everett yuehong zhang

THE IMPOTENCE EPIDEMIC

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MEN'S MEDICINE AND SEXUAL DESIRE IN CONTEMPORARY CHINA

Everett Yuehong Zhang

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To Arthur Kleinman

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INTRODUCTION

The Impotence Epidemic in China

In both Beijing and Chengdu in the late 1990s, concern about *yangwei* (陽痿, the shrinking of *yang*, i.e., male sexual impotence) was more visible and "contagious" than it had been during the Maoist period more than twenty years earlier. Flyers on lampposts along city streets advertised clinics that specialized in curing sexually transmitted diseases and male sexual dysfunction, and commercials appeared in the media touting *zhuangyang*, herbal tonics to cure impotence. Discussions of impotence in the media and on the Internet had become common. In the early 2000s, on a television program showcasing useful gadgets, the inventor of a new type of bicycle seat with a hole in its center boasted that the design would help reduce the risk of male impotence and make a huge contribution to Chinese people's sex lives, given that China is such a bicycle-oriented country.[1]

One Sunday afternoon in late 1999, I observed an especially vivid illustration of this "contagion" in public spaces, when *Television Clinic*, a call-in show on Beijing Television (BTV), aired a special program on erectile dysfunction (ED). The program was sponsored primarily by Pfizer, the pharmaceutical company. Three nationally known urologists answered callers' questions on two hotlines. During the one-hour program, they were inundated with calls and, unable to respond to all of the questions being raised, could only direct many callers to hospitals in Beijing where they could seek consultation or medical treatment for impotence. I observed the live broadcast from inside the TV studio. Four male assistants took the phone calls, jotting down callers' questions and then passing them on to an employee of Pfizer's Beijing office. He selected questions for the three urologists to answer. The four assistants later chatted with each other about their brief conversations with callers who had sounded especially eager for advice. One imitated a

Figure 1.1: Three nationally known sexual education experts or urologists answering questions about male sexual dysfunction through a hotline on the program "Television Clinic" of Beijing Television Station (BTV). The anchor person is on the far left and the two persons on the far right are taking phone calls.

caller who lamented, "My situation is bad . . . I can't do it, however pretty she is!" Another assistant said, "Many women called in, asking about their husbands' problems!" As the phone calls had poured into the studio, one of the three camera operators, a middle-aged man, exclaimed to me, "ED is becoming an epidemic!"

Various lines of evidence confirm the growing prominence of male impotence in post-Mao China. First, although they appeared as far back as the 1970s, the clinic flyers mentioned above had, by the 1990s, become common sights in the urban landscape. The clinics advertised by the flyers were often back-alley operations. Those who ran them were uncertified doctors, considered by many as, at best, *jiming goudao zhi tu* (those who crow like a cock or snatch like a dog, i.e., get up to petty tricks) or, at worst, *jianghu pianzi* (charlatans fooling round). A strong stigma was attached to such clinics.

They were not impotent men's only recourse, however. Since the 1980s, *nanke* (men's medicine), a new division of Chinese medicine that specialized in treating impotence and other male sexual problems, had emerged in hospitals throughout the country. By the end of the 1990s, nanke had become

Figure 1.2:
An advertisement for a zhuangyang patent capsule. The central lines read: "Taking only three pills, you could get it up."

Figure 1.3:
An advertisement for a clinic on a lamppost in a back alley in Beijing, touting rapid efficacy of curing impotence, premature ejaculation, and sexually transmitted diseases.

Figure 1.4: An advertisement for a clinic in Beijing.

a widely established specialty, bringing the concern about impotence out of back alleys and into mainstream hospitals.

A second line of evidence involves literary representations of impotence. In the early 1980s, the well-known novel *Half a Man Is Woman*, by Zhang Xianliang, portrayed a political prisoner's experience of impotence in the Maoist period. Since then, such portrayals have proliferated. In movies such as *Furongzhen*, *Qiuju daguansi*, and *Ermo* and in novels such as *The Rabbit in the Grassy Ground of de Gaulle International Airport*, *The Defunct Capital*, and *Shanghai Baby*, impotence is evoked as a symbol not only of damaged masculine capacity but also of the crises experienced by different groups of people during the post-Mao reform, indexing the shifting social context in which impotence has occurred.

A third line of evidence is the marked increase in sexual joking, or *kouyin xianxiang* (the phenomenon of the lustful mouth, i.e., intensely erotic conversations). The sharing of erotic jokes has in recent years become a veritable fad thanks to cell phone text messaging. The joking often focuses on impotence. For example, one private entrepreneur joked, "Xianzai shi wanshang ying bushui, zaoshang ying buqi" (Nowadays, men just do not want to go to bed in the evening and have difficulty getting up in the morning). "Getting

up" is a pun referring to involuntary nocturnal erections (not experiencing them is considered a sign of the decline of potency or of impotence). This man was describing the lifestyle of entrepreneurs and businessmen, who spend much of their time *gouduing* ("thickening" relationships with) state officials or business partners, attending banquets, and seeing prostitutes in the evening. Another businessman joked, "Jiating zuoye kao chiyao; kewai zuoye kao ganjue" (Nowadays, a man relies on drugs to do "homework"—i.e., have sex with his wife—and he relies on feelings or sensations to do "outside work"—i.e., have affairs or see prostitutes).

What is one to make of this "epidemic"? Have more Chinese men suffered from impotence over the past 20 years than in previous years? These two questions call our attention to the close relationship between the rise of the epidemic and the tremendous changes that Chinese society has undergone in the postsocialist era. In this book, I address that relationship, asking whether massive socioeconomic changes account for the epidemic.

Countering the "Biological Turn"

Impotence has historically aroused public concerns in various parts of the world. For example, in seventeenth- and eighteenth-century France as well as in other parts of Catholic Europe, the clergy would grant a divorce to a married couple when presented with evidence that the husband was impotent. This rather public show of investigation and trial was intended to ensure reproduction and thus protect the "sacred nature" of the family (Darmon 1986; McLaren 2007). In the eighteenth century, impotence also became a public issue in Europe partly because of rising concern about masturbation, which was perceived to cause all kinds of problems (including impotence) that led to degeneracy and depopulation (McLaren 2007; Laqueur 2003). More recently, in the early 1970s, a wave of discussion about impotence washed through the media in the United States, the cover story of one issue of *Esquire* magazine asking, "The Impotence Boom: Has It Hit You Yet?" (Nobile 1972). In this case, concern allegedly reflected the increasing pressure on men's potency due to women's empowerment through the sexual revolution and the feminist movement. Historical concerns—about the weakening of the family and the "degeneracy" of the population—did not strike me as particularly relevant for understanding the impotence epidemic in China. Women's demand for sexual fulfillment, the putative reason for the "impotence boom" in the United States, offered suggestive interpre-

tive clues but fell far short of accounting for China's epidemic, which was unprecedented in scale.

At first glance, the epidemic suggested that more Chinese men were suffering from impotence in the 1990s than had been the case two decades earlier. If true, how do we explain such an increase? I turned to existing studies for explanations. However, when I began my fieldwork in the late 1990s, I found that studies of impotence outside the fields of biology and psychology were rare and that there had been no ethnographies of impotence. Impotence was mentioned only in passing or euphemistically in a number of anthropological studies (e.g., Gregor 1977; Gilmore 1990; Herdt 1994; Parker 2009; Godelier 1986; Allison 1994; Cohen 1998), or it was presented as a consequence of undergoing special ritualistic bodily alterations, as in the case of India's third sex (Nanda 1998; Cohen 1995), a phenomenon limited to small groups of men. It was not until the 2000s that ethnographic presentations of impotence began to go beyond anecdotes and become a small but integral part of anthropological studies of masculinity, sexuality, and HIV/AIDS (e.g., Gutmann 2007; Frank 2002). Even in "masculinity studies," one could find few examples that explored the experiences of impotent men.[2] The invention of Viagra in the late 1990s spurred studies of impotence in many fields of the social sciences and the humanities—among them, anthropology, sociology, gender studies, cultural studies, public health, history of science and medicine, philosophy, and communication (e.g., McLaren 2007; Potts and Tiefer 2006; Fishman 2006; Loe 2004; Botz-Bornstein 2011). However, those studies focused more on symbolic representations of the social and cultural effects of anti-impotence technologies than on the bodily experiences of impotent men, with the exception of scattered journal articles (e.g., Potts 2004; Potts et al. 2003).

While psychology and biology have contributed a great deal to our understanding of impotence, their limitations are obvious. The disciplines with the *psy* prefix, for example—psychoanalysis, psychology, psychotherapy, psychiatry, psychological counseling, and so on—tend to lose sight of social context in their etiological analyses of impotence. Below, I provide a brief review of the contributions and shortcomings of psychological and biological approaches to impotence and of the shifting dominance between them.

In his clinical practice in the early twentieth century, Sigmund Freud observed what he called "psychic impotence," which he believed to be "much more widespread than is supposed" (1989b:398). Psychic impotence occurred, he believed, because "the affectionate and sensual currents in love"

failed to coincide (398). Male adult sexuality was overshadowed by the Oedipus complex developed in childhood, when the son's sensuality became incestuously fixed on the mother. The result was that, later in life, affection and sensual desire could not merge to enable a man to complete sexual intercourse, or affection was rendered precarious and was disrupted by a lack of sensuality, leading to impotence. Those who suffered from psychic impotence were caught in an impossible situation: "Where they love they do not desire and where they desire they cannot love" (397). Despite Freud's very perceptive insight that family life was the social matrix for the formation of sexual habit, he interpreted impotence as "a universal affliction under civilization" rather than "a disorder confined to some individuals" (398) and as a predominantly psychic abnormality. Thus, his insight was stripped of its power by his presumptions of the essential nature of the Oedipus complex and of increasing repression under civilization and by his dismissal of the rich variety of social forces that might contribute to the condition but that did not fit his thesis of civilization's sexually repressive effect.

Wilhelm Stekel, an Austrian psychoanalyst and onetime collaborator of Freud, wrote a two-volume book on male impotence based on over 120 clinical cases. While he provided a wealth of detail, he did not go beyond the Freudian tradition (Stekel 1959 [1927]; see chapter 3, this volume). Psychoanalytical and psychological approaches continued to develop in the decades after Stekel, culminating in William H. Masters and Virginia E. Johnson's (1970) sensitization therapy in the 1950s and 1960s with its emphasis on strengthening interpersonal relationships to cure impotence (see chapter 4). By and large, for most of the twentieth century, the psychological view dominated the study and treatment of impotence (e.g., Rosen and Leiblum 1992; Kaplan 1974). Sexual therapists did pay attention to more immediate social conditions (e.g., the influence of family background and religious beliefs) but seldom related impotence to broader social and cultural conditions and changes.

Psychology's dominance began to wane in the 1970s, undermined by rapid biomedical development (see chapter 7) that spurred widespread medicalization or, more specifically, biomedicalization of human conditions and problems (Lock and Nguyen 2010; Clarke, Mamo, Fosket, Fishman, and Shim 2010). Tom Lue, a renowned U.S. urologist, pointed out in 2000 that the medical field of impotence had taken "a biological turn": "The past three decades have witnessed a dramatic change in the treatment of men with erectile dysfunction. Treatment options have progressed from

psychosexual therapy and penile prostheses (1970s), through revascularization, vacuum constriction devices, and intracavernous injection therapy (1980s), to transurethral and oral drug therapy (1990s)" (2000:1812).

The pendulum thus swung to the biological side in diagnosis and treatment of impotence, reaching its peak when Viagra, an anti-impotence drug, was invented in the late 1990s in the United States. It was introduced into the Chinese market in 2000. Reflecting this new development, one of the most prominent statements about the etiology of impotence asserted that "the penis [in the context of] a rigid erection is the equivalent of a hydraulic system" (Goldstein 1998). Curing impotence, from the biological perspective, requires solving problems related to the blood dynamic system in the human male—ensuring blood's unimpeded delivery to the penis at the proper pressure—just like fixing a hydraulic system for irrigating crops. With the invention of Viagra, then, the pendulum swinging between psychology and biology seemed finally to stop on the side of biology. Human potency was now largely understood as "penile erection," which "is a *neurovascular event* modulated by psychological factors and hormonal status" (Lue 2000:1802, emphasis added).[3]

With this biological turn, two views dominated interpretation of the impotence epidemic in China. Urologists argued that, because the standard of living had risen, people's intake of fat and sugar had increased, potentially increasing the risk of cardiovascular diseases and diabetes, which are closely associated with impotence. The psychological explanation, represented in the country by newly emerging professionals in psychotherapy and related fields, maintained that as the pressure increased to make money in the consumer society created by post-Mao economic reform, male potency fluctuated. While the two perspectives touched on the change that was taking place in Chinese society, they nonetheless were problematic. First, they assumed an increase in the incidence of impotence in the population, which had not been proven. Second, they treated impotence primarily as a neurovascular event with a psychological layer attached to it.

Traditional Chinese medicine (TCM) had managed impotence for more than 2,000 years and had developed a systematic set of diagnostics and treatment long before the ideas of Western medicine (e.g., urology) and psychotherapy were introduced into China. TCM did not, however, develop a formal specialty focused on impotence until nanke (men's medicine) came into being in the 1980s, a symbol of the epidemic (see chapter 1). Nanke offered its own explanations for the epidemic. Two perspectives dominated—one

focused on *shen* (the kidney) and the other on *gan* (the liver)—though both paid attention to the adverse impact of changing lifestyles on the male body, in accordance with Chinese bodily cosmology (see chapters 5 and 6). But, under the pressure of biomedicalization, TCM's concern about the impact of social context on impotence tended to be muted.

My anthropological training pushed me to see the impotence epidemic as more than a biological phenomenon and impotence itself as more than a neurovascular event. First, I drew on the trademark contribution of anthropology to studies of diseases and illnesses—understanding the social and cultural contexts and conditions in which diseases occur (e.g., Lock and Nguyen 2010; Kleinman, Das, and Lock 1997; Good 1994; Good et al. 2010; Scheper-Hughes and Lock 1987; Turner 2008). Arthur Kleinman's (1986) demonstration that widespread neurasthenia in China had been associated with political and social conditions in the aftermath of the Cultural Revolution offered an immediate inspiration for exploring the impotence epidemic beyond the "neurovascular event" thesis. Judith Farquhar (2002) pointed to impotence as a symptom of China's transformation, calling for a close examination of how the impotence epidemic had accompanied profound changes—such as decollectivization, privatization, individualization, and commercialization (see, e.g., Kleinman et al. 2011; Yan 2010; Zhang and Ong 2008; Hansen and Svarverud 2010; Liu 2009; Rofel 2007)—that might have had an impact on people's sexual lives.

Second, unlike those who view impotence as a specifically male neurovascular event, I explored both men's and women's experiences with the condition. Experience (*tiyan* in Chinese) is not simply a combination of the biological and the psychological but also includes forces that the body incorporates and feels (Heidegger 1962; Merleau-Ponty 1962; Bourdieu 1977; Csordas 1993; Kleinman 1999).

The English phrase *bodily experience* is similar in meaning to the Chinese term *tiyan* (體驗, to feel with the body).[4] *Ti* (體) means "body," and *yan* (驗) connotes "proving," "examining," and "testing." But the English term *body* does not capture the full connotation of the word *ti*, nor does the double-syllable phrase *shenti* (身體) in Chinese have the same general referent as the English term "the body."[5] A number of studies have pointed out such a gap between shen, ti, or shenti in classical Chinese and the "body." Shen, ti or shenti tend to be open to connotations such as the personhood, the whole person, and even the "being" as seen in the phrases such as shenshi (personal history), shenfen (status), zhongshen (the whole life), and so on (Elvin 1993;

Ames 1993; Brownell 1995; Kohrman 2005; Jullien 2007; Y. Zhang 2007). This linguistic openness of shen, ti, or shenti embodies Chinese philosophical understanding of the integration of human and the universe on the one hand and the practical existence of human beings within the world on the other hand, which is lost in their translation into the body. The whole genre of the anthropological studies of Chinese medicine testifies to just that. In contrast, the term *body* commonly refers to "a discrete given, an independent and isolated object" (Kuriyama 1999:262) and is more a definition of the post-Enlightenment entity than of the ancient Greek. There was no "shenti" in ancient China in the sense of "the body" today.

However, perhaps as the result of the vernacular revolution in the early twentieth century in which double-syllable phrases tended to replace their single-syllable classical Chinese antecedents, the popular usage of shenti in modern Chinese coincided with the increasing influence of the Western anatomy-based notion of the "body" and replaced the meanings of *shen*, *ti*, or *shenti* in the bodily cosmology of Chinese medicine, Chinese philosophy, and Daoism. As a result, shenti today on many occasions refers to the body. In this book, for the sake of convenience, I use the body to refer to shenti in general but remind the reader from time to time of the gap between the body and shenti, however narrowed it has become.

Since no epidemiological study of impotence in China was available, we are not sure that many more men suffered from impotence in the post-Mao era than in previous periods. Yet the impossibility of confirming an increase in incidence of male impotence in the population, instead of mystifying the epidemic, only opened up a new horizon for exploration of lived experience; the increasing visibility of impotence in and of itself pointed to a new way for me to think about the epidemic. I began to ask whether this increasing visibility had been driven by society's desire—men's as well as women's—to face it and seek its treatment. If so, how?

Recognizing Desire

In inquiring into what compelled men to seek medication for impotence, I was immediately drawn into the traumatic nature of their experience, because impotence was so commonly perceived as a death knell for masculinity. It was not unusual to hear an impotence patient say that he would rather die than continue to live with the condition. According to a survey I conducted, 66.9 percent of patients in Beijing and 57.4 percent of patients

in Chengdu would choose to remain potent and die at 65 rather than live to 80 after suffering from impotence for decades.[6] Not surprisingly, many patients looked depressed (see chapters 1, 3, 4, and 7).

The shame associated with impotence derived from the thesis that impotence is a universally acknowledged, timeless, and context-free threat to essential masculinity. Because this essentialist view is hegemonic, the issue is singularly resistant to questioning and reflection. With few exceptions (e.g., Candib and Schmitt 1996 in the humanities and the anthropological studies cited in chapter 1), the literature on how impotence damages masculinity and thus generates unspeakable shame for a man is based more on assumptions than on careful inquiries. The stark contrast between the presumed centrality of potency to masculinity and the lack of empirical social scientific studies of men's experience of loss of potency (outside of clinical psychology) makes a study of impotence experience critically important. To demystify and destigmatize impotence and to question the perception that impotence spells death for one's masculinity, it is necessary to break through the "concerted euphemism" attached to it.

My sample of interviewees showed that impotence in China was not correlated with class, education, profession, or geographic region. Factoring out age, it seemed that, statistically, any man could become impotent.[7] Notably, however, the impotence epidemic appeared to be associated with drastic changes in the social world, revealing that the traumatic nature of impotence including the extreme shame associated with it could be socially and culturally produced.

Many impotence patients reported that they experienced disturbances and instability in their immediate lifeworlds at the time of symptom onset. For example, being laid off from state-owned enterprises during the restructuring of the economy from centralized to market-oriented was a painful experience for many men partly because they had never imagined such a thing, with its attendant decline in social status, could happen. Some men complained that they had been indoctrinated to serve under socialism and then been left behind by postsocialism. But their bodily experience of impotence was often a more powerful articulation than their verbal complaints of the unfairness of their loss of employment during the transition (see chapter 3).

Even those who seemed to benefit from the post-Mao transformation were not immune to the epidemic. For example, in the new consumer culture, business was conducted in the context of abundant and easily accessible food, tobacco, alcohol, and sex. When a businessman felt obligated to

constantly engage in a nightlife of banqueting, binge drinking, and seeing prostitutes, the bodily consequences—including impotence—could be traumatic (see chapter 5).

It gradually became clear to me that impotence in post-Mao China was experienced as a disturbance resulting from multiple forces of social transformation that were, to quote Freud, "too powerful to be dealt with or worked off in the normal way" by the body (1964:275). Impotence became a way for the body to respond to this disturbance. But, departing from the Freudian thesis of universal pressure to which men were subjected under civilization, I focused on the specific impact of the post-Mao transformation.

Anthropology has developed powerful conceptual tools for examining how social injustice is inscribed on the body and causes suffering: "structural violence" (Farmer 2004), "the violence of everyday life" (Scheper-Hughes 1992, "social suffering" (Kleinman, Das, and Lock 1997), and "social abandonment" (Biehl 2005). Those frameworks serve as powerful inspirations for interpreting many cases of impotence.

At the same time, anthropology has also produced compelling ethnographic accounts of people's amazing resilience and capacity for desire despite the social injustice they are forced to endure (Biehl 2005, 2010; Scheper-Hughes 1992). I had expected my study of impotence to be about suffering, but I was surprised to find that a unique characteristic of the impotence epidemic had been buried in the narratives of traumatic experience: the articulation of unsatisfied desire and the longing to enjoy sex.

For example, some older people were encouraged by discourse extolling the positive impact of sexual gratification on the well-being of the elderly and by the establishment of nanke, and they challenged the popular view that just because one's potency declines as one ages, one should give up on sex. More and more older men began to seek medical help for impotence, and doctors I interviewed indicated the maximum age among patients seeking treatment was being pushed higher and higher. The ages of the patients I talked to ranged from 18 to 81.[8] Also, the increasing eagerness with which men sought medication for impotence often reflected the urging of women—after couples had had a child under China's one-child policy. Reproduction, then, was not a major reason to seek medical intervention for impotence.

The reason for the suffering associated with impotence—the frustration of sexual pleasure—was recognized and legitimated by nanke and brought

out into the open. The impotence epidemic in post-Mao China became a positive sign of what Gilles Deleuze and Félix Guattari called "desiring production" (1983, 1987).

"Wait a minute," the reader might ask, "are you saying that the impotence epidemic might be understood as something other than suffering, a masculine crisis, or an ominous sign of social woes?" My answer is that an individual case of impotence might be experienced negatively in terms of suffering and crisis, but the willingness and urge to seek medical help to satisfy sexual desire represented a positive orientation. Therefore, I view the impotence epidemic in general terms as a positive event of "desiring production" in post-Mao China.

IMPOTENCE AS "DESIRING PRODUCTION"

The idea of "desiring production" was a unique contribution Deleuze and Guattari made to our understanding of capitalism, particularly by enriching the Marxist view of capitalist production of capital and labor while critiquing the psychoanalytical tradition of conceptualizing desire negatively confined in the Oedipus complex.[9] Referring to the mode of capitalism based on creating motivations (investing, gaining ownership of property, consuming goods, etc.), "desiring production" described the force of capitalism in terms of generating flows and producing desire. "Capitalism is in fact born of the encounter of two sorts of flows: the decoded flows of production in the form of money-capital, and the decoded flows of labor in the form of the 'free worker' . . . Capitalism tends toward a threshold of decoding . . . and unleash[es] the flows of desire" (Deleuze and Guattari 1983:33). If precapitalist society tended to code desire, that is, to place restrictions on the desire, capitalist production tended to decode desire, that is, to unleash the flows of desire. Therefore, an analysis of capitalist production is nothing other than a combination of an analysis of political economy and the economy of desire.

Collapsing the line between desiring production and social production, "desiring production" sheds light on "the intrinsic power of desire to create its own objects" and "the objective being of man, for whom to desire is to produce" (Deleuze and Guattari 1983: 25, 27). Therefore, "social production is purely and simply desiring production itself under determinate conditions" (29).

Many anthropological studies of the post-Mao reform have been anchored in the issue of soaring individual aspirations. Those individual aspirations moved away from the collective passion in the Maoist period,

under the determinate conditions of the rise of market economy, individual desire, increasing private ownership, and so on. For example, why did children in Dalian in Liaoning Province desire to migrate to Western countries (Fong 2011), and why did villagers in Longyan in Fujian Province aspire resolutely to such migration (Chu 2010)? Why did people in Zouping in Shandong Province desire more education (Kipnis 2011)? Why were members of the emerging middle class in Kunming in Yunnan Province so eager to own apartments (L. Zhang 2010)? Why did people in Wenzhou in Zhejiang Province want to build so many Christian churches (Cao 2010)? And why did villagers in Mengzhou in Hebei Province aspire to commit suicide (Wu 2010)? Notably, the rise of sexual desire, an exemplification of desire, has been explored extensively (e.g., Yan 2003; Farquhar 2002; Rofel 2010; Zheng 2009; Osburg 2013; Friedman 2006; Farrer 2002; Jeffreys 2006; Ho 2011; Schein 1997; Jankowiak 1993).

Most of the studies cited above focus not only on people aspiring to achieve specific goals in life but also on the making of those aspirants into certain types of persons, selves, or subjectivities—described, for example, in terms of "individualization" (Yan 2010), "the divided self" (Kleinman et al. 2011), "personal voice" (Honig and Hershatter 1988), the "desiring subject" (Rofel 2007), and the "subject of desire" (E. Zhang 2007).

The impotence epidemic provided a perfect opportunity to demonstrate how the subject of desire was produced. For example, the birth of nanke (men's medicine) emerged to encourage impotent men to come forward and seek treatment. Men as well as women now dared to articulate their desire for sexual enjoyment, because the moral nature of sexual desire was altered and the shame associated with impotence downgraded (see chapter 1).

On a more "meta" level, desiring production not only has incited desire for specific objects—for "this or that"—but also has produced the tendency to desire—the desire to desire. I am making a Deleuzian reversal here of the Lacanian notion of desire as "lack in being." According to Jacques Lacan, "Desire is a relation of being to lack. It is the lack of being properly speaking. It isn't a lack of this or that, but lack in being whereby being exists" (1991:223). Deleuze and Guattari refuse to see desire as lack but as often impeded, particularly in precapitalist structures. Therefore, the production of desire in capitalist society not only allows for its fulfillment through satisfaction of specific needs but also promotes the overall tendency to desire in itself. In practice, in the recent past under Maoist socialism, collective passion instead of individual desire was promoted, and more often than

not, sexual desire was discouraged or even repressed (chapter 2). The rise of individual desire in post-Mao China has greatly changed the Chinese society and the subjectivities of the Chinese.

Therefore, disagreeing with the common assessment that the impotence epidemic is a negative event, I consider it a positive one, because it signifies the ontological shift in human existence in China from downplaying desire to promoting the desire to desire. We could even call the impotence epidemic "a contagion of desire." It is one of the most profound changes in recent Chinese history. Answering the question of how "the contagion" happened requires turning to ethnography.

Entering the Field of Impotence

I conducted fieldwork in clinics in the city of Beijing, in the north, and Chengdu, in the southwest, focusing on one clinic as a primary research site in each city. The two-site choice acknowledged the traditional sensitivity in Chinese studies to differences between northerners and southerners in styles of living, as reflected in cuisine and cultural habitus, as well as in physical type. Even though the common distinction between "robust northerners" and "delicate southerners" has been subject to revision (Hanson 1998), north–south differences remained a legitimate concern in traditional Chinese medicine (Wang 1995; Feng and Cheng 1997). This distinction was reflected in the etiology of impotence, according to some doctors of TCM. For example, many southerners suffered from impotence because of heavy dampness and heat in the body resulting from the humid climate, whereas northerners often suffered from impotence because of *yin* deficiency caused by the dry climate.

Another important reason for my selection of sites is that I had developed social networks in the two cities. I spent four years attending college in Chengdu and six years in Beijing attending graduate school and working for the Chinese Academy of Social Sciences. My networks not only integrated me into local social fabrics but also generated direct contact with impotent men and others relevant to my research. For example, a friend of mine arranged a dinner so that I could meet and chat with a cohort of *laosanjie* (graduates of high or junior-high schools in the first three years of the Cultural Revolution [1966–1968] who went down to the countryside in 1969). These conversations not only provided invaluable source material for my understanding of the ups and downs of this group of people but also eventu-

ally led to a number of individual in-depth interviews. Two of the men at the dinner and the husband of one of the women had suffered from impotence. My conversations with people in their homes, in offices after hours, and in restaurants opened up a rare horizon for me to enter into deep experiential predicaments and the human efforts to cope with them.

Complementing the geographical balance, I also pursued a balance between biomedicine and TCM. In general, an impotent man in a Western country has two treatment choices—he can see a urologist or a psychotherapist. At the time of my study, an impotent man in China also had two choices—to see a doctor of Chinese medicine or a doctor of biomedicine. Psychotherapy was just beginning to attract patients. The global biological turn in the medical treatment of impotence was, thus, juxtaposed to a "local" cultural practice that included techniques such as herbal decoctions and acupuncture and that generated distinctive expectations and demands in and interactions with patients (e.g., Kleinman 1980; Farquhar 1994; Hsu 1999; Scheid 2002; Barnes 2005; Zhan 2009). It became necessary for me to travel between the two medicines to understand not only the strengths and weaknesses of each but also the shifting dynamic between them.

Beijing and Chengdu were two of the four cities in which, in the 1950s, colleges of TCM had been established; they became major bases for the preservation and development of TCM under the Maoist state and remained so in post-Mao China. In Beijing, I chose a hospital of biomedicine (Yuquan Hospital) as a major research site, and I visited a number of hospitals of TCM there, including hospitals affiliated with Beijing University of Chinese Medicine. In Chengdu, I chose the Hospital of Chengdu University of Traditional Chinese Medicine (CUHTCM) as my primary research site, and I also visited a hospital of biomedicine there. When Viagra was introduced into the Chinese market in 2000, I had a front-row seat to observe how it was received. Contrary to biomedical expectations, the response was disappointing. Investigating this surprise led me to discover a lively medical pluralism in the field of impotence, reflected in multiple diagnoses and treatments and in "body multiple" (Mol 2002) that counter the hegemonic reduction of impotence to a neurovascular event.

In my two major field sites—the Department of Sexual Medicine in Yuquan Hospital in Beijing and of Nanke in CUHTCM—I conducted observations and interacted with patients and doctors as a research intern, joining other interns, most of whom were graduate students. Yuquan Hospital, located in Haidian District in Beijing, was formerly owned by the Minis-

try of Electronic Industry and was eventually commercialized to manage its own revenue. The Department of Sexual Medicine was one of the most popular departments in the hospital, primarily because it was headed by Ma Xiaonian, a well-known sexologist in the 1990s, who advocated sexual openness both in his medical practice and publications and on his talk show on Beijing People's Radio Station (Zhang 2013). CUHTCM is located next to the university campus in Jinniu District in Chengdu. Its nanke specialty was established in 1994. Because Dr. Zhang, its head, was also head of the urology department (located in a separate space), the commingling of TCM and biomedicine was a prominent feature of nanke at that hospital (see chapter 6). Some interns at the Beijing site were conducting research. One, for example, a graduate student of education from a normal university in a southern province, was working on her thesis, which involved measuring sexual dysfunction; interns at the Chengdu site, by contrast, were learning diagnosis and treatment.

While regularly visiting my primary field sites, I also talked to people in various walks of life in different locations—in parks, restaurants, and nightclubs; at social gatherings; in their apartments; in teahouses, coffee shops, or bars; and so on. In addition, I followed doctors to observe them as they engaged in activities outside the hospital, for instance, participating in radio talk shows and visiting sex shops, and I joined them in special sessions of collective diagnosis and treatment in other hospitals. I visited pharmacies, university student dormitories, private clinics, and other pertinent sites. Altogether, I observed and interviewed about 350 patients diagnosed with impotence or related problems and/or their spouses or sexual partners (predominantly Han Chinese). I also observed and interviewed two dozen doctors (half of whom were doctors of biomedicine and half doctors of TCM).

Inspired by Margaret Lock's (1995) studies of menopause in Japan, I combined qualitative and quantitative studies, administering two surveys to two different groups. One survey investigated the socioeconomic status of patients and self-perceptions of impotence and included questions about etiology, definition, preferences for treatment, and ways to cope with impotence and gain sexual pleasure. The second survey investigated perceptions of the male sexual organ, which yielded insights useful for understanding the experience of sexual satisfaction and frustration. I administered the surveys to about two-thirds of the patients I talked with and to about six hundred college students. My sample student population had relatively equal numbers of males and females and science and nonscience majors and in-

cluded participants from five universities. These two surveys greatly contribute to the ethnographic insights of this book.

Yangsheng (the cultivation of life): ethical regulation of desire

Having recognized that "the impotence epidemic" was a result of desiring production, my daily contact with patients and practitioners of TCM made me aware of the ethical limits of such production of desire. Desiring production in the Deleuzian sense has its own limits. One of the limits consists of "decoding" flows (lessening restrictions to create deterritorialized flows) and its countering tendency—"coding" flows (imposing restrictions on them). To extend Deleuze and Guattari's insights, I found it illuminating to consider the "recoding" of flows of desire a manifestation of the countertendency to and the ethical limits of "the contagion of desire." The rise of yangsheng (the cultivation of life) was an example of such recoding.

I had already encountered yangsheng from routinely chatting with people doing exercises or practicing *qigong* in parks near a university campus where I was staying in Beijing. What prompted me to pay more attention to it was the introduction of Viagra into the Chinese market in 2000. Viagra obviously incited expectations among patients and doctors that impotence could be quickly fixed. An impotence-free era seemed to have finally arrived. Pfizer estimated that China had the largest population of impotent men globally, reaching more than 102 million, and the company felt sure that Chinese men and women would embrace Viagra.

Despite the media sensation surrounding the introduction of this "magic pill," I observed a less than enthusiastic response, both in Beijing and in Chengdu. The reluctance of many Chinese men to accept Viagra was due to multiple concerns but definitely involved an understanding of potency that went beyond the simple ability to achieve an erection. Patients perceived potency in terms of one's overall vitality, something that has to be cultivated methodically over the long run and should not be suddenly induced when it is "needed." The story of Viagra in China was a surprise in the context of the biological turn in the medical field of impotence but also an encouraging revelation of the resilience of TCM informed by the ancient Chinese wisdom of "cultivating life" (see chapters 5, 6, and 7).

Yangsheng, a systematic set of tenets and practices for maintaining health, including sexual health, to gain longevity is documented in the literature of