking Ah Niu how he was doing and whether he was taking any medications. Ah Niu began screaming, and we left the scene.

We then went to Uncle Long’s own house nearby. To my surprise, Dr. Gao refused Uncle Long’s invitation to enter the house, and instead sat on the doorstep. Uncle Long took out a medley of pill bottles for us to examine. I asked him whether Ah Niu was willing to take the pills. “Of course not,” he responded. “I have to hide them in his rice or soup. And look at the sleeping pills. Whenever I want to go inside and clean his room or change his clothes, I have to mix some of these in his meal and put him to sleep first.”

Uncle Long told me he had two other sons and a daughter besides Ah Niu, but they had all married and moved out. Dr. Gao delicately asked whether Uncle Long’s wife was still there—she had been paralyzed by a stroke the previous year, and as I learned, the doctor had not gone inside for fear of disturbing her. But Uncle Long now told us she had passed away earlier in the year, leaving him as the sole caregiver for his son.

Ah Niu was now thirty-eight years old, and had been ill since 1991. “He used to be the smartest and most filial among all my kids,” Uncle Long said with a sigh. In high school, probably in reaction to peer bullying, Ah Niu started having headaches and acting strangely, and later doctors diagnosed him with schizophrenia. He managed to finish school and work for two years, but soon his symptoms worsened. He began smashing things and hitting people. These behaviors and the repeated hospitalizations—sixteen over the years—made it impossible for him to work anymore. At home, he often screamed in the middle of the night, which drew complaints from neighbors and admonitions from the police. In 2006, his parents decided to put him in the locked room. Unfortunately, even confinement could not contain his aggression. He often threw things from the window, and he had once injured Uncle Long. Over the years, Ah Niu had smashed three CD players that Uncle Long had put in his room. He had also broken the television and the light bulb in the room, which still awaited Uncle Long’s repair.

When we were about to leave, Dr. Gao suggested that he might be able to set up a three-month, free inpatient stay for Ah Niu, although he was unsure whether the district’s quota had been reached this year. Uncle Long shook his head, saying that Ah Niu had been beaten up in the hospital before, and would not be willing to go again. As we bade Uncle Long goodbye and walked back to the car, Dr. Gao asked me what I had learned from the field so far. “It is the first time I have ever seen a patient locked up,” I said, “like those I’ve seen in the news.” Dr. Gao raised his voice, with a slightly embarrassed smile: “Oh dear, please don’t tell my supervisor that there are patients being locked up here! What you saw does not count; it only counts when the person’s hands and feet are tied.” I was struck by his definition of confinement, but Dr. Gao shifted gears: “Nowadays people like talking about humanitarianism. Whoever is chained needs to be unchained. But think about Ah Niu. How could he not be locked up?”

In the years of fieldwork following this initial experience, I would encounter three more patients locked up at home, all of them looked after by women (a mother or wife). Curiously, despite program policies that require CMHPs to report and end the confinement, the CMHPs in all four cases chose to turn a blind eye. Two of them did not raise any concerns at all; the other two (including Dr. Gao) proposed free hospitalization to caregivers, but did not insist when they refused. Why? What can the program’s public denouncement of home confinement and CMHPs’ private acquiescence to it tell us about the workings of biopolitical paternalism? In his equivocation about whether Uncle Long’s action constituted

confinement at all, was Dr. Gao acknowledging a different logic of care and kin relations?

The Coercive Edge of Community Mental Health

The discourse of the 686 Program situates home confinement as pure coercion resulting from families' ignorance of, or lack of access to, biomedical care. In reality, the practice is inseparable from the state's focus on risk management, which can go as far as requiring coercion in certain cases. As Dr. Gao implied, the high risk of violence that Ah Niu posed required his confinement, and the home could serve as a space of confinement just as well as the psychiatric hospital. In fact, the home may prove an inevitable choice for most cases, because the neoliberal market economy makes public goods such as free psychiatric beds a scarcity. A district-level community mental health supervisor in Nanhua told me that, in 2013, her district had more than 4,700 seriously mentally ill patients but only five free psychiatric beds. Because the 686 Program aims to protect mentally ill patients from harming the *public*, CMHPs often have to save these precious resources for patients who are extremely poor *and* violent, who have damaged property or injured people *outside* their homes. Patients confined *at home* are typically only able to cause damage or injury within their own household. It thus becomes hard to prioritize providing them with free hospitalization. Instead, CMHPs provide caregivers with medications to help them subdue the patients at home, ensuring risk contained there. By facilitating home confinement, CMHPs are facilitating the biopolitical paternalism of the state, especially the coercive edge of population management,⁷ when the state is not even willing to invest sufficient resources into the task of coercion. In this process, the risk that caregivers face, especially as women or elderly people having to handle strong, sometimes aggressive adults, remains unrecognized and even becomes heightened.

Biopolitical paternalism conceals its coercive edge partly by celebrating the humanitarian potential and scientific prowess of psychiatry: once moved from the home to the hospital, the patient will supposedly experience miraculous improvement (if not cure) and will be able to live a dignified human life. Of course, we now know that the public psychiatric beds to which patients confined at home should be moved may not actually exist. Resource shortage aside, the claim of psychiatric efficacy is also questionable. Patients whom I have seen confined at home have all undergone repeated hospitalizations, and these experiences have disrupted their life trajectories, rendering their recovery and social participation even more difficult. Community mental health practitioners sometimes privately agree with

caregivers that another round of hospitalization would not help much. Meanwhile, CMHPs tend to see those cases as among the few that will inevitably degenerate, either because they were not treated early or systematically enough, or because they are simply unlucky. These interpretations uphold the discursive supremacy of psychiatry while marking certain patients as irredeemable, people who should just be left at home.

However much the state tries to conceal this situation, caregivers are acutely aware that their everyday labor to look after patients—whether through confinement or not—is defined precisely as the public responsibility of managing a risky population that has been outsourced to them. At a community health station, I saw a middle-aged woman complain to her friend that, after looking after her mentally ill husband at home for a few years, she had recently been told by local government officials to get off welfare and to work. Her friend, who was also a wife and caregiver, suggested: “Well, you can just tell them, ‘my job is to watch over a patient. What if I didn’t do that and he went crazy? What if he ran out and beat people up or even slashed at strangers? Believe me, the first person he would attack is you!’” Indeed, while they may not see patients from this lens, caregivers sometimes feel the need to strategically emphasize their loved ones’ potential for violence. In so doing, they highlight their contribution to the state’s biopolitical agenda, the deprivation that this supplemental labor brings, and the despair and resentment they feel.

Compassion and the Unbearable Burden of Suffering

When it is made available, the free inpatient stay typically lasts only up to three months. Even though it may give them respite, some caregivers hesitate to take the opportunity, in part because they fear patients will retaliate after discharge. Besides this concern for themselves, these caregivers also fear for patients’ feelings and well-being. In my interviews, the caregivers who choose to keep patients at home—whether or not under lock or in restraints—tend to use the phrase *cannot bear (buren)* to explain their decision. Like Uncle Long, they know from the past that their mentally ill relatives would not only fail to benefit but might well suffer from the experience of inpatient stay. They are intensely uncomfortable with aspects of institutionalization, such as the crowded ward, the physical discomfort, the staff’s neglect, possible bullying from other patients, and so on. “My heart ached when I saw him/her [the patient] go through these,” several caregivers told me; “I can’t bear seeing him/her suffer again.”

The term *cannot bear* has its roots in a gendered history of Chinese thought. According to Mencius, an early sage of Confucianism, humans instinctively cannot bear seeing the suffering of other sentient beings, and such compassion constitutes the starting point of benevolence, a core virtue that undergirds kingly governance (Chen 2007). However, as Confucianism became institutionalized and adapted into the framework of a gendered and hierarchical order, the ethical sentiment of “cannot bear” or compassion became feminized and devalued. By the twelfth century, “womanly/motherly benevolence” had become associated with the “inability to bear small things” and “inability to bear [the discomfort resulting from] love/compassion” (X. Zhu 2013). These associations define the discomfort unbearable to mothers, such as children’s growing pains, as the minor and necessary cost of realizing greater goals and principles. Motherly compassion is therefore viewed as a potential weakness that should be reined in by fatherly endurance and discipline.

Today, the historically gendered discourse of “cannot bear” continues to shape different parties’ approaches to coercion and compassion. By using the term *cannot bear*, caregivers convey their discomfort with the coercive aspect of hospital treatment and the suffering it produces; implicitly, this constructs their practices at home as less coercive and more compassionate. Meanwhile, especially in public discussions, health professionals often criticize caregivers who express unease with hospitalization as “sentimental,” “weak,” and “feminine,” even when said caregivers are men. From the professionals’ perspective, the caregivers’ womanly (or womanlike) compassion prevents them from seeing how coercion ultimately serves the biomedical vision of care—however remote that is—and the biopolitical task of population management. Therefore, as the maternal labor reveals its compassionate nature and distinguishes itself from psychiatric coercion, biopolitical paternalism discursively disparages it so as to maintain its own caring image. This despite the fact that in practice, neoliberal social policies rely very much on caregivers’ refusal to use hospitalization in preference for managing patients at home. Through these entangled readings of “cannot bear,” compassion becomes reinforced as maternal and reduced as a supplement—as a diminished but essential component—of biopolitical paternalism.

Home confinement, of course, is not without its burden. My fieldwork shows that in households where patients are locked up, exposure to their suffering is immediate, constant, and substantial. In some cases, the locked room is inside the household, so that the smell of the patient’s unwashed body and excrement permeate the entire house. In other cases, the patient’s room is separated from the main domicile, but family members remain within earshot of the patient’s screams and

sighs. If caregivers cannot bear the discomfort of letting their loved ones suffer in the hospital, how can they bear the emotional and practical burden of keeping patients at home and witnessing the overwhelming suffering?

The answer is this: these supposedly “sentimentally weak” women (and men) bear the burden through extreme personal effort to alleviate as much of the patient’s suffering as possible. Every day, they pay close attention to patients and send materials into the locked room to meet patients’ needs: they serve meals three times a day, often including patients’ favorite dishes; they set up water hoses and other cleaning equipment inside the room for patients’ sanitation; and as we have seen in Ah Niu’s case, they sometimes provide patients with entertainment devices despite the family’s poverty. These processes of care are fraught, especially since the externally imposed task of risk containment leaves caregivers to handle patients’ potential aggression without public support. Because patients can be calm for a while and suddenly destroy things that caregivers take great pains to provide, caregivers have to constantly adjust the amount of material goods and freedom they should—or can afford to—give to patients. Each time they withhold an item or keep a door shut, they regret the contraction of the patient’s world, while also feeling helpless and choiceless in having to make that decision. These emotionally and ethically difficult decisions add to the burden quietly borne by caregivers.

As we have learned, the 686 Program sees patients primarily as sources of potential violence who need to be cured, or at least well-managed, before being recognized as proper humans and reintegrated into society. In contrast, even in the direst circumstances, caregivers tend to see patients as able to engage and not permanently violent. They try hard to connect to patients, paying close attention to signs of kindred recognition even when patients show aggression or refuse to communicate. In one household, a woman told me that her mentally ill husband had beaten up everyone who came near his cage, except for his young daughter. In another household, the mother told me that when her mentally ill son once tried to poke her hand with the cigarette she had just given him, she scolded him, threatening not to give him cigarettes anymore. “He stopped, and doesn’t do that again. What a kid,” the mother said with a shrug and a smile. In those moments, at least, caregivers see themselves or other family members as being taken into patients’ hearts and participating intrinsically in patients’ existence (Sahlins 2011). They interpret changes in patients’ behavior, aggressive or otherwise, as emerging from kin relations and expressing kindred affects. This familial and deeply human connection marks the starting point, and the reward, of caregivers’ compassionate engagement.

The suffering that families endure also becomes an emotional burden for CMHPs, but their responses differ. When Dr. Gao drew back from Ah Niu's room and refused to enter Uncle Long's house, he obviously felt disturbed by the possibility of seeing the miseries of both the patient behind bars and the mother on the deathbed. Yet his job did not enable him to alleviate the suffering that the neoliberal health and welfare policies had wrought on Long's family. In fact, it probably perpetuated the suffering by demanding that families contain high-risk patients while giving them little support. Meanwhile, in equivocating about whether Uncle Long's arrangements even constituted confinement, he might have tacitly acknowledged the compassionate care happening inside the household, care that went beyond the capacity or imagination of community mental health, and that made life more bearable for patients, however slightly. Yet as he turned away from the scenes of suffering, not bearing the burden alongside the caregiver, he helped reinscribe the public image of a powerful, caring father state and the program's mission of population management, while leaving the task of coercion and the practice of compassion to the privatized and deprived space called home.

CONCLUSION

In the formation of biopolitical paternalism, as evinced in the discursive and institutional arrangements of the 686 Program, care is defined biomedically as symptom control and elimination, and it is emphasized for the purpose of maintaining social order and public security. The state fashions itself as a caring father by intervening in home confinement and developing services for the general patient population. It then outsources most responsibilities for patient care and management to families, expecting caregivers to embody and smoothly enact a set of paternalistic powers and authority as it does, to have no need for coercion or deception. In everyday practice, however, caregivers may indeed resort to covert medication and even home confinement. This is partly because as women and elderly people, they have to respond to public demands of patient management from a position of vulnerability rather than of paternalistic vigor. Meanwhile, as they listen to patients' cries and sighs, as they hesitate to discuss the diagnosis with patients, to demand medication compliance, or to seek help through hospitalization, these caregivers also quietly question biopolitical paternalism, pointing to its limits of care—in terms of both resource shortage and the inability to address patients' needs—as well as its hidden edge of coercion. By hiding acts of medication and keeping patients at home, they seek to alleviate patients' suffering—including that

produced by psychiatric coercion—and to nourish lifeworlds unrecognized by the biomedical order. Such is a maternal labor of compassion.

In an attempt to avoid the ethical and ontological challenges posed by these maternal practices, psychiatric discourse publicly dismisses or decries them, as if they were completely external and counterproductive to the vision of community mental health. In reality, however, the neoliberal social policies that privatize care and limit the provision of public goods not only treat these practices as acceptable but also make them necessary for risk management and containment. The pressure that CMHPs consequently exert on caregivers, as well as the psychopharmaceuticals that the program provides, help sustain these practices. In [Derrida's \(1997, 145\)](#) terms, caregivers' maternal practices are rendered supplemental to biopolitical paternalism as a "subaltern instance" or even "negativity of evil." Yet as they "transgress and at the same time respect the interdict" ([Derrida 1997, 155](#)) of the primary, these maternal supplements work to fulfill the task of biopolitical paternalism precisely by overcoming the inadequacies it has and repairing the injuries it makes. As such, they are indispensable to our understanding of biopolitical paternalism.

In China, many other members of the population besides people with SMIs are deemed too immature, dangerous, or vulnerable to govern themselves, threatening the body politic ([Cho 2013](#)). With the combination of a growing security apparatus and the withdrawal and limited resurrection of public welfare, the post-socialist state may well highlight paternalistic management of these groups and then relegate it to devalued, precarious, and female labor. Throughout the world, biomedicalized techniques of rule continue to redefine individual well-being and population security, and neoliberal economic policies continue to transfer responsibilities to achieve these new ideals away from the state. As such, many projects of governance have turned to private paternalistic strategies, especially everyday techniques of direction, instruction, and surveillance (e.g., [Soss, Fording, and Schram 2011](#); [Shever 2013](#)). In light of our findings, we may ask how these projects in and beyond China mobilize kinship metaphors or practices, and how they define and distribute responsibilities for population management. Meanwhile, given the tenuous positions of paternalism's agents—be they parents, case managers, or street-level bureaucrats—and given their intimate exposure to their charges' vulnerability, we should also ask whether they may quietly engage in any further supplemental practices, how those practices are gendered, and what kinds of subjects and relations they nurture.

In closing, it is important to note that unearthing maternal supplements does not mean glorifying or romanticizing them. The caregivers involved in home confinement or covert medication would be the first to refuse any romanticization. After all, although such practices might make the life of the patient a bit more bearable, they are still performed under the severe pressure of risk management and coercion by the state. Doing supplemental labor when the state turns away also generates much despair and resentment. Still, by considering these supplemental practices with sympathy rather than contempt, we can start to address the ills of biopolitical paternalism and transform community governance. Since 2015, the 686 Program has developed some new services, such as providing SMI patients with vocational rehabilitation training and subsidizing caregivers for their labor in monitoring patients. More research is needed to explore whether these new developments re-entrench the program's existing practices and problems or whether they open up new horizons for community mental health work. In general, instead of restricting the vision of care and putting all the responsibility on family members, we should learn from their insights and vulnerability about what works, use this understanding to help redesign the task of mental health care, and distribute the task more equitably among wider social circles. Instead of trying to burnish the state's image with limited resources, we should reform pay for services, increase public investments, and build a team of grassroots service providers dedicated not to rationing support or managing people, but to working with individuals and families on their own terms.

ABSTRACT

This article examines how the community mental health program run by the Chinese state conceptualizes, mobilizes, and molds the family. My fieldwork shows that, on the one hand, the program defines care biomedically and connects it to managing security risks in the population. The state fashions itself as paternal while displacing most responsibilities for patient care and management onto the supposedly authoritative families. On the other hand, caregivers—mostly women and the elderly—may resort to practices publicly denounced but privately enabled by the program, such as covert medication and home confinement. They do so not only to manage patients from a position of vulnerability and deprivation but also to compassionately engage with patients' suffering and non-medical desires. These two entangled kinship correlates of state power, which I call "biopolitical paternalism" and its "maternal supplements," prove critical for understanding the work of community governance in China and beyond. [care; biopolitics; paternalism; family; mental health; community governance; China]

NOTES

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1. Among the media reports that feature home confinement and psychiatric unlocking, I choose to use the *New York Times* article because it concisely invokes several key themes (the patient's violence, the caregiver's helplessness, and the doctor's heroic benevolence) and because the Peking University Mental Health Institute serves as the leading institution of the 686 Program.
2. In this article, I follow the customs of the field and use the word *patient*. This is not an endorsement of psychiatric knowledge. Rather, the term allows me to pay attention to the discursive construction of persons labeled as such and the experiences that they have as a result of this construction.
3. Nanhua is a pseudonym, as are the names of my fieldwork interlocutors here.
4. Because these reports on home confinement—international or domestic—often end with psychiatrists going in and unlocking the patients, or appealing for government-funded medical intervention, they were likely to be orchestrated by the psychiatrists themselves or by allied policymakers.
5. The gendered language is intentional here, because most patients confined at home are depicted as male, and people typically see male patients as more violent.
6. In Nanhua in 2013, a patient could receive up to CNY 150 or USD 22 worth of medications per month, while a free basic physical checkup was offered quarterly.
7. The idea of the edge comes from Paul Brodwin and Livia Velpry's (2014, 524) argument that no matter how passé or minor it may seem, institutional constraint still constitutes psychiatry's "rough edge of practice."

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