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"Am I in 'Suboptimal Health'?": The Narratives and Rhetoric in Carving out the Grey Area Between Health and Illness in Everyday Life

Lijiaozi Cheng

Department of Sociological Studies, The University of Sheffield, Sheffield, UK

Correspondence: Lijiaozi Cheng (lijiaozi.cheng@gmail.com)

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ABSTRACT

This paper examines the concept of 'suboptimal health' (subhealth, 亚健康), a term popularised by traditional Chinese medicine (TCM) professionals and widely used in public health discourses in China at the turn of the century. Despite criticisms of it being a commercial buzzword, subhealth provides a unique lens for individuals to articulate their health experiences concerning work and life pressures. Through virtual ethnography on Chinese social media such as Weibo and interviews, this study explores the usage and implications of subhealth in everyday life. It particularly focuses on how young Chinese people employ this concept to navigate and express health-related issues. Drawing on Leder's concept of the lived body, as well as literature on illness narratives and the sociology of diagnosis and risk, the study argues that attention to the everyday narratives of subhealth could potentially open up a space for a greater range of narratives of embodiment and might even offer a space for collective critique in a context often dominated by individual responsibility narratives. In some cases, it also enables private and public narratives that critique lifestyle factors detrimental to health. Ultimately, this paper hints at the conceptualisation of "subhealth narratives" as a research framework.

1 | Introduction: Subhealth as "A New Concept of Health for the 21st Century"

Suboptimal health status (SHS, 亚健康, yajiankang in Chinese Pinyin) is a concept that emerged in China in the late 1980s/early 1990s. This notion, alternately termed 'suboptimal health', 'sub-health' or 'subhealth', is employed to describe a spectrum of subjective bodily symptoms such as fatigue, drowsiness and headaches that lasts over a period of time. These symptoms, although concerning, often do not lead to a specific medical diagnosis. Thus, subhealth signifies a state of perceived but not clinically diagnosed poor health (W. Wang and Yan 2012). This concept has burgeoned into a notable subdiscipline within Chinese medicine and has permeated academic and popular discourses, although it has diminished in popularity in recent years.

Subhealth has been framed as a novel concept that encapsulates a universal condition beyond the scope of biomedicine, necessitating Chinese medicine, other health practices or supplements as remedies. Wang Yuxue (2002), one of the early proponents of the concept of 亚健康(subhealth), uses the theory of Chinese medicine to explain the concept of suboptimal health while at the same time emphasises the novelty of this concept from the perspective of western medicine. A separate space is carved out of the conceptual space of health and put under a separate name,

that is, subhealth. In this sense, the concept of suboptimal health builds on the notion that biomedical thinking sometimes (though not always) constructs a binary between health and disease (Hofmann 2005) while suboptimal health is supposedly capturing the space in-between. A sense of invention is invoked here, as made evident in the title of Wang's book, *Subhealth: A New Concept of Health for the 21st Century*. As observed by Zhan (2009a, 2009b), subhealth emerged among traditional Chinese medicine circles as part of a process of remaking itself for the urban middle class and this operates in an imagined transnational framework within China—that is, sometimes, even among traditional Chinese medicine professionals, it is seen as a "western" concept, as supported by "foreign medical experts".[1]

It is coined in such a way to connect to a Western conception of the onset of incipient illness and the threat of chronic illness but also extend it to the wider population. In its presence in the Chinese context, subhealth is operationalised as an "audacious project of labelling the majority of the world's population with a newly discovered medical condition, lack of health", a medical condition that encompasses the worries and concerns of most of the people (Bunkenborg 2014, 138). It was often associated with the lifestyle people have in the 21st century and the stress people experience in urban life, and it was repeatedly framed as a major public health problem for 21st century China. For example, China Daily published some articles warning its readers "Be aware, you might be in suboptimal health" (Huang 2004) and urged citizens to pay attention to their suboptimal health status before they end up with more serious health conditions. In this process it also entered the popular discourse, becoming part of the vocabulary to talk about one's health. Herein lies the uniqueness of this concept: it is operationalised like a disease label but people are reminded that it is not a disease label. You are still in the realm of health. This ambiguity makes it appealing to the commercial sphere but it is also worth looking at how it is interpreted in the everyday life which so far has attracted little critical attention. In this paper, I will unpack how it has permeated everyday life and how the narratives are deeply embedded in the contexts of everyday life and work. The aim of this paper is to ask, what does it mean to carve out this conceptual space in the everyday life of young people in China?

In this vein, this paper focuses on the discursive and narrative constructions of subhealth rather than discussing the ontological status of the concept, examining how its inherent ambiguity is manifested in both collective and individual health narratives amidst the evolving social arrangements of work. By focusing on the liminal experiences that lie between feeling well and recognising oneself as living with an illness, the concept of subhealth serves as a lens to capture these nuanced narratives. Specifically, the notion of suboptimal health delves into the 'health-side of risk ambiguity' (Jauho 2019, 867), providing the vocabulary necessary for a critical analysis of various social configurations.

2 | Subhealth, the Urban Professionals in China and Its Commercial Agenda

The bodily symptoms associated with suboptimal health were characterised as pertaining to a particular set of populations in China, the urban professionals, and often framed within commercial narratives that underscore the necessity for external interventions. This is exemplified in a 2010 Centrum advertisement, for example, which uses the metaphor of wire walking between high-rises to symbolise the precarious balance between work and health faced by young office workers. In the advertisement, the precariousness of their situation is visually represented by individuals walking on thin wires above the city, whereas a celebrity endorser contrasts this by walking on a stable platform, promoting the product as a solution to 'suboptimal health'. This visual metaphor not only encapsulates the daily struggles of the target demographic but also positions health supplements as essential for maintaining balance amidst modern life's challenges.

The popular understanding of subhealth can be concisely glimpsed in this excerpt taken from a question in the administrative proficiency test as part of the national civil service examination[2]:

> The term 'sub-health' is passed from abroad. 'Sub-health' has a high occurrence rate (发生率) in the world. It is a state of discomfort caused by psychological and social stress. In recent years, the incidence of 'sub-health' has gradually increased at home and abroad, so it is meaningful to launch research projects on 'sub-health'. Literally speaking, 亚 (sub) means 'second to, not good enough'. 'Sub-health' is a state between health and disease.
>
> One item that does not match the meaning of this text is ().
>
> A. 'Sub-health' has a high incidence (发病率) worldwide.
>
> B. The term 'sub-health' came from abroad.
>
> C. 'Sub-health' is an uncomfortable state of the human body caused by the pressure of the psychosocial environment.
>
> D. 'Sub-health' is the state between health and disease.

The text itself summarises all common understandings of subhealth that have been circulating in popular discourses: that it is a Western concept, that there is a high occurrence rate in the world, that it is bodily discomfort associated with stress and that it is a state between health and disease. The answer to this question is A because in choice A, the sentence used the phrase 发病率, meaning 'disease incidence', which is used exclusively for diseases but the design of this question is meant to trick (and remind) the exam takers that subhealth is not a disease. This example showcases how the construction of subhealth contain a set of contradictions. It can also be seen that although its emergence in China is tied up with the professional project of Chinese medicine, it is seen as "from abroad".

Moreover, the popularity and contingency of this concept are closely tied to the marketing of nutritional and other health products or services, with subhealth grouping various symptoms under a single label for companies to target. In this way, the promotion of the concept of subhealth is seen as a result of

collective health anxiety (Jing 2019), resembles disease mongering, though from the perspective of health rather than illness (Chan 2006). After a concentrated period of knowledge production and the prevalence of subhealth in media discourse, the concept has faced significant criticism, for example from Jing (2019). Critical studies on subhealth typically present two main arguments: first, that a more precise scientific classification of subhealth is necessary, or second, that subhealth represents another instance of 'disease mongering' (Chan 2006).

Bunkenborg offers an alternative anthropological perspective. His 2014 article delves into the contemporary discourses surrounding subhealth, offering a genealogy of this concept based on documentary data. Bunkenborg (2014) concludes that the concept is closely tied to the state's intensive emphasis on body quality. He posits that the discourse on subhealth embodies a preoccupation with personal insufficiencies and the compulsion for self-improvement, mirroring public health's focus on population quality (素质, suzhi). Furthermore, Bunkenborg (2014) calls for additional ethnographic research that moves beyond state and population frameworks. He traces the genesis of the suboptimal health concept to efforts geared towards optimising the state's workforce. While acknowledging the infusion of the subhealth concept into popular discourse, Bunkenborg (2014) contends that there remains much to uncover about how it is defined and quantified across different institutions. However, his critique aligns with the dominant biopolitical view, which is heavily state-centric and often overlooks the concept's broader societal integration. This paper contends that while Bunkenborg acknowledges this broader integration, he does not fully explore its implications in his analysis. Therefore, this current paper aims to focus on what has often been overlooked in critical discussions of subhealth (which in itself is limited and thin), that is, how this concept may be taken up in everyday lives.

3 | Suboptimal Health and the Space of Risk and Prevention

As seen in the characterisation of suboptimal health, particularly in more recent medical literature, suboptimal health is framed as a reversible state and a precursor to more established diagnoses (W. Wang and Yan 2012). Many definitions emphasise the experience of bodily complaints without organic pathologic changes. In more medically precise terms, it is defined as a state of being preclinical and reversible without any changes in organ lesions. It has also been conceptualised as 'stress response', a result of the interactions between environmental, psychological and physiological stimulations (Li et al. 2013).

Positioned within a preventative paradigm, suboptimal health prompts scholars in public health to pursue its concise definition and measurement scales and promote lifestyle changes as interventions (Y. Wang et al. 2016). This concept mirrors the notion of "proto-disease" in Western medicine, as described by Rosenberg (2009), which highlights a preclinical stage marked by an accumulation of risk factors or indistinct symptoms that may foreshadow the development of a distinct disease. The aim is to intervene before the condition progresses down the "pathological slippery slope" (Rosenberg 2009, 803).

Despite efforts to establish a clear ontology, suboptimal health remains elusive with prevalence estimates fluctuating significantly depending on the scales and methods used (Y. Wang et al. 2016). Similar to concepts such as the "at risk state" (Aronowitz 2009), "proto-disease" (Rosenberg 2009) and "proto-illness" (Gillespie 2015), suboptimal health shares commonalities with the notion of risk, as advancements in medical technology enable the prediction of disease risk and foster the emergence of pre-disease concepts. Armstrong (2002) describes this shift as surveillance medicine, which targets 'normal populations' and redefines illness beyond the physical body, marking a "fundamental remapping of the spaces of illness" (p. 393). This new surveillance medicine also allows for the localisation of illness outside the corporal boundaries of the body (Armstrong 2002).

In this context, Dumit (2012) discusses how risk becomes equated with illness which then equates with the need for treatment (see also, Kreiner and Hunt 2014). Illness becomes a threshold to cross, defined by clinical trials and health screenings. Gillespie (2012) explores how risk shapes health identities, introducing the concept of "measured vulnerability." This concept highlights how statistical efforts to manage risk can paradoxically increase uncertainty and anxiety, demonstrating that the pursuit of certainty often amplifies uncertainty. Gillespie (2015) further shows how being at risk can alter one's social relationships. As Jauho (2019) notes, risk "adopts an ambiguous position between health and illness/disease" (p. 867). Jauho (2019) also comments that most research on risk tends to emphasise the illness or disease side of ambiguity (rooted in medical knowledge) rather than the health side (which tends to involve a more generalised embodied feeling). For instance, he observes that individuals with elevated cholesterol may actively avoid adopting a patient identity, instead considering themselves "chronically healthy individuals" (Jauho 2019, 877).

To some extent, the emergence of the concept of subhealth can be seen as part of this historical trajectory, invoking the notion of "partial patients" (Greaves 2000) or "patients-in-waiting" (Jauho 2019). However, understanding subhealth as the ambiguous space before going down the "pathological slippery slope" still requires an orientation rooted in biomedical knowledge, and an individualised focus. In fact, this concept also opens a space for moving away from strictly biomedical, disease-centred approaches and a neoliberal individual focus. In the following part, this paper seeks to draw on the sociology of diagnosis and theories of embodiment to illuminate the narrative dimensions surrounding suboptimal health, often from the "health side of ambiguity."

4 | The *Dys-Appearing* Body and... Subhealth Narratives?

A phenomenological view of the body emphasises the lived experience of the body as an inseparable part of our being, seeing it as "the most abiding and inescapable presence in our lives" (Leder 1990, 1), challenging the Cartesian dualism that posits a separation between body and mind. In everyday life, the body is often "absent," receding from direct attention (Leder 1990). In Jutel's (2023) reflections on menstruation, we

see that the body's absence allows space for subjective intentions to come forward—"freeing oneself from the body takes on a positive valuation" (Leder 1990, 1). However, there are moments when the body becomes acutely present, or "dys-appearing" where discomfort or dysfunction brings it into focus. As Leder (1992) notes, when one falls ill, what is disrupted is not merely a malfunctioning "body-machine" but a transformation of one's entire world: "A disease undermines our sense of self and autonomy, our relations with others, our habitual experience of space and time" (Leder 1992, 5). In this article, I draw on Leder in my analysis and uses words such as embodiment and "embodiment doubt" in line with this idea of "dys-appearance".

Havi Carel (2016) proposes a particular phenomenological approach in analysing the lived experience of illness. When writing about the reason to use phenomenology to analyse illness, she writes,

> Illness is a breakdown of meaning in the ill person's life. Because of the disruption of habits, expectations, and abilities, meaning structures are destabilised and in extreme cases the overall coherence of one's life is destroyed.
>
> (p.14–15)

Therefore, she proposes to view illness as a 'deep phenomenon' that will reveal 'patterns of embodiment' and their disruption which is fundamentally narrative as well as phenomenological (Carel, 2016). Although Carel's definition primarily addresses more serious health conditions, her approach can also apply to experiences within the realm of 'suboptimal health,' particularly in understanding how subhealth experiences relate to an individual's biography. Furthermore, health and illness are not always mutually exclusive. For example, Carel (2007) introduces the notion of "health within illness," where individuals find ways to adapt and maintain elements of health even within the experience of illness (p. 96).

Navigating illness involves complex changes in embodiment and social relationships. Bury (1982) introduced the concept of chronic illness as a biographical disruption, illustrating how it constitutes a 'critical situation' that fundamentally alters patients' self-identity and interpersonal connections, based on semi-structured interviews with a series of rheumatoid arthritis patients. Particularly for younger individuals, receiving a diagnosis typically associated with older age marks a 'biographical shift' from a normal life trajectory to one perceived as abnormal and damaging (Bury 1982, 171). Building upon Bury's research, Charmaz (1983) explores the deep 'loss of self' experienced by those with chronic illnesses, where individuals witness their 'former self-images crumbling away' without the emergence of new, equally valued identities (Charmaz 1983, 168). Williams (1984) extends this discussion, focussing on the dynamic ways individuals with long-term conditions, such as rheumatoid arthritis, integrate their illness into their life stories. He suggests that they must 'reconstitute and repair ruptures between body, self, and world...' in search of coherence (Williams 1984, 197).

Liminal experiences are another aspect of the illness journey. Monaghan and Gabe (2015) introduce the idea of asthma as a 'biographical contingency,' affecting individuals sporadically and contributing to an intermittent sense of self. Similarly, Saunders et al. (2018) explore the 'biographical suspension' experienced by those with severe sciatica. They describe this condition as living in a liminal state, '...whereby individuals put life on-hold...' (Saunders et al. 2018, 28), caught between their past and anticipated future selves. This paper will draw on the concept of 'biographical suspension' in the discussion of subhealth narratives. However, as Weinberg (2021) notes, the literature on illness experiences often relies on biomedical knowledge as a foundational theoretical resource, conflating diagnostic categories with ontological status as the basis for analysing illness experiences.

Subhealth, however, operates as a semi-diagnosis—an extremely vague label without consistent ontological resources. As a "basket label," it lacks the definitional solidity typical of diagnoses with practical applications around it often remaining unclear. What, then, does a pseudo-diagnosis without consistent recourse to "thingness" offer? Can we move beyond the need for a clear "thingness" to capture phenomenological narratives? Addressing health ambiguity requires shifting focus from disease-centred approaches to health-centred ones, emphasising a phenomenological and narrative approach.

Utilising data from individuals identifying with "suboptimal health," this article aims to articulate the narratives and rhetoric shaping this space, in assigning responsibility for subhealth and in exploring solutions. The emphasis is on contemporary lay discourses among young Chinese people, offering insights into the everyday interpretations and implications of subhealth.

5 | Methods

This paper draws on a subset of data from a larger multi-sited ethnography (Marcus 1995, 2011; Hine 2015) that looked at the conceptual history and lived narratives of suboptimal health. For this study, data were sourced through virtual ethnography on social media platforms, particularly Weibo, and interviews with individuals raised in China. Institutional ethical approval was granted before data collection.[3] I stated in the profile of my Weibo account that I am a researcher based at *The University of Sheffield* collecting data about subhealth so that if I participate in discussions or interact with other users online, people will be fully aware of my identity. I searched for "亚健康 (subhealth)" on Weibo daily from November 2020 to April 2021, documenting and compiling relevant posts. This immersion helped understand how sense is constructed around the topic and define relevant research areas on Weibo (Hine 2011). From April to October 2021, I transitioned to a web crawling tool to gather posts.

Because of pandemic-related travel restrictions, interviews were conducted remotely with participants from my network of family, friends and acquaintances to ensure trust, which is crucial when discussing subhealth experiences (Parker, Scott, and Geddes 2019). Of the 25 interviewees, 23 were young adults, educated at the university level or higher, residing in cities or abroad and were primarily contacted via WeChat. 19 of the

interviewees self-identified as females and 6 as males. The reason to focus on young adults (in their 20s and early 30s) is that with initial interviews and social media scoping, it was noticed that the use of this concept was found mostly in this group. Interviews, mainly conducted as WeChat audio calls, varied in length depending on how the participant relate to the concept of subhealth. They are around 1 hour, and some of them last even 2 hours. With two of the interviewees, two interviews were conducted as they had a lot to share. During the interviews, I asked them.

1. Have you heard of subhealth? How? Where?
2. How do you understand it? What do you think of it? Why?
3. Do you ever feel you are in subhealth? Can you tell me more?

From these initial questions, I then gave them the space to tell me about how they think of their health, what they do about it and the narratives of health, embedded in their life stories. Conversations about subhealth posed challenges as suboptimal health is often experienced (if participants find value in adopting the concept at all) as a transient state that comes and goes. In addressing suboptimal health, this project delineates the conceptual boundary where it is not merely a term denoting a set of symptoms but a dynamic concept that structures thought, guides discourse and bears the imprint of its cultural and historical lineage, shaping individual subjectivities and collective understandings of health (Plunkett 2016). Although the use of the term 'subhealth' has waned after the loss of its practical appeal, as a dynamic concept it is still of great importance, as will be clear in the following discussion of "subhealth narratives".

The analysis of both interview and social media data prioritised emerging themes and narrative structures. Recognising narratives do not solely represent facts (Behar 1990), I approached them within the participants' cultural contexts, focusing on their narrative structures. All data are anonymised and names are pseudonyms, or self-chosen nicknames. Although all the data I collected on Weibo are publicly available, I agree with Boyd and Crawford (2012, 672) that "it is problematic for researchers to justify their actions as ethical simply because the data are accessible." I have fully anonymised the data by hiding the username of the person or any personal information in the post. When directly quoting them, I will use English translations without providing Chinese original words, so that there is no possibility of searching for and finding the person who posted it, which can eliminate any potential harm.

In the following sections I will present my data on "subhealth narratives", highlighting the embodied doubt in and liminality of these narratives and some of the key narrative turns. I will then discuss how these narratives can move beyond the discourse of personal responsibility of health and towards social critique.

6 | Liminal Narratives of Suboptimal Health

This section will summarise the main characteristics of subhealth discourses and narratives that are posted on social media and captured in interviews. A key element of the discourses of subhealth focuses on identifying a conceptual space for intervention, treatment or at least some acts of self-care. In one Weibo post:

> You and I are both mortals, and no one can escape the current hormones, pesticides, additives, water, air pollution, and sub-health...
>
> (Weibo post 1)

It is an anxiety enticing commentary on life in contemporary China, with the post then going on to advertise a health product. Even after the popularity of subhealth died down, it still sometimes occurs in commercial discourses which often present subhealth as a problem before presenting a treatment. Some interviewees commented on the vagueness of the concept and that due to its extreme vagueness, they did not find the concept helpful (Lu, late-20s, male); or that it is masking experiences of ageing as subhealth (Jing, late-20s, male).

At the same time, the commercial undertone in a lot of the subhealth discourses means that some people go through a process of finding oneself in the conceptual space and rejecting the label of subhealth. The case of Qu is representative in this sense. She initially considered herself in subhealth which facilitated her purchases of health products such as vitamins and primrose oil as well as other health products for fatigue or lack of concentration. However, gradually she became suspicious of the concept and thought it was better to focus on particular symptoms instead of attaching such a label to herself. There was a sense of disenchantment with the concept, a process of growing out of the concept (Qu, late-20s, female). In our interview, she talked of seeing her health just like 'what was said in the advertisement' and cited symptoms that regularly occurred in the advertisements: weak limbs and lack of concentration. This was also mentioned by other participants—for example, Fiona (early to mid-20s, female) also mentioned those symptoms. It might be possible to say that the symptoms mentioned by the advertisement might have led to an enhanced bodily awareness along those lines. Qu recalled how she no longer attributed these symptoms to subhealth. In the past, subhealth constituted a blanket explanation paired with quick remedies (different health products) but now she would just look for specific changes she could make in her life.

In one social media post,

> My 30-year-old body cannot bear the working state of a 23-year-old, and the intensity during the day always causes insomnia and anxiety at night. Isn't this the middle-aged sub-health crisis mentioned on TV when I was a child? Wearing eye masks and headphones while playing music half an hour, and the moment the music stopped, I became more sober? Will I have a sudden death?
>
> (Weibo post 2)

This post illustrates how mass media discourses from 2 decades ago may have influenced current perceptions of subhealth.

Terms like "sudden death" were commonly reported in newspapers around the turn of the century, often linked to extreme cases of subhealth and health neglect, which has shaped the narrative we see here.

The mode of research seems to capture them differently as well. From the interviews, participants saw subhealth as normal and a recurring part of everyday life, or to be more specific, subhealth, when recounted in the participants' narratives, seems to revolve around a sense of 'my body does not function as well as before' and to be related to various 'discomforts' and their various ways of grappling with, resolving or coming to terms with this. Those interviews I conducted about people's understanding and narratives of subhealth were not necessarily in those moments when they see their subhealth as a crisis but spanned different times. On the other hand, the Weibo narratives captured subhealth in its ongoing moments. There is a sense of talking to an imaginary interlocutor on Weibo about one's health conditions, to check one's health condition with 'the other' to regain a sense of self. These narratives are fundamentally private yet public, detailing the most intimate narratives about one's bodily experiences and doubts but waiting to be seen by friends and strangers. These more personal narratives of subhealth did not seem to be aiming to attract many views; instead, they initiated an avenue to talk about one's health and a way to motivate lifestyle changes and to record these moments.

A lot of the Weibo narratives start with a subtle doubt about the lived body at moments of "dys-appearance" (Leder 1990) while aiming to find people sharing such subtle experiences:

> Does anyone's neck ring all the time like mine? It doesn't hurt but it has been ringing for several months. It squeaks when I move my neck. Sometimes I feel like it's blocked. If I twist my neck to make it squeak, it temporarily becomes more comfortable, and then it feels blocked again. I am actually gradually getting used to it ringing, and I asked the doctor and got told that the ringing was normal. But it is too frequent (surprized emoji) for me and I don't know if it has anything to do with my sinusitis (sub-healthy patients are too miserable!!!).
>
> (Weibo post 3)

As can be seen in this post, this Weibo user characterises themselves as 'subhealthy patients', an oxymoron. This post describes in detail the feeling of neck ringing. A medical encounter is mentioned here: this person asked the doctor for reassurance that 'this is normal' but even upon receiving such confirmation this feeling/discomfort still troubled them, leading them to conclude that this is the misery of 'subhealthy patients'. This is one representative instance of an enhanced acute awareness of the body. This awareness triggered the user to post this question to the interlocutors on Weibo for affirmation, looking for others who share the same experience. Here is another example:

> List of recent sub-health states: nosebleeds, neuropathic migraine, gingival inflammation and swelling, the legs of the calves being suddenly numb and crisp, coldness in the bones, and the bones clicking in the evening. It seems that it is time to get up early to get rid of sub-health (dog head emoji).
>
> (Weibo post 4)

As can be seen in this example, a diverse range of bodily discomforts and symptoms are seen as subhealth. The narratives of subhealth at those moments take a certain structure. A common element in subhealth narratives is a contemplation on the state of health for the self. A lot of the Weibo narrative involves talking about the embodied and phenomenological feeling of the slightly disrupted body, when the body is no longer absent (Leder 1992) to conclude that one is in subhealth; alternatively, people might label themselves as in subhealth on the basis of health examinations, reflecting a general dissatisfaction with their well-being over a certain period or after experiencing unexpected bodily limitations after physical activity. Interestingly, while much public health literature on subhealth excludes medical diagnoses, individuals often adopted the category to describe borderline test results, minor chronic conditions or frequent hospital visits. Subhealth could appear as a 'diagnosis' from health examinations or be inferred from the need for follow-ups and ambiguous health findings.

There often is an attempt to think about what has caused this subhealth—so perhaps in the form of comments on the lifestyle or work. This is then followed by making resolutions. Usually after contemplating on the state of health, those narratives would conclude with different resolutions, for example, that they need to adapt their lifestyle. Alternatively, they might try to make a point on general life attitudes or work attitudes[4], something in the vein that work is not that important and health is more important. The following is an example that has all three elements:

> I have always needed to work at the desk for a long time,
> I thought that a hundred poisons wouldn't invade me,
> But now feeling the panic of sub-health,
> And the crisis of middle-aged people's declining body constitution and tendency to get fat.
> It's time to keep fit and beautify 😂
>
> (Weibo post 5)

There is a sense of "colonising the future" as discussed by Lawton (2002), anticipating future health while encountering present lived reality. Lawton (2002) concludes from her research that embodiment plays a central role for people in anticipating future ill-health and taking health related actions and that people's change in health behaviours tend to be reactive. The moves in subhealth narratives seem to follow this point, where expressions such as "on the way to subhealth" or "on the edge of subhealth" invoke present bodily awareness (with or without the support of objective metrics) and future expectation of the self and expressions such as "I need to conquer/tackle/address/beat subhealth" constitute reactive actions. The conclusion of being in subhealth seems to always indicate a resolution to facilitate more care of the self.

Therefore, one of my interviewees, Wenwen (mid-20s, female), commented that:

> I think that sub-health is just a label that has been attached to us in the past few years, or the past decade, but I don't think this label is bad, because it reminds us to take the initiative to exercise, to get rid of this label. It urges us to reflect on our physical condition, and our mental state.

Xulang's case helps us summarise the main points in this section. In Xulang's account, subhealth was a feeling that her body was getting in the way. Her body did not feel as energetic as before, she experienced pains in her waist and she had to lie in bed. Those were the times when the body suddenly becomes present and alien. These experiences of subhealth constituted a reminder for changes in lifestyle while situated on the side of health but faced with the possibility of sliding into illness; they reminded her to take action so that she did not cross that threshold. She characterised that feeling as 'on the way to illness'. Recounting a period when being told that she is "in subhealth":

> I think that at that time, after they mentioned that they think I am in subhealth, I agreed with them. Because I did feel that I was in a sub-healthy state, and I had been in a sub-healthy state throughout that period. ... Maybe it was on the way. Do you know? Just on the way to get sick, but it hasn't arrived yet. Haven't crossed that line yet. I felt that if I got a little more extreme, I might become unhealthy. I also think that because I didn't sleep enough, and I couldn't eat well, and it's very abnormal for a while. And I was not full of energy or something. I knew I must be different from usual. And I felt very tired, extremely tired.
>
> (Xulang, early 30s, female)

This led Xulang to reflect on her life at that time, prompting her to make adjustments and engage in pre-emptive health practices.

7 | Subhealth as "Biographical Suspension" in Personal Narratives?

But what if what is not in a position to make changes? Sky represents a distinctive case among my interviewees because she actively employed the concept of subhealth to describe her state of well-being prior to our interview. Sky, a friend, worked as an investment manager at a busy financial company in Shanghai. She mentioned her perceived constant state of physical and mental subhealth in an article on her WeChat public account, prompting me to invite her for an interview, which she accepted.

When I asked Sky why she used the particular term of subhealth to describe her condition, she said:

> Actually, it is not that I have seen anyone use this term, but why do I use it? It is because when an adjective needs to be added in front of the word 'state' (to describe myself), I feel that anxiety or any other concrete conditions that are subbranches of subhealth cannot fully be adequate. I am in this state and it is a comprehensive state, and I need such a word, so I used suboptimal health (亚健康). So I think it's because I'm not so healthy and I can't say I'm sick. I can't say that I'm not healthy either. I am in a state that I can barely take control, but I need a lot of willpower. Then I also feel that I have continued to be in this state for a while now, and I can't change it temporarily, so it's quite sub-healthy.
> ...
> So my thought process is very simple. Because I think that I am definitely not healthy, but not to the level of unhealthy, so I use the word in the middle.
>
> (Sky, late-20s, female)

Sky felt increasingly dissatisfied with her life, noticing changes in her sleep and diet patterns, attributing it to the body's early warning system against stress. She described her hectic work life, leaving her drained and seeking comfort in high-calorie foods late at night. Despite her previously healthy habits, including running marathons, her demanding job left her struggling to maintain a healthy lifestyle. This reveals that so-called "unhealthy lifestyles" can often be traced back to systemic issues and not just personal choices. In her words:

> I don't have my own time. I must make it up. No one can go back home after overtime at 11:30 pm or 10:30 pm and sleep right away. I really can't. I need to relax for a while. Then I started relaxing. Because every time after I took a shower, it was already 10:30 pm or 11 pm, and after I started to relax for a while, that would be for at least an hour, and it would be 12:00 or nearly 1. It is at least 1 o'clock when I fall asleep. And because I used my control power during the day, and because people's willpower is limited, after my willpower is invested in controlling the rhythm of work, controlling work, and controlling emotions in work, you know, many shitty things happen at work, you have to control it and ensure that you are not emotionally affected. You have to be emotionally stable facing others.
>
> (Sky, late-20s, female)

Sky's endeavour to understand and articulate her condition as "subhealth" represents an attempt to find coherence in a state that defies easy categorisation. Consulting a therapist and seeking to adjust her life within the constraints of her work environment, Sky's narrative is one of resilience and the search for stability amidst systemic challenges. Her story highlights the complexity of navigating health and illness in a stressful and exploitative work context, emphasising the need for a

vocabulary that captures the nuanced experiences of individuals living in the grey areas of well-being.

In this context, Sky felt compelled, at the time, to adopt "subhealth" to describe her health status. For Sky, "subhealth" aptly captured her experience—neither entirely healthy nor definitively ill, but unmistakably aware that something was amiss. This term allowed her to articulate her position in the ambiguous terrain between health and illness, reflecting the intertwined nature of her physical and mental states. It enabled her to seek a narrative that could bring coherence to her life's disruptions. Sky's story illustrates the role of "subhealth" in acknowledging the impact of lifestyle on well-being, highlighting a collective acknowledgement among individuals when personal efforts to change are insufficient, thereby embracing the state of ongoing "subhealth." Sky gave her own definition of subhealth that emphasises its being a physical and mental issue that has lasted a long time but usually does not get much attention. She used third person pronouns to discuss what she appears to think to be a shared reality among people who work in cities. She defined subhealth as mild problems that people grow used to but not urgent enough to prompt changes. In this way, she was invoking a "public narrative" of subhealth.

She told me that if someone was unhappy with their job and that they decided to quit their job, then that would not be subhealth because they were able to make changes, which is an interesting definition, one that focuses more on a general state of life and health instead of a bodily state.

In some way, these narratives of chronic embodied doubts fit what Bury (2001) calls 'contingent narratives' but here we are not seeing narratives of chronic ill health. Instead, we see accounts of chronic bodily "dys-appearance"—individuals grappling with a crisis of self and biographical coherence, yet without any formal diagnosis, as was the case in Bury's (2001) study. They are in a liminal space of "biographical suspension", situated within the routines of everyday life. Some, such as Xulang, use these moments as opportunities to enact lifestyle changes, whereas others, unable to adjust due to work constraints, begin to sense that the issue may be beyond individual control thereby forming a critique of their living conditions. This use of the term of subhealth is inextricably connected to the current working pattern in China. They are almost mentally preparing themselves for the possibility of being ill and calling that liminal space subhealth. This contrasts directly with the work of Bury (1982) and Charmaz (1983) where chronic illness disrupts everyday life and one's sense of self. Here, narratives of the self, depict the daily grind reflecting on everyday life and everyday health practices. The self in subhealth is a self not disrupted but captured in a liminal mundane space.

8 | Beyond Subhealth and Being a 'Corporate Slave' (社畜)

It is in this context those private subhealth narratives start to enter the public sphere and discourses of personal responsibility are subverted in some of the discussions. This post attracted 10k likes and 8.9k reposts:

> The verbal tricks of capitalists: turning subhealth caused by work into subhealth caused by lack of exercise.
>
> (Weibo post 6)

I am taking one particular pathway of reposts to offer a glimpse into one thread of discussions on subhealth and work. This post is reposted, with a comment 'be aware everyone'; the next repost and comment says 'yes indeed' followed by the next repost and comment 'my stomach ache and cervical discomfort all started after I started to work'. Another user joined this public discussion: 'mystery solved, it is work that has caused me misfortune'. The last comment in the picture says 'That is so true. Having had a "long holiday" away from work this spring new year due to the pandemic, I felt all my subhealth symptoms disappear. And now that I am back to work again, they are all back'. There are opposing discourse constructions that say the following:

> The verbal tricks of the youth: turning subhealth caused by unhealthy lifestyle into subhealth caused by work.
>
> (Weibo post 7)

In both Weibo narratives and the interviews, there is an apparent tendency to treat overwork and stress-related symptoms as the new normal. In these scenarios, the functioning of the concept of subhealth seems to have changed a little. In some discursive iterations of subhealth, instead of initiating a resolution, subhealth becomes a stable identity formation, that is, the identity of a working individual, or as seen in the following comment, subhealth is jokingly viewed as a medal for the modern individual:

> Now I really feel that sub-health is the medal of modern people, and occupational diseases are the glory of corporate slaves. To die from overwork is to die in the worthy path.
>
> (Weibo post 8)

In some sense, subhealth is seen as connected to youth lifestyles and youth identity, in some cases no longer as a state to move in and out of but an identity, as seen in this question posted by one Weibo user:

> Can you even call yourself young if you are not subhealthy?
>
> (Weibo post 9)

There are also jokey comments such as:

> Everybody, just be subhealthy and enjoy everyday. Yeah
>
> (Weibo post 10)

Even in more serious complaints of bodily symptoms, the post ends by saying 'I am the sub-health champion' with mock-pride:

> It's annoying. I have a headache for half of a month, and I take pain killers for ten days of a month. I am the sub-health champion.
>
> (Weibo post 11)

This is firmly grounded in the social reality of China today. The term 'corporate slave' (社畜) and "cows and horses" (牛马) has been increasingly used by employees in China in self-parodic terms. Surveying the social media data has revealed that subhealth is seen as particularly related to the current stressful working patterns in big cities. Increasingly, employees in large cities, especially in technology companies, are expected to work from 9a.m. to 9p.m. for six days a week, a regime called 996 work culture. According to J. J. Wang (2020), the '996' work regime in China is the result of a combination of unhinged global capitalism and a Confucian culture of hierarchy, and for her it is a work regime 'that constitutes modern slavery'. Fogarty (2019), in a BBC article, comments that it is 'the Chinese grind-it-out work culture that workers joke could land you in the ICU'. Since around 2019, 996 work culture has attracted more and more public attention. In Yang's (2018) discussion of mental health in China, widespread subhealth is seen as a result of diverse sources of anxiety in the life of Chinese citizens. In the interviews, some participants commented that the term subhealth was no longer suited for the current time. Quite a few mentioned the term 'corporate slave' instead. Jasper (mid-20s, female) commented that she felt subhealth was too weak a term for the modern work condition, and being an editor, if she needed to write a new story that urged people to take care of their health. She would write about someone who suffers from more serious conditions due to work and who, eventually, with good care of the self, 'recovers back into subhealth'. She commented that she would find it unusual if anyone claimed to be completely healthy. Most of the interviewees shared this understanding that young people in the big cities are 'consuming their body/health' too much.

9 | Discussion

As I have illustrated above, the broad concept of suboptimal health harbours certain features that, due to its elusive nature, may prove challenging to define or maintain consistently. Originally proposed to describe a specific state of being for a particular demographic, it struggles to consistently uphold claims of "thingness." But perhaps that is where it holds potential. In some instances, it remains a useful, comprehensive term—offering a vocabulary to capture the totality of one's lived experiences and embodied realities. Intriguingly, the discussions of subhealth often navigate a space between the personal and the societal, making it both a 'private matter' and a 'public concern.'

The findings suggest that subhealth is frequently adopted as an everyday diagnostic label, a means of articulating experiences of bodily "dys-appearance" (Leder 1992) entangled with fear of future illness. It is often used to denote a vague persistent state encompassing various discomforts—a label individuals turn to when experiencing nagging concerns about their well-being. In such moments, participants describe a feeling of teetering on the edge of illness or sensing a need to make conscious efforts to maintain health. These narratives convey an entanglement of chronicity and urgency: one edge borders on health, another on illness with subhealth as an ambiguous yet enduring reality. It is at those edges people's narratives revolve around.

In some way, subhealth narratives are narratives of 'biographical suspension' where this is defined as a liminal state when there is fear of "a critical situation" of serious medical condition, an unsettledness, a critique of material reality and environments and an uncertainty as to what to do and how to make sense of daily living. There is a search for causes, but most interestingly in some of the cases this has evolved into a critique of causes, and this goes beyond Bury's (2001) idea of 'contingent narratives' which only address causes in the past. This is a liminal space not just in relation to a particular condition, such as Monaghan and Gabe's (2015) article on young people's experiences of asthma as "biographical contingency", being a problem to the self 'only sometimes' and invisible in other times but those subhealth narratives are narratives of 'biographical suspension' from the health side of ambiguity, defined in the participants' own terms instead of having to draw on biomedical vocabulary.

The liminal nature of subhealth narratives also lends itself to a critique of broader social conditions. These narratives transcend the individual, eschewing a disease-centred approach based on biological causation. They do not yet disrupt the lived world to a point demanding profound introspection—though they are precariously close. It is a biographical continuity stemming from prior experiences but in suspension with an ever-present fear of change. Precisely because of this character, suboptimal health correlates directly with current living conditions, enabling a deeper exploration of health and its determinants. This is why these stories echo elements of Bury's (2001) 'contingent narratives' but exceed them, offering a potent critique of current causes. Therefore, I argue that these what I tentatively call "subhealth narratives" present a valuable framework for sociologists to understand "embodied doubt" and proactive health behaviours, documenting an interplay of normalcy, crisis, meaning-making and critique.

Author Contributions

Lijiaozi Cheng: conceptualisation (equal), data curation (equal), formal analysis (equal), funding acquisition (equal), investigation (equal), methodology (equal), project administration (equal), writing–original draft (equal), writing–review & editing (equal).

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Data Availability Statement

The author has nothing to report.

Endnotes

[1] Notably, in a lot of discussions and publications on suboptimal health, the concept is equated with the term "the third status." Accounts of the origin and inspiration behind suboptimal health frequently reference "the third status," a concept proposed by the Soviet scholar N. Berkman in the journal *Philosophical Issues*. However, Berkman's "third status" is generally cited only to lend foreign authority to the concept, with the actual content of Berkman's work rarely, if ever, discussed in detail. In some cases, subhealth is also framed as a "Western" concept, linked to the WHO's approach to health. The detailed discussion of the origin of the concept is beyond the scope of the current article and will be discussed in detail in my upcoming publications.

[2] There are websites that publish and offer answers and explanations for those preparing for exams—this was taken from this site: http://www.chinagwy.org/html/xczl/cs/201701/56_184605.html.

[3] This paper is drawing on data collected for my PhD. My PhD was originally conceived to be based on participant observation at a traditional Chinese medicine clinic in England but the pandemic meant that I had to reconceive my project to include social media data as well as broaden my interview sample which included young Chinese people. I submitted ethical amendment and gained approval before proceeding with the changes.

[4] In the social media data, "middle age" often refers to individuals approaching or in their 30s, reflecting an age-related pressure and prevalent ageism. This usage diverges from the standard definition of "middle age," highlighting how societal expectations accelerate age-related milestones and anxieties for younger adults in contemporary China.

References

Armstrong, D. 2002. *A New History of Identity: A Sociology of Medical Knowledge*. Houndmills, Basingstoke, Hampshire: Palgrave.

Aronowitz, R. A. 2009. "The Converged Experience of Risk and Disease." *Milbank Quarterly* 87, no. 2: 417–442. https://doi.org/10.1111/j.1468-0009.2009.00563.x.

Behar, R. 1990. "Rage and Redemption: Reading the Life Story of a Mexican Marketing Woman." *Feminist Studies* 16, no. 2: 223–258. https://doi.org/10.2307/3177849.

Boyd, D., and K. Crawford. 2012. "CRITICAL QUESTIONS FOR BIG DATA: Provocations for a Cultural, Technological, and Scholarly Phenomenon." *Information, Communication & Society* 15, no. 5: 662–679. https://doi.org/10.1080/1369118X.2012.678878.

Bunkenborg, M. 2014. "Subhealth: Questioning the Quality of Bodies in Contemporary China." *Medical Anthropology* 33, no. 2: 128–143. https://doi.org/10.1080/01459740.2013.835811.

Bury, M. 1982. "Chronic Illness as Biographical Disruption." *Sociology of Health & Illness* 4, no. 2: 167–182. https://doi.org/10.1111/1467-9566.ep11339939.

Bury, M. 2001. "Illness Narratives: Fact or Fiction?" *Sociology of Health & Illness* 23, no. 3: 263–285. https://doi.org/10.1111/1467-9566.00252.

Carel, H. 2007. "Can I Be Ill and Happy?" *Philosophia* 35, no. 2: 95–110. https://doi.org/10.1007/s11406-007-9085-5.

Carel, H. 2016. *Phenomenology of Illness*. Oxford: Oxford University Press.

Chan, B. T. 2006. "Exploiting Marginality in Health: Is 'Subhealth' Another Case of Disease Mongering?" Presentation at the Inaugural Conference on Disease-Mongering, Newcastle, Australia, April 11–13, 2006.

Charmaz, K. 1983. "Loss of Self: A Fundamental Form of Suffering in the Chronically Ill." *Sociology of Health & Illness* 5, no. 2: 168–195. https://doi.org/10.1111/1467-9566.ep10491512.

Dumit, J. 2012. *Drugs for Life: How Pharmaceutical Companies Define Our Health*. Durham: Duke University Press.

Fogarty, P. 2019. "China's '996'." *BBC News*. https://www.bbc.com/worklife/article/20190718-china-996.

Gillespie, C. 2012. "The Experience of Risk as 'Measured Vulnerability': Health Screening and Lay Uses of Numerical Risk." *Sociology of Health & Illness* 34, no. 2: 194–207. https://doi.org/10.1111/j.1467-9566.2011.01381.x.

Gillespie, C. 2015. "The Risk Experience: The Social Effects of Health Screening and the Emergence of a Proto-Illness." *Sociology of Health & Illness* 37, no. 7: 973–987. https://doi.org/10.1111/1467-9566.12257.

Greaves, D. 2000. "The Creation of Partial Patients." *Cambridge Quarterly of Healthcare Ethics* 9, no. 1: 23–33. https://doi.org/10.1017/S0963180100001043.

Hine, C. 2011. *Virtual Ethnography*. London: SAGE.

Hine, C. 2015. *Ethnography for the Internet: Embedded, Embodied and Everyday*. London: Routledge.

Hofmann, B. 2005. "Simplified Models of the Relationship Between Health and Disease." *Theoretical Medicine and Bioethics* 26, no. 5: 355–377. https://doi.org/10.1007/s11017-005-7914-8.

Huang, Y. 2004. "Xiao Xin, Ning Ke Neng Chu Yu Ya Jian Kang [Be Aware, You Might Be in Subhealth]." *ren min ri bao [China Daily]*, no. 15.

Jauho, M. 2019. "Patients-in-Waiting or Chronically Healthy Individuals? People With Elevated Cholesterol Talk About Risk." *Sociology of Health & Illness* 41, no. 5: 867–881. https://doi.org/10.1111/1467-9566.12866.

Jing, J. 2019. "sheng ming jia zhi de she hui wen hua jian gou" [The social and cultural construction of the value of life] In *Gong min jian kang yu she hui li lun [Citizen's health & social theory]*. Beijing: She hui ke xue wen xian chu ban she.

Jutel, A. 2023. "10: Our Bodies, Our Disciplines, Our Selves." In *Interpreting the Body*. Bristol, UK: Bristol University Press.

Kreiner, M. J., and L. M. Hunt. 2014. "The Pursuit of Preventive Care for Chronic Illness: Turning Healthy People Into Chronic Patients." *Sociology of Health & Illness* 36, no. 6: 870–884. https://doi.org/10.1111/1467-9566.12115.

Lawton, J. 2002. "Colonising the Future: Temporal Perceptions and Health-Relevant Behaviours Across the Adult Lifecourse." *Sociology of Health & Illness* 24, no. 6: 714–733. https://doi.org/10.1111/1467-9566.00315.

Leder, D. 1990. *The Absent Body*. University of Chicago Press.

Leder, D. 1992. "A Tale of Two Bodies: The Cartesian Corpse and the Lived Body." In *The Body in Medical Thought and Practice. Philosophy and Medicine*, edited by D. Leder, 43, 17–35. Dordrecht: Springer. https://doi.org/10.1007/978-94-015-7924-7_2.

Li, G., F. Xie, S. Yan, et al. 2013. "Subhealth: Definition, Criteria for Diagnosis and Potential Prevalence in the Central Region of China." *BMC Public Health* 13, no. 1: 446. https://doi.org/10.1186/1471-2458-13-446.

Marcus, G. E. 1995. "Ethnography in/of the World System: The Emergence of Multi-Sited Ethnography." *Annual Review of Anthropology* 24, no. 1: 95–117. https://doi.org/10.1146/annurev.an.24.100195.000523.

Marcus, G. E. 2011. "Multi-Sited Ethnography: Five or Six Things I Know About it Now." In *Multi-Sited Ethnography: Problems and Possibilities in the Translocation of Research Methods*, edited by S. Coleman and H. P. Von, Oxford: Taylor & Francis Group: ProQuest Ebook Central.

Monaghan, L. F., and J. Gabe. 2015. "Chronic Illness as Biographical Contingency? Young People's Experiences of Asthma." *Sociology of Health & Illness* 37, no. 8: 1236–1253. https://doi.org/10.1111/1467-9566.12301.

Parker, C., S. Scott, and A. Geddes. 2019. "Snowball Sampling." In *Sage Research Methods Foundations*, edited by P. Atkinson, 367–371. https://doi.org/10.4135/9781526421036831710.

Plunkett, D. 2016. "Conceptual History, Conceptual Ethics, and the Aims of Inquiry: A Framework for Thinking About the Relevance of the History/Genealogy of Concepts to Normative Inquiry." *Ergo, an Open Access Journal of Philosophy* 3, no. 20200313: 27–64. https://doi.org/10.3998/ergo.12405314.0003.002.

Rosenberg, C. 2009. "Managed Fear." *Lancet* 373, no. 9666: 802–803. https://doi.org/10.1016/S0140-6736(09)60467-0.

Saunders, B., B. Bartlam, M. Artus, and K. Konstantinou. 2018. "Biographical Suspension and Liminality of Self in Accounts of Severe Sciatica." *Social Science & Medicine* 218: 28–36. https://doi.org/10.1016/j.socscimed.2018.10.001.

Wang, W., and Y. Yan. 2012. "Suboptimal Health: A New Health Dimension for Translational Medicine." *Clinical and Translational Medicine* 1, no. 1: 1–6. https://doi.org/10.1186/2001-1326-1-28.

Wang, Y., S. Ge, Y. Yan, et al. 2016. "China Suboptimal Health Cohort Study: Rationale, Design and Baseline Characteristics." *Journal of Translational Medicine* 14, no. 1: 1–12. https://doi.org/10.1186/s12967-016-1046-y.

Wang, Y. 2002. "Ya Jian Kang: 21 Shi Ji Jian Kang Xin Gai Nian [Subhealth: A New Concept of Health for the 21st Century]." In *Na Chang: Jiangxi Ke Xue Ji Shu Chu Ban She*. Nanchang: Jiangxi Science and Technology Press.

Wang, J. J. 2020. "How Managers Use Culture and Controls to Impose a '996' Work Regime in China That Constitutes Modern Slavery." *Accounting and Finance* 60, no. 4: 4331–4359. https://doi.org/10.1111/acfi.12682.

Weinberg, D. 2021. "Diagnosis as Topic and as Resource: Reflections on the Epistemology and Ontology of Disease in Medical Sociology." *Symbolic Interaction* 44, no. 2: 367–391. https://doi.org/10.1002/symb.504.

Williams, G. 1984. "The Genesis of Chronic Illness: Narrative Re-Construction." *Sociology of health & illness* 6, no. 2: 175–200. https://doi.org/10.1111/1467-9566.ep10778250.

Yang, J. 2018. *Mental Health in China: Change, Tradition, and Therapeutic Governance*. Cambridge, UK; Malden, MA: Polity.

Zhan, M. 2009a. *Other-worldly: Making Chinese Medicine through Transnational Frames*. Durham: Duke University Press.

Zhan, M. 2009b. "A Doctor of the Highest Caliber Treats an Illness Before it Happens." *Medical Anthropology* 28, no. 2: 166–188. https://doi.org/10.1080/01459740902851570.