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Semiotic Collisions and the Metapragmatics of Culture Change in Dr. Song Yujin's "Chinese Medical Psychology"

This paper is about interaction in the clinic of Dr. Song Yujin, a physician who practices "Chinese medical psychology" in Beijing, China. In particular, we highlight how Dr. Song challenges deep-seated ideas about family, personhood, and healing among his patients. Through close study of one interaction that Dr. Song has with a patient and her family, we demonstrate how Dr. Song draws upon prosody, gaze, teaching talk, and terminology to construct a local metapragmatic framework within which his utterances, gestures, and other semiotic devices can be interpreted as appropriate and familiar yet also strange and challenging. By examining Dr. Song's approach as it occurs in a contentious clinical "border zone" involving texts, bodies, and medical practices, we demonstrate how an emphasis on the micropolitics of interaction in specific clinical contexts can complement the scholarly study of cultural, social, medical, and personal change over time. This approach, we argue, has broad implications for the ways in which linguistic anthropology can contribute to the ethnographic study of cultural change as it emerges in complex interactions that often hinge on the tension between cooperation and resistance. [Chinese Medicine, psychology, China, doctor-patient communication, innovation]

Introduction

This paper is about interaction in the clinic of Dr. Song Yujin,¹ a charismatic physician who practices a form of "Chinese medical psychology" (*zhongyi xinlixue*) in one of the largest Chinese medicine hospitals in Beijing, China. Dr. Song's therapeutic system is based on an adapted form of developmental psychology. It further incorporates ideas and practices from *qi gong* energy healing, Cognitive Behavioral Therapy (CBT), psychotherapy, and hypnotherapy in the treatment of core developmental issues in the personality or "self" (*ziji*). In the landscape of Chinese medical psychology in China, where there is currently no accepted standard or authoritative articulation of what exactly Chinese medical psychology consists of, Dr. Song's system exists alongside several divergent "currents of tradition" (Scheid 2007) that have developed in this nascent field since the 1980s. Dr. Song's therapy stands out in several key ways, however, from other forms of Chinese medical psychology, including its unique emphases on emotional expression, self-

understanding, and rigorous independence, as well as its incorporation of psychotherapeutic dialogue and hypnosis. Dr. Song's approach to caring for patients thus diverges considerably from most systems of Chinese medical psychology.

In terms of patients' expectations regarding the meanings and entailments of doctor-patient interaction in Chinese medicine, this divergence often gives rise to what we are calling *semiotic collisions* in Dr. Song's clinic. Such collisions are complex, layered interactions that depend in large part upon Dr. Song's efforts to create a metapragmatic framework (Agha 2007; Hanks 1993; Silverstein 1993) in which his words, gestures, and other semiotic strategies, are interpreted as both appropriate and familiar yet also strange and challenging. What we are calling collisions, then, are often buried within multiparty interactions that simultaneously hinge on the enactment of power through what McDermott and Tylbor (1995) might call interactional collusion within the institution of Chinese medicine. For McDermott and Tylbor (1995, 232), power is enacted in conversations unfolding between "the apparently powerful and the apparently impotent." As such, conversations become the medium for the reproduction of cultural/institutional power in such a way as to complicate what they argue to be the "soup-in-the-bowl" of standard speech act theory as laid out by Austin (1962) and Searle (1965), where the "soup" of interaction seems to exist outside the "bowl" of culture (McDermott and Tylbor 1995, 230). Along with other scholars who have suggested that audience participation, even if only in non-cooperation, plays a role in the emergence of power (Ahearn 2001; Brenneis 1986), we show here that both collusion and collision often co-occur in Dr. Song's interactions.

Basing our analysis on data collected over the course of three summers of participant observation, video-recording, and interviews with patients, interns, and students in Dr. Song's clinic,² our focus in the present paper is on one extended encounter with Dr. Song, his patient, and her family. We concentrate in particular on the *consultation-phase* of treatment with Dr. Song—a ritualized meeting that occurs during patients' first visit as well as before and after therapy sessions for ongoing patients. Consultation-phase meetings offer a unique opportunity to witness clashes between familiar and strange understandings of selfhood, family, and healing in contemporary China. We thus emphasize the ways in which Dr. Song, through various pragmatic and semiotic strategies, is continuously engaged in the work of constructing interactional frameworks within which he challenges patients' culturally salient ideas about self, family, and illness. Specifically, we discuss the ways in which Dr. Song's semiotic work, in which he draws upon a certain metapragmatic awareness of how certain speech styles have definite effects in the clinic (Lemon 2002), is tied to his efforts to change deeply held and culturally salient notions of self, family, and medicine. Dr. Song's ultimate agenda, as we describe in detail below, is to change Chinese culture, particularly the ways in which the Chinese "relational self" (Yan 2016) is enacted vis-à-vis practical expressions of concern and care.

To the extent that he focuses on urging patients to organize their self-narratives in psychological terms, the work that Dr. Song accomplishes here thus aligns with the metalinguistic labor that Carr (2011, 15) highlights as central to the task of therapists who work to teach patients how to narrate their lives in new ways that coincide with accepted "clean and sober" interpretive frames. Whether it is understood as work, labor, or simply social action—with all of the complex meanings that these terms carry (e.g., in the theories of Karl Marx or Hannah Arendt)—we draw inspiration from Duranti (2015, 4) in highlighting the ways in which Dr. Song's explicit intentions to change Chinese culture are diffused in interactions where his utterances, gestures, prosody, and other semiotic strategies accomplish different things with different interlocutors at different times. We thus demonstrate the ways in which patients (or their families), even when they seemingly cooperate with Dr. Song, work with their own repertoire of semiotic resources to defend their well-known ways of being in the world. Patients' resistance thus often generates a semiotic collision in the clinical "border zone" (Mattingly 2010) created in Dr. Song's offices. Here, doctor-patient interaction is "rife with misunderstanding . . . [and] interpretive trouble" (Mattingly

2010, 11) as conflicts between the narratives or “healing genres” (128) of clinicians, patients, and patients’ families are made present in clinical interactions.

In addition to offering a perspective on how clinicians variably draw upon language to socialize patients into their roles as patients (Buchbinder 2011, 2015; Clemente 2015; Heritage and Maynard 2006; Stivers 2011), we further argue that a study of semiotic collisions in the clinical setting deepens our understanding of the ways in which indexically familiar or first order “ethno-metapragmatics” work alongside less familiar “metapragmatic entailments” (Silverstein 2003, 194, 196) such that “historical change or at least dialectical dynamism . . . [is] inherent in the way . . . social semiosis seems to operate” (Silverstein 2003, 203). In other words, the study of semiotic collision (alongside collusion) offers insight into the role of interaction in the emergence of cultural change—here as it pertains to Chinese medicine, as well as in the everyday experience of personhood in China. Scholars of Chinese medicine have long noted that the ways in which medical practice develops in concert with social and cultural processes (Andrews 2014; Unschuld 1985). Such work has demonstrated that, contrary to being a static system, Chinese medicine is a complex assemblage of theories and practices that is always undergoing various types of innovation (Andrews 2014; Farquhar 1994; Hsu 2001; Lei 2014; Scheid 2007; Zhan 2009). Recent research on what Yan (2009) calls the “individualization” of Chinese society has likewise shown that, in concert with changes in socioeconomic structures, an increasing mismatch between certain ways of “doing” self or “doing” family in China has led to changes in the way that individuals approach the complex projects of self-development and self-expression (Evans 2012; Hansen and Svarverud 2010; Huang 2014; Kleinman et al. 2011; Kuan 2015; Ong 2008; Pritzker 2016; Rofel 2007; Yang 2015; Zhang 2017). The current study complements such work by demonstrating, at least in part, *how* such changes emerge in complex interactions that are far from straightforward in terms of cooperation or resistance.

Orientations

Redevelopment Therapy

At the time of the writing, Dr. Song Yujin is a physician in his early 60s. Raised in a small village in rural China, he is the youngest son in a family that he describes as extremely strict and often physically abusive. Though he dreamed of becoming a teacher, after he returned from working in a remote rural area during the Cultural Revolution, he was forced by his father to study Chinese medicine. He practiced for a short time in a small town before coming to Beijing to pursue his Master’s in *qi gong* and acupuncture therapy. Though he eventually came to enjoy his practice, Dr. Song became increasingly disillusioned with Chinese medicine. It seemed to him that it was ineffective and incompatible with “modern life,” and he began to take more interest in psychology. In the early 1990s, after practicing acupuncture in a large Beijing hospital, he was granted the opportunity to study behavioral psychology abroad, an experience that reinvigorated his passion for developing a new kind of Chinese medicine that he eventually called “redevelopment therapy” (*zai chengzhang liaofa*). This therapy incorporates classical Chinese medicine, *qi gong*, developmental psychology, Cognitive Behavioral Therapy (CBT), psychotherapy, and hypnotherapy in the treatment of people’s core selves (*ziji*). As such, it can be seen as one example of recent efforts toward what L. Zhang (2014, 286) refers to as “culturing psychotherapy” in China through “a process of constant dialogue and re-articulation between multiple forms of knowledge, practice, and ethics” as individual practitioners develop unique forms of practice that are supposedly better for treating native Chinese individuals. Since the early 2000s, Dr. Song has practiced redevelopment therapy in the psychology department of a large Chinese medicine hospital in Beijing.

Dr. Song’s overarching theory has changed considerably in the past five years, but at the time of this writing his major emphasis is on locating emotional traumas, as

well as *lack* of traumas, that have influenced patients' developmental processes, resulting in their inability to mature or "grow up" (*zhangda*). Many of Dr. Song's patients are thus diagnosed as being "immature" (*bu chengshou*). In part due to the one-child policy, and in part due to traditional Chinese family models, he argues that most of them suffer from a version of what he defines as "overdependence" (*yilian*) on parents or grandparents. He sees his main work, therefore, as disentangling patients from their attachment to others, making them more independent so that they can fulfill their roles as adults in society. For Dr. Song, these roles are represented by standard, heteronormative expectations that adults will get married to a person of the opposite gender, have children, and work in a career that "serves society." Despite such expectations, Dr. Song sees his work broadly as the development of a special form of Chinese medical psychology that is specially tailored to Chinese people, and is specifically designed to change what he sees as pathological family relationships that stunt the growth of the self.

Dr. Song motivates such "self-growth" by requiring that patients engage in an intense self-inquiry process involving a "homework assignment" given to them on their first visit. The assignment, consisting of a list of questions asking them to detail all of their emotional memories from birth to the present, often generates multiple pages of elaborate writing from patients that they are instructed not to show anyone in their family. Dr. Song and his interns then study these pages in great depth. In particular, they are looking for key emotional traumas—for example the death of a parent or the loss of an intimate relationship—that may have occurred at specific age intervals. They are also notably looking for lack of traumas or other events that in some way have challenged the patient to individuate from their caregivers. They then use their analysis to determine a psychological diagnosis—usually related to lack of maturity or over-entanglement in the family—and to decide upon a set of "stories" that are told to the patient whilst he or she is in a state of hypnosis-like relaxation. These stories are based on Dr. Song's theories about what should happen during the development of a human being at certain age intervals. Patients who are struggling with issues related to sexuality and fear, for example, are "relaxed" or hypnotized and led back in time to their adolescent years, and often younger childhood years. Under hypnosis, they are then given a new "self" (*ziji*) who was able to successfully navigate relationships with the opposite gender. The treatment usually lasts two to three months, but sometimes can go on for much longer with the goal, as Dr. Song explains, of "getting into the past" and "changing fundamental personality issues." Treatment success according to this physician is not all in his hands, however. Dr. Song also introduces statements about what the patient must do in order to get better. Dr. Song's speech is thus replete with directives that offer assignments to patients about ways they need to change their behavior outside the clinic.

The Familiar and the Strange

As mentioned above, there are many different schools or "currents of tradition" (Scheid 2007) in contemporary Chinese medical psychology. Generally speaking, however, most of these are not vastly different from general Chinese medicine. They are based, in this sense, on the classical statement that the mind and body are one (*xinshen heyi*). Even though an excess of any one of "the seven emotions" (*qi qing*) is understood to be a common cause of physical distress, the patient's *qi* can therefore be adjusted successfully through acupuncture, herbs, and massage. Emphasis is thus placed on harmonization (*tiaoli*) of emotions within the context of overall physical as well as relational health (Y. Zhang 2007). Many Chinese medical physicians thus work within an overarching framework of socially situated or relational "self-realization" (*xiushen*) rather than a psychological framework of individual self-development. Tu (1994) describes the Confucian notion of self-realization by explaining that it "is not a lonely quest for one's inner spirituality but a communicative act empowering one to become a responsible householder, an

effective community worker, and a conscientious public servant" (1994, 182). In her recent study of doctor–patient interaction in Chinese medical psychology, Y. Zhang (2007, 137) thus notes that "the doctor can be seen as embodying the hegemony of established social orders" in that talking is functions as a kind of "persuasion or manipulation of emotions" that works more like moral (re)education than any sort of psychological counseling that a Westerner might understand. Chinese medical practice in the treatment of psychological disorders, she argues, "is not just a way to heal, but also a process to transmit cultural values and social ideology" (136). Here, instead of helping the patient discover "his or her 'true feelings'" (125), physicians invoke "the voice of society" to get the patient "to step out of her 'self' and assume the perspective of a culturally defined 'wise and mature' person" (134). In Zhang's study, such talk was complementary to the central treatment of herbs and/or acupuncture, which was administered based on pulse and tongue diagnoses. One could thus say that the metapragmatic frameworks established in the doctor–patient interactions that Y. Zhang analyzed thus aligned with culturally salient notions of physician/patient roles with respect to collusion and the institutional reproduction of power in the clinic.

Like the physicians Y. Zhang describes, Dr. Song does emphasize the notion of "maturity," and speaks frequently in terms of moral and cultural values as well as social ideologies that support the cultural notion of relational self-realization. This kind of moral instruction offers patients a sense of familiarity, as it coincides with the practices described above. Like the physicians in Y. Zhang's study, Dr. Song further presents himself as an extremely authoritative physician. His words, tone, body language, and physical presentation—along with the materials he draws upon in the clinic, including patient charts, test results, even the bodies of patients and interns—convey a definitive certainty to patients and onlookers. This demeanor, which can be summarized as a strong traditional Chinese medical doctor who performs confidence in "his treatment" vis-à-vis an authoritative, morally charged discursive register that demands compliance from patients, is also familiar to patients seeking guidance.

The clinical setting where Dr. Song works, always wearing a white lab coat and constantly flanked by a cadre of young interns and residents, further provides patients with an environment that is familiar. Dr. Song's intake and treatment rooms are standard for large hospitals, at least at first glance. Patients register at a central hospital location, pay a fee, and then wait on long benches outside his office. Once called, they enter a front room, in which there is a single desk and multiple chairs. This is where consultations take place. Within this setting, there is a general lack of privacy, which is a distinguishing feature of most public hospitals in China. Patient intakes and consults thus involve multiple parties including the doctor, interns, patient, and family members, and are often interrupted by other patients asking about prescriptions or complaining about wait-times. In this setting, copies of quotes from classical Chinese medical texts, posted to the walls alongside standard acupuncture model posters, further offer patients a familiar environment. Though the treatment portion of Dr. Song's therapy involves more unfamiliar environments, as patients are taken to individual rooms with bed and soft music, consultations initially proceed in a setting that affords interactions where Dr. Song asserts his authority to speak to patients as what Zhang calls "the voice of society" in a familiar manner.

Beyond these similarities, Dr. Song's system diverges considerably from classical Chinese medicine. Indeed, as mentioned above, Dr. Song believes that there are fundamental limitations to Chinese medicine's ability to treat psychological issues. In contrast to more familiar approaches, Dr. Song contends that psychological issues (*xinli wenti*), primarily lack of maturity, are not only distinct from physical symptoms (*shenti zhengzhuang*), but cause them. Physical treatments like acupuncture and herbs cannot therefore treat the root of the problem. Instead, following in the steps of Chinese medical physicians in history who have advocated for direct emotional treatment of the emotions—for example, in the five-phase mutual control therapy of Zhang Zihé (G. Zhang 2000)—Dr. Song advocates for treating "the mind with the mind." Instead of

drawing on traditional methods for doing so, however, Dr. Song argues that it is necessary to borrow from Western psychology, which he argues offers better tools for dealing “logically” with the person. Dr. Song thus generally refuses to feel pulses, look at tongues, or prescribe herbal formulas. He will sometimes do all of these things in order to make patients, in his words, “more comfortable,” but for the most part, patients are told that medicine will not help their problem. They are told, in fact, that their symptoms are related to psychological issues often stemming from their family of origin that they must not only find, but must talk openly about. Further, they must come back twice a week for several months to undergo hypnotherapy so that they can be “re-developed” into mature psychological beings with independent “selves.” Dr. Song avows that his system still qualifies as Chinese medicine, however. This claim is based on the fact that his practice is (a) based in Chinese culture, (b) utilizes a certain Chinese medical *style* of practice, and (c) incorporates techniques from medical *qigong* into the relaxation phase of treatment.

Regardless of whether Dr. Song’s approach is or is not “really” Chinese medicine, it is entirely unexpected and highly unfamiliar for most patients who come to him for treatment. Like the patients in Y. Zhang’s study, they have come for herbs to help them sleep, reduce their anxiety, or help them feel more enthusiastic about life. Some of them may also expect a short conversation about their lifestyles, the food they eat, the time they go to sleep, or their exercise. Many of them, as both Y. Zhang (2007) and Ots (1990) observe, present physical complaints as indexes of psychological suffering.³ This makes Dr. Song’s approach especially strange. Indeed, patients and their families often question Dr. Song, both in their initial meetings as well as their follow-up consultations. Such questions are expressed through language as well as embodied signs of resistance, doubt, and surprise. Dr. Song, in turn, draws upon language, gesture, gaze, and even other bodies to manage these questions, invoke his authority, and to “lower the resistance” of patients (his words). He uses this authority strategically, in other words, to “sell” patients and their families on the value and relevance of his approach. Dr. Song tirelessly works to convince patients that he not only understands the problem more clearly than perhaps anyone else, but that he is also the only one capable of treating it. Dr. Song is thus conscious and strategic about his use of a familiar way of speaking and “doing” authoritative doctor of Chinese medicine because he is aware that he is asking patients to accept some very strange ideas about the cause of their discomfort and the appropriate approach to treating it.

As we show in the following section, Dr. Song draws upon a distinct metapragmatic awareness of how his authoritative, pedagogical speech style maps onto the expected situation in the clinic. At the same time, however, his goal is not to simply collude with patients in order to “help each other to posit a particular state of affairs” that ultimately reproduces shared cultural/institutional norms (McDermot and Tylbor 1995, 218–219). He does often draw upon what might be called collusive strategies in the sense that they reproduce certain norms with regards to authority, gender, and society. But Dr. Song *also* works, through gaze shifts, prosodic intonation, teaching talk, and the deployment of expert terminology, to get people to change other norms, in particular the ways they understand themselves, their roles vis-à-vis their family members, and the efficacy of Chinese medicine. Patients and their families are far from passive in their resistance to this physician’s strange perspective, however. Semiotic collisions thus unfold in complex interactions where different stakeholders variably collude with and collide with Dr. Song at different moments. The study of such complex interactions, as we stated above, can help us understand how cultural changes in medicine, intimacy, and individuals’ experience of selfhood emerge in interactive situations that are far from straightforward in terms of cooperation or resistance.

Song at Work

This section examines a set of excerpts from one interaction in Dr. Song’s clinic, derived from a video recorded encounter with a consented patient and her family.

Transcripts are represented in both Chinese and English, using symbols from Jefferson (2004). Our analysis, where appropriate, draws upon the scholarly work of researchers in conversation analysis and linguistic anthropology. Though this work is not often based on Chinese interaction, we supplement our interpretations with contextual explanations that pertain specifically to Chinese interaction.

The patient in the following excerpts was a 23-year-old recent college graduate from north China who had traveled about four hours to Beijing to see Dr. Song. At the time of the interaction, she had come back for her second visit. Her chief complaint was related to her menstrual cycle, which lasted 10–20 days out of each month and included painful spasms in her back. The patient's symptoms had started about one year previously, between the time of her college graduation and an incident where she had been frightened by a dog. Since then, she had become "obsessed," and had started feeling a great deal of anxiety in addition to experiencing changes in her menstrual cycle. In her homework, she explained that she lived with her parents, who imposed strict limitations on her movements and communications. They only allowed her out of the house for one hour per day, for example, and restricted her use of her mobile phone. Because physical symptoms in his system are often seen to be based on overdependence in the family, these restrictions were where Dr. Song focused his diagnosis.

At the point when the interaction below began, Dr. Song had read the patient's homework, and was meeting with her and both of her parents to discuss her case. The patient was seated at the end of Dr. Song's desk, where he was sitting facing the consultation room audience of students, interns, and researchers. This included his chief intern, who was sitting across from Dr. Song taking notes on the computer and organizing various papers throughout the consultation. The patient's mother stood behind her, while her father was even further behind her. The mother was expressing a theory about what caused her daughter's menstrual problems, but Dr. Song refuted her theory with his own set of explanations that contradicted hers:

Excerpt 1: "That doesn't have anything to do with this"

- 1 M: 她那个月经跟中间的
Ta nage yuejing gen zhongjian de
 but her period, in the ((squeezes fingers together)) middle



Figure 1. (Excerpt 1, Line 1): "But her period, in the middle"

- 2 D: =那个跟这个没关系
nage gen zhege mei guanxi
 that doesn't have anything to do with this
 ((waving hand and gazing at P))



Figure 2. (Excerpt 1, Line 2): “That doesn’t have anything to do with this”

- 3 M: 没关系↑?
mei guanxi↑?
 Nothing to do with it↑?
- 4 D: 你不懂下一次不回来了
ni bu dong, xia yici buhui laile
 You don't understand. Next time, that won't happen
 ((points at P, looks at M))
- 5 M: 啊
ah
 Ah
- 6 D: (.) 下次不会出现了
 (.) *xiaci buhui chuxian le*
 (.) Next time it won't happen ((looks away, then down))
- 7 M: 啊啊
ah ah
 Ah ah
- 8 D: (1.4) <WH 想想> 主要你 (1.0)
 (1.4) <WH *xiangxiang*> *zhuyao ni* (1.0)
 (1.4) <WH Think> The most important thing is you (1.0)
- 9 要让她有情绪也不走这东西
yao rang ta you qingxu ye bu zou zhe dongxi
 need to let her, when she has feelings, not to influence this thing
 ((makes chopping motion))



Figure 3. (Excerpt 1, Line 9): “You need to let her, when she has feelings, not to influence this thing”

- 10 D: 不走月经,不走抽
bu zou yuejing, bu zou chou
 not to influence her period, not to give her spasms ((looks away))



Figure 4. (Excerpt 1, Line 11): “not to influence her, not to give her spasms”

- 11 D: 好不好?@@
hao bu hao? @@
 Okay?@@
 ((takes paper from intern, and looks up at interns/researchers))
- 12 M: 啊啊
ahah
 ah ah@@
 ((looks up at interns/researchers, laughs with D))



Figure 5. (Excerpt 1, Line 11) “Okay?”

This excerpt offers an example of how Dr. Song begins to construct a local metapragmatic framework (Hanks 1993) in which his statements entail certain consequences for the patient and her family. It began with Mother talking about the time between her daughter’s graduation and the dog scare. When she spoke, she squeezed her fingers together, bringing these two separate events together as well as to the forefront of the discussion. In response, Dr. Song waved his hand, turned to the patient, and said, “that doesn’t have anything to do with this” (Line 2). Here, we note, he used gaze, deictics (*that* and *this*), along with the counter-gesture of wiping something away, to separate the events that Mother had linked together, especially vis-à-vis the immediate conversation. Alongside his gaze shift to the patient, deictics here served to situate the context of the utterance, with *this* referring to the patient’s problems, and *that* referring to incidents that Mother had associated with the symptom development, as well as Mother’s very analysis. Deictics thus served here as metapragmatic devices “insofar as they regiment[ed] the relation between a referential object and a pragmatic context relative to which it [was] individuated” (Hanks 1993, 129; see also Wilce 2008), and were complemented by gesture as well as by a shift in gaze away from Mother that indexed both disengagement from her theories (Goodwin 1981), as well as a resource for displaying a stance of disagreement (Haddington 2006). Dr. Song thereby made the patient’s suffering more proximal, and central to a medical visit, at the same time distancing or making non-proximal both the events described by Mother as well as Mother’s analysis of the problem.

It is notable here that the way that Dr. Song immediately contradicted Mother’s theories in this excerpt offers a contrast to the “cautious, disengaged manner” that Gill and Maynard (2006) found used by Western doctors in their disconfirmation of patients’ explanations for their illness—at least in the information-gathering phase of the medical interview that they examined. Dr. Song’s approach, which could be described as more direct and confrontational, reflects a more pedagogical, authoritative style of interaction common to Chinese medicine (Y. Zhang 2007).

In this case, we suggest, a considerable amount of metapragmatic work was also involved, as Dr. Song foreshadowed the major shifts that he was asking the patient's parents to make in their understanding of their visit and their enactment of their role as parents. This shift began after Line 3, where Mother questioned Dr. Song's assessment that *this* and *that* didn't have anything to do with one another. In Line 4, with his gaze remaining fixed on the patient as the "assessable" as well as the "resource for constructing a shared participation framework" (Haddington 2006, 285), he accused Mother of not understanding. This was immediately followed by a prediction that "it won't happen again" (Line 6), after which he shifted his gaze toward Mother in a "facial pursuit" that served here as an affective cue "inviting a response" (Peräkylä and Ruusuvuori 2012, 75). This response ("ah,") is given in Line 5, after which Dr. Song paused, looked downwards and made a chopping motion with his index and middle fingers, and issued a directive to Mother to "think," as well as to refrain from influencing her daughter when she "has feelings" (Lines 8–10). This directive was made slightly more explicit, in Line 10, when Dr. Song said "not to give her spasms." This utterance was paired with a dramatic shift in gaze away from the patient and her family, further indexing a stance of disapproval (Haddington 2006). He followed this up with a confirmation request in Line 11 ("Okay?"), still not looking at either the patient or her family but gazing at the group of interns as well as the researchers, and laughing.

Mother laughed along with him (Line 12), also looking up at the interns and researchers. Here, we argue, the work that Dr. Song engaged in involved shifting the metapragmatic focus of the interaction—away from a situation where parents and physician align to figure the patient's issues out together, to a situation where the patient took center stage as the recipient of something unspecified that her parents were doing to cause her illness. He further used gaze at the end of the excerpt to draw in the silent, yet ratified participants (interns and researchers), thereby expanding the participation framework considerably (Goffman 1981). Finally, he drew upon laughter as an interactional resource (Jefferson 1985, 34)—one that often signals affiliation (Jefferson et al. 1987)—to further involve his audience as well as to draw Mother into a shared mood that, at least on the surface, is aligned. Mother's laughter here, we argue, served as a pragmatic strategy that Glenn (2003, 122) suggests is "a basis for resting ... in ways that perhaps maintain some affiliation." Tensions between collusion and collision thus began to emerge in this excerpt.

In the following portion of the interaction, Dr. Song kept his gaze focused on his audience and further detailed Mother's mistaken interpretation of her daughter's symptoms:

Excerpt 2: "The family is too concerned"

- 1 D: ((Gaze fixed on students))
 (1.2) 她一有情绪的人她 (.1)
 (1.2) *ta yi you qingxu de ren ta* (.1)
 (1.2) Once she has feelings, her symptoms come, she (.1)
- 2 妈妈就下套了(.)
mama jiu xiataole (.)
 Mom has set up a trap (.)
- 3 说是这是两次月经之间说是
jiu shi zhe shi liangci yuejing zhijian shuo shi—
 saying that this is between her periods (.), saying—
 ((holds two hands up))



Figure 6. (Excerpt 2, Line 3): “Saying this is between her periods”

- 4 扯!牛头不对马嘴
 CHE—niutou budui mazui
 NONSENSE—the horse’s jaws don’t match the cow’s head—
 ((waving hands))
- 5 这是别↑的事带来的
 Zhe shi BI::E↑DE SHI dailai de
 this is brought on by ↑SOMETHING E::LSE (.)
- 6 M: 嗯呵@@=
 enh heh
 enh heh @@=



Figure 7. (Excerpt 2, Line 7): “Wrongly attributed. The family is too concerned.”

- 7 D: =归因错了(.) 家人太心疼了↑(.)
guiyin cuole (.) *jiaren tai xinteng le*↑(.)
 =Wrongly attributed (.) the family is too concerned ↑(.)
 ((turning to P))
- 8 还有呢,爸爸管太多了=(0.5)
haiyoune, baba guan ta taiduole=
 and also, her father manages her too much=
- 9 M: =对
 =*dui*
 =Right
 ((D turns shifts gaze to look up at M))

In the beginning of this excerpt (Lines 1–5), with his gaze still fixed on his students, Dr. Song accused Mother of “setting up a trap” that he interpreted as “nonsense.” It was “something else” that brought “this” on, *this* here still foregrounding the patient, and her assessable illness. The fact that “something else” was spoken more loudly and at a higher pitch served to prosodically index an intense affective stance (Couper-Kuhlen 2012; Goodwin and Goodwin 2000). Here, Dr. Song also drew upon the strategy of *teaching talk*, which—like the teaching physicians in Atkinson’s (1988) study—he uses often in the clinic not only to socialize his students but also as a metapragmatic “attempt to steer the interaction in the ‘correct’ directions” (Atkinson 1988, 187) through what Goffman might term “byplay” (134). Dr. Song will thus often turn to his students and observers (including any other patients who happen to be in the room), as he did here, and offer some general commentary related to the case. Such talk, we argue, is only on the surface meant for the interns. It is also meant for the patient, who then witnesses the frantic note-taking as students scramble to record his perspective. As such, it serves the purpose of allowing Dr. Song to perform his authority and vast knowledge, and often accomplishes the metapragmatic work of creating an interactive frame in which a hesitant patient might be convinced that he is right about the cause of the issue and about what should be done about it.

In response to Dr. Song’s teaching talk, Mother laughed nervously (Line 6), again possibly highlighting her desire to resist while maintaining affiliation (Glenn 2003). At this, Dr. Song turned to the patient, going on to talk about her in the third person, and upgraded his accusation that Mother had “wrongly attributed” her symptoms, and said that “her family is too concerned” (Line 7). He then underscored the fact that, in his assessment, her illness was her parents’ fault, specifically Father’s fault for “managing her too much” (Line 8). When this elicited a “right” (Line 10) from the mother, Dr. Song finally looked at her again. In addition to continuing to use gaze in this sequence to manipulate engagement and index stance, Dr. Song’s use of the term *xinteng* in Line 7 is significant. *Xinteng*, which can be translated literally as heart-pain, indexes a kind of care in China that Louise Sundararajan explains as a kind of “pity” or “constant worry,”

The pity felt towards the other being small and weak, the constant worry and concern for them being susceptible to hunger, coldness, or hurt from the outside world constitutes the source of the pain. The pain prompts the experiencer to do something all the time to make sure that the other is well taken care of, and this pain may be soothed momentarily by care. (Sundararajan 2015, 80)

Sundararajan continues to explain that the experience of *xinteng* in close relationships prompts people to express “care” through worry. Such care, Kipnis (1997, 29) explains, is embodied in “illness visits” that his research participants in a Chinese village perceived “as actively contributing to curing

the sick." Extending this argument to the hospital setting, the care and concern of *xinteng* is also expressed in the diligence with which parents bring their children, and children bring their parents, to get professional care. In the present excerpt, Dr. Song identified the worry that Mother (and by extension, Father) were expressing as "too *xinteng*." Also, in adding that Father "manages" her too much, he used a combination of prosody, gaze, teaching talk, and terminology to draw into question the culturally shared notions of care that could also be seen as shaping the family's visit. This shift in perspective, we argue, was tied to Dr. Song's diagnosis of the patient, who, we recall, wrote about her struggles with wanting more freedom. Dr. Song perhaps then saw himself as an advocate for the patient, who was notably silent throughout the encounter, keeping her gaze fixed on Dr. Song and smiling intermittently in implied collusion with *both* the physician and her parents. At a broader scale, the shift that Dr. Song was making by questioning the parents' care for their daughter can be seen as key to his overarching aim to change Chinese culture, one family at a time.

Dr. Song underscored this work by going on in the following excerpt to issue an even more explicit upgrade of blame that also brings in the patient's "self":

Excerpt 3: "Daughters will always leave"

- 1 D: 孩::子自己的事情 (.)
 HAL::zi ziji de shiqing (.)
 CHI::ld has her own things happening (.)
 ((D looks away and down))



Figure 8. (Excerpt 3, Line 1): "The child has her own things happening."

- 2 爸爸管太多了↑
 BAbā guan taiduo le↑
 FATHER manages her too much↑ (1.0)
 ((D gazes at F))



Figure 9. (Excerpt 3, Line 2): “Father manages her too much”

3 M M needs to be moved back in alignment with D: @@
 ((M turns and gazes at F))

4 D: 太心疼了↑ (1.6)
tai xintengle↑ (1.6)
 too concerned↑ (1.6)
 ((M shifts her body back and forth, gazes briefly again at F))

5 女儿总是要出嫁的
nuer zongshi yao chujia de
 Daughters will always will leave the home to get married (1.0)
 ((D shifts gaze down))



Figure 10. (Excerpt 3, Line 5): “Daughters will always leave the home to get married”

- 6 你放她一马她将来对你更好 (.)
ni fangta yima, ta jianglai dui ni genghao (.)
 You let her go, so in the future she will be better to you (.)
- 7 M: 哦哦@@
o, o@@
 oh, oh@@
 ((M laughs, D looks up at students))
- 8 D: 你不懂了吧↑ (2.0)
ni budong le ba↑
 You don't understand↑? (2.0)
 ((M nods))
- 9 就这一个女儿这一个女儿忒当宝了
jiu zhege yige nuer, zhe yi ge nu er TEI dangbaole
 This daughter, you baby this daughter TOO MUCH
 ((M frowns and nods))
- 10 忒当宝 (.)
tei dangbao
 baby her too much. (.)
- 11 这个病是你们当出来的病 (1.7)
zhege bing shi nimen dangchu laide bing
 This illness is an illness that you have brought on (1.7)
 ((D looks down))

In Line 1, Dr. Song referred to the patient as a “child,” again raising both pitch and volume, thereby highlighting both the relationship of the patient to the parents as well as continuing to index his emotional stance. This child, he noted, “has her own things happening.” Here, he used the term “self” (*ziji*) to refer to the patient’s self. Along with a gaze shift down, which indexed disapproval and further disengagement, Dr. Song’s proposal that a 23-year-old “child” should have its own self-projects—and in fact, already *does* have its own “things” happening—pointed simultaneously to his insider knowledge of the patient through his reading of her homework as well as to his overarching project of urging people to rethink the ways in which the “self” matures over time, especially vis-à-vis the family. Another accusation of Father’s over-management followed, again with marked prosody indexing a stance of exasperation. Though Dr. Song began his repetition of this accusation with his gaze focused downwards, he paused and then looked up at Father, repeating that he is “too caring” (Line 4). This was the first time that Father, who had until now been silently standing behind Mother with a nondescript countenance, had been addressed directly. In the midst of this shift in the conversation, Mother demonstrated her resistance as well as her continued desire to appear aligned, laughing nervously again, and shifting her body and gazing back and forth at Father, the students, and Dr. Song (Lines 3–4).

After a pause, when Dr. Song was sure that he had caught Father’s attention through shared gaze, he stated that “daughters will always leave the home to get married” (Line 5). This, we suggest, served as a critical move. In his directive to “let her go” (Line 6)—in which for the first time in the encounter he directly addressed Father as “you,” Dr. Song again linked his analysis of the patient’s physical problems to her father’s restrictiveness, invoking the heteronormative cultural assumption that women will move out of their house to get married. Drawing on this cultural “cosmic absolute” (Silverstein 2003, 202) at the same time as he questioned the very basis of this family’s operation in terms of care, Dr. Song thus completed a sequence that shifted blame entirely to the parents. More nervous laughter (again, possibly indexing resistance with the desire to align) followed from Mother (Line 7), and Dr. Song again turned to his audience for confirmation. Dissatisfied with Mother’s “oh” and laughter, as well as Father’s silence, Dr. Song questioned their understanding again in a confirmation request (marked here by the final particle *ba*, which indexes a rhetorical question or suggestion) that again addressed them directly as “you”

(Line 8). Though this did elicit a nod from Mother, Dr. Song reiterated the blame, saying that they baby their daughter too much, and stating bluntly that they have caused the illness (Lines 9–11).

The blame had been fully issued at this point, and even though she displayed outward signs of alignment (laughter, nodding), Mother continued to talk about her theory that the “illness” had something to do with the daughter’s graduation from college and subsequent scare by the dog,

Excerpt 4: “Even when she argues with her future husband”

- 1 M: 多少年了,大学一毕业了
duoshao nian le, daxue yi biye le
 So many years, once she graduated from college
 ((M is looking away from D))
- 2 就不得这个毛病了
jiu bude zhege maobing le
 she came down with this illness=
- 3 D: 没有这个病(.)
meiyou zhege BING (.)
 There is no such ILLNESS (.)
- 4 chhh-很快就过去了
cheh—henkuai jiu guoqu le
 chehh—it will be over soon.
- 5 M: 嗯
eh
 eh
- 6 D: 你们慢慢要给她自由了(.)
nimen manman yao gei ta ZIYOU le (.)
 You two slowly have to give her more FREEDOM (.)
- 7 你不给她自由肯定-你看 (1.2)
ni bu gei ta ziyou zhe ge bing—ni KAN (1.2)
 If you don’t give her freedom, then this illness—LOOK (1.2)



Figure 11. (Excerpt 4, Line 9): “It is because her father puts limits on her freedom”

- 8 上次,两次月经中间,半个月的时候 (.)
shangci, liangci yuejing zhongjian, bange yue de shihou
 last time, two times between her period, when it was half a month
- 9 就因为爸爸限制了她的自由 (3.0)
jiu yinwei (.) baba xianzhi le tade ziyou (3.0)
 it is because (.) her father puts limits on her freedom (3.0)
 ((D looks down and makes chopping gesture))
 ((F moves for the first time to see more clearly, and smiles at D))
- 10 M: <WH 对>
dui
 <WH Yes>
 ((M shifts on her feet, smiles awkwardly))
- 11 D: 得病了(.)
you debing le (.)
 that she got sick (.)
 ((D looks up at M))
- 12 当然啦,我以后让她限止自由
dangran, wo yihou rangta XIANZHI ziyou
 Of course, in the future I will make it so that even with LIMITS on her
 freedom
- 13 也不得病(.)
ye bu debing (.)
 she won't get sick (.)
- 14 让她跟她以后丈夫吵架
Rang ta gen ta yihou zhangfu chaojia
 I will make it so that even when she argues with her future husband
- 15 也不得病 (3.0)
ye bu debing
 she won't get sick
 ((D looks up and smiles brightly))



Figure 12. (Excerpt 4, Lines 14–15): “I will make it so that even when she argues with her future husband, she won’t get sick.”

In the beginning of this final excerpt, Mother notably looked away from Dr. Song and reiterated her theories of causation. At this, Dr. Song promptly rejected even the notion that there was an illness, shaming the mother with a “chhehh” sound (indicating obviousness and disgust) that was followed by another prediction that “it will be over soon,” pending their ability to give her more freedom (Lines 3–6). After issuing the directive to give her more freedom, Dr. Song did not pause. Instead, he launched directly into a negative prediction implying that if they do not give her more freedom, then the “illness” (which according to his earlier talk did not even really exist) would get worse (Line 7). Before proceeding with this prediction, however, Dr. Song changed tactics, interrupting himself and reiterating his prior explanation of the problem, namely, that her menstrual issues were related to limitations that Father imposed on her freedom (Line 9). After this final reiteration of blame, Father moved out from behind Mother for the first time in the encounter, and smiled at Dr. Song. Dr. Song, capitalizing on this shift in participation framework, said nothing. Finally, after a full three seconds, Mother offered a whispered “acceptance” of his explanation (Line 10), while she shifted back and forth on her feet and smiled embarrassedly. Instead of responding to her apparent discomfort, however, Dr. Song took Mother’s “yes” and ran with it to drive his point home again by finishing his sentence—a repeat of blame—in Line 11.

Immediately following this statement, Dr. Song continued on to make a prediction/promise about the future. Here, he explained that he would “make it” so that she wouldn’t get sick in the future, “even with limits on her freedom” (Lines 12–13). Whether they chose to follow his directive to let go of their daughter or not, Dr. Song argued, he had the power to change her fundamental condition, and to do so to the extent that she wouldn’t get sick even with their imposed limitation, and even when she argues with her imagined future husband (Lines 14–15). This served as a multilayered promise that not only could he make her better, but that she will be better enough even to get married and live a happy life with her (future) husband. While it tied back to his earlier assertion that daughters (should) always leave the home, this promise (regardless of what Austin or Searle might say about its felicity conditions) functioned pragmatically to shift authority over the patient from the parents to himself. Dr. Song thus set up an interactional frame in which he, as expert, not only had insight into both the past (the cause of the problem) and the conditional future, but also the power to change the patient regardless of the parents’ compliance. At this point, he looked up at Mother and offered a bright smile. Mother laughed nervously. Dr. Song thus drew upon a structured use of gaze shifts, prosody, terminology, and participation framework shifts to establish a metapragmatic framework within which his statements positioned him as an “authority over” instead of an “authority with” with the parents. Within this framework, he communicated that (1) the parents were to blame for the illness—specifically by caring for their daughter in a certain culturally consistent yet ultimately detrimental way, and (2) he had the power to change her, both psychologically, and physically, even without their compliance.

Changing Culture?

The previous section demonstrates how Dr. Song, while supporting certain key cultural conventions such as marriage and the moralistic framework of Chinese medicine, constantly challenges longstanding cultural models for enacting family, self, and illness. In his insistence on integrating Western psychology, he also intervenes in the enactment of Chinese medicine as a healing modality that supports rather than contests “traditional” ways of being. We have shown how he voices these challenges and interventions through both multiple interactive moves, including offering direct explanations, shaming, blaming, controlling the floor, interrupting, performing, making predictions/promises, offering directives, drawing upon deictics to frame the interaction, and using teaching talk as a way to demonstrate his

authority. Over the course of the interaction presented above, Dr. Song's explanation that the parents' way of enacting care for their daughter was cause of their daughter's symptoms thus emerged over the course of multiple turns. Throughout all of these turns, Dr. Song used various semiotic strategies to effectively invoke his authority, challenge his interlocutors, and elicit agreement from them. Dr. Song, we note here, is well aware that he uses such tactics. His explicit, articulated goal with such strategies is to break through patients' resistance quickly so that he can then offer the types of direct explanations that fundamentally challenge most peoples' expectations about Chinese medicine as well as the way to best heal the self in the context of the family. In interviews and conversations, he thus justifies his adoption of this dominant style with the argument that he is mostly dealing with patients who are so accustomed to being dominated that they would otherwise never change.

Beyond a study of the immediate situation, how might we be able to understand the "force" of Dr. Song's strategies in terms of its effect (Austin 1962)? After all, with their silence, their reluctant "agreement," and their nervous laughter, Mother and Father were far from passive in this interaction. Their resistance, we argue, served as a key part of a semiotic collision that was also, at times, collusion in terms of the norms of institutional interaction. Perhaps the most obvious indication of the *lack* of efficacy or force in the current example is the fact that, after this meeting, the patient and her family never returned for further treatment. With this information alone, we might argue that, despite Dr. Song's intense efforts to change peoples' core beliefs about the self and the family—or perhaps because of them—the encounter was essentially unproductive.

Though this may sometimes be the case, it is also important to consider the role of the silent patient in the current example. In her private interview, the patient offered a great deal of insight into some of the effects that Dr. Song's perspective had had on her own self-understanding. After seeing Dr. Song twice, she explained,

"I feel like my understanding [of myself] has broadened, and that the things I recognize are a bit deeper. . . . I [feel like] my thinking is not as naïve. Like I feel like with the stuff he was just saying, the stuff having to do with my parents, with regards to my emotions. I've come to see some things."⁴

This comment highlights the patient's "broadened" understanding of herself, and her family, as a result of Dr. Song's analysis of her situation. It was followed by a short discussion of how she realizes that changes need to be made in her relationship to her parents. Insisting that she would like to make such changes, but perhaps by drawing upon a slightly less harsh approach than Dr. Song had suggested, the patient went on to say that after just two sessions in the clinic, she had begun to feel more like "herself." Whether or not this awareness will "stick" or not, this perspective underscores the ways in which Dr. Song's approach sometimes does work the way he intends it to: by shifting, even only slightly, deeply lying frameworks of selfhood, family, love, and medical care.

Even though we have no idea whether this patient will take different actions based on this self-report, it does suggest the extent to which even brief encounters can play a significant role in individuals' projects of "self-authoring," in which "the 'I' draws upon the languages, the dialects, the words of others to which she has been exposed" (Holland et al. 1998, 170). Here, in the contentious "clinical border zone" (Mattingly 2010), the effects of Dr. Song's intentions emerged in a set of complex interactions—including the initial appointment, the patient's writing up of her homework as well as Dr. Song's reading of it, and the consultation presented above—that were multiply textured by both cooperation and resistance, both collusion and collision. Each set of such interactions in Dr. Song's clinic unfolds slightly differently, depending on the interlocutors involved. Many patients, along with their families, *do* pursue extensive treatment with Dr. Song over the course of months and sometimes years. The focused study of more examples of interactions in Dr. Song's clinic alongside this one is thus warranted. We suggest that the set of interactions presented here provides a starting

point for understanding how cultural changes in medicine, intimacy, and individuals' experience of selfhood can emerge in complex interactions that involve multiple layers of cooperation and resistance.

Conclusion

The notion that Dr. Song is creating a unique form of medicine by fusing Western psychological ideas with Chinese medicine is one that he often discusses as a kind of culturally influenced translation, born of genuine need for people to change themselves in contemporary society. Dr. Song is thus tuned in to an increasing mismatch between certain ways of "doing self" or "doing family" in China and the demands of contemporary life. Dr. Song's questioning of family models puts him on par with other physicians, psychologists, parents, and individuals who are increasingly beginning to question established models of the family in China (Kuan 2015; Yan 2016). As several scholars have described, this includes an enormous outpouring of popular media, including online forums, internet groups, self-help books, and television programs, as well as continuing education workshops devoted to helping people to find more developed ways of expressing themselves as well as supporting their children to become stronger individuals (Evans 2012; Huang 2014; Kuan 2015; Lee 2011; Pritzker 2016; Yang 2013). Dr. Song's work to support his patients' expression of their individual feelings falls into alignment with many of these cultural trends, albeit with a slightly different definition of what constitutes healthy or successful selfhood. His harsh and authoritative demeanor differ considerably from other forms of psychological work in China, however, which often freely incorporate the gentler register of so called "psychospiritual development" (see Pritzker 2016). Studying the ways that Dr. Song attempts to force his view on people, however, provides an ethnographic window into a particular physician's attempts to change what he understands to be "Chinese medicine" in the midst of a particular moment of tension in China, where the framework of personhood vis-à-vis the family is increasingly being called into question.

Even if scholars agree that what Dr. Song is doing is not technically "Chinese medicine," we suggest that the study of individuals who undertake projects of innovation in the name of Chinese medicine is relevant to overall efforts to understand how competing versions of this diverse practice come to exist. Following scholars who show that Chinese medicine is a complex assemblage of theories and practices that is always undergoing various types of innovation (Andrews 2014; Farquhar 1994; Hsu 2001; Scheid 2007; Zhan 2009), we thus question the notion that Chinese medicine is a static tradition. We further argue that the current study suggests *how* such innovations are dialogically accomplished in interactions that extend far beyond the clinic into the personal lives of patients. This, for methodological reasons related to the lack of access to real-time interaction, is difficult to grasp historically. Looking at such interactions through the lens of linguistic anthropology, in particular by focusing on microinteraction, offers a more nuanced understanding of how innovation in medicine is enacted in everyday practice in a series of complex, semiotically mediated engagements among differently positioned social actors.

In conclusion, our analysis of Dr. Song suggests that a close study of everyday interactions in clinical settings can offer insights into the ways in which clinical interaction participates in the concerted co-constructed transformation of culture. By examining Dr. Song's approach as a kind of "living translation" (Pritzker 2014) that occurs in a dialogically emergent and conversationally unpredictable "contact zone" (Pratt 1991, 1992) involving texts, bodies, and medical practices, we thus demonstrate how a theoretical and methodological emphasis on the micropolitics of interaction in certain institutional contexts can complement the scholarly study of cultural, social, medical, and personal change over time. This approach, we argue, has broad implications for the ways in which linguistic anthropology can contribute to the ethnographic study of how changes in culture emerge in complex interactions that

qualify neither as complete collusion nor complete collision, but hinge on the tension created between the two.

Notes

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3. Ots argues that this phenomenon need not be read as an uneducated “somaticization” of emotional complaints. Instead, he points out that in China, “there exists a long tradition of expressing emotions in somatic metaphors [that is] in part . . . based on the sophisticated and systematized observation of the correspondence of emotional and somatic complaints” in Chinese medicine (Ots 1990, 26).

4. “就是感觉认识面可能更广一些,然后认识东西也更深刻一点,有些东西就想的不那么幼稚了,就是感觉像他刚才说的,就是关于父母啦,什么情感上的,认识到了这些东西”

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