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

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Editor

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

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Foreword

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

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

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

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

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

Dr. Afzal Javed
President
World Psychiatric Association

Acknowledgement

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

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Chapter 1
Introduction

Harry Minas

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

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

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

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

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

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

Mental Health System Development in China

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mental Health of the Chinese Diaspora

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

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

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

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

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

Structure of the Book

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

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

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

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

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

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

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

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Part I
Mental Health in China

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

Fabien Simonis

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

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

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

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

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

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

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

Law, Policies, and Society

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

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

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

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

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

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