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How South Korea Constructed a Shadow Carceral State through Institutions for People with Mental Disabilities in the 1980s

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Abstract

This article reexamines the history of placing people with mental disabilities in carceral facilities in South Korea from a feminist disability studies perspective. The large-scale institutionalization that took place during the military dictatorship of Chun Doo-hwan (1980–1987) has typically been analyzed as a product of the government's violent attempt at social control and the economic interests of private welfare institutions that cooperated with the government. This article uses the concept of a shadow carceral state to rethink how people with mental disabilities were institutionalized in South Korea in the 1980s, and argues that during the period of democratization, the framing of institutional reform as based on liberal human rights and identity condoned unjust and unequal structures that continue to produce abnormal *populations that are housed in institutions.*

Keywords: institutionalization, capacity/debility, mental disabilities, family, intersectionality

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Introduction

In the era of democratization in South Korea in the late 1980s, civil society fought for the release of prisoners who had been subjected to the military government's violent and coercive detention practices during the dictatorship of Chun Doo-hwan (1980–1987). However, an exclusive focus on political prisoners led to the neglect of welfare institutions for the disabled and the socially disadvantaged, such as Brothers Home, the country's most notorious welfare facility.[1] Only recently, after decades of democratization, have scholars begun to point out that democratization not only failed to lead to needed conversations about the institutionalization of social others, but actually intensified the processes of othering and institutionalizing the socially disadvantaged. For example, Kim Daehyun (2021a, 2021b) observes that the logic of "treatment and welfare" behind institutionalizing social others such as vagrants, prostitutes, and the mentally ill intersects with the logic of incarcerating political criminals. He argues that post-democratic calls to abolish coercive detention have failed to capture this intersection. Choo Ji-hyun (2017) and Choi Jong-sook (2021) argue that civil society's focus on defending fundamental rights to freedom during the democratization movement explains why it failed to apprehend overlapping forms of institutionalization that confined and excluded various social others. They point out that all resistance to political incarceration was channeled into overthrowing the dictatorship and abolishing detention for political purposes, and issues related to social exclusion and inequality—the very issues that produced social minorities such as poor petty criminals and vagrants—were not on the agenda of democratic movements.[2] Other studies

1. Brothers Home (Hyeongje bokjiwon) was founded as an orphanage after the Korean War and later transformed into a facility for vagrants. It became a hotbed of crime, including forced labor, assault and murder of inmates, and embezzlement of state subsidies. The case of Brothers Home is so well known that it has been covered by the international media (T. Kim and Foster 2016). J. Kim et al. (2023) have reported a more detailed history of the human rights violations committed there.
2. According to Choi Jong-sook (2021) of the Korea Democracy Foundation, the conditions at Brothers Home, which first came to public attention in 1987, were quickly forgotten on

have found that the exclusion of social minorities is itself an effect of creating social hierarchies based on multi-layered differences between categories of *normal* citizens within civil society. Lee Jeong Seon (2021) examines how ragpickers, members of the urban poor, and others who actively participated in the 1980 Gwangju Uprising were quickly erased from the discourse about the uprising as a result not only of state violence but also of the social hierarchies and forms of exclusion that had accumulated in civil society at the time.

This article builds on these studies to illuminate the formation of a shadow carceral state in the spaces of social welfare facilities for people with disabilities and psychiatric hospitals during the 1980s and the transition to democracy in the late 1980s and 1990s. Critical criminology researchers Beckett and Murakawa (2012) use the concept of the "shadow carceral state" to describe the nature of mass incarceration today, particularly in North America, but it is also useful for analyzing mass institutionalization in the 1980s in South Korea. According to Beckett and Murakawa, mass incarceration in today's liberal democracies is characterized by hybrid and opaque institutional processes such that "the formal control system features blurred boundaries between inside and outside; broadened and fuzzy definitions of crime; an expanded social control net; and dispersed state social control mechanisms beyond prison walls" (Beckett and Murakawa 2012, 222). Mass incarceration deploys a variety of actors and devices to circumvent conflicts with visible state apparatuses, laws, and policies, and opposing public opinion in situations where the kinds of direct and violent forms of state control that were possible in the past are no longer available. In light of the history of overt state violence under the dictatorship of Chun Doo-hwan, which included relying on the Samcheong gyoyukdae (Samchung Reeducation Corps) and enacting the Sahoe bohobeop (Security Surveillance Act), using the term "shadow carceral state" to capture the

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the political and social stage at the time. This is because, as she points out, in 1987, the pro-democracy movement feared that the Brothers Home case would divert the movement's focus from the death by torture of Park Jong-chul and the overthrow of the dictatorship.

politics of incarceration in the 1980s may at first seem unconvincing. However, as Kim Daehyun points out (2021a), even the notorious preventive detention measure under the Security Surveillance Act was based on the logic of scientific treatment and welfare, and psychiatric hospitals and welfare institutions operated with greater stability and expanded more than ever under the Chun Doo-hwan government, laying the foundation for current conditions. By using the concept of a shadow carceral state to rethink institutionalization in the 1980s, this article examines how heterogeneous and hybrid policies, actors, and devices work together to transcend the dichotomies of normal/abnormal, disabled/non-disabled, inclusion/exclusion, and life/death, and accommodate multiple modes of *including* (as opposed to socially excluding) various bodies (not *subjects* or *identities*) as they are placed in in-between spaces.

The article begins by briefly reviewing work in feminist disability studies that positions disability as a historically fluid and relational (as opposed to a fixed) category. It then examines how the Chun Doo-hwan government established the shadow carceral state in the 1980s and discusses debates about how institutionalization was reoriented during democratization as both an ongoing process and an effect of the shadow carceral state. This article highlights how the types of institutions and the spectrum of people who have been subject to them are carceral facilities for people with disabilities, especially psychiatric hospitals and institutions for people with intellectual disabilities. However, it is not easy to draw a clear line between types of institution and the people they house. For example, the psychiatric sanatorium, one of the institutional settings this article focuses on, is difficult to distinguish from welfare institutions and hospitals because they *accommodate* but do not *treat* people with mental illnesses.[3] The term

3. Psychiatric sanatoriums (*jeongsin yoyangwon*) are facilities for people with mental disabilities that were created in Korea in the wake of the Korean War. The first psychiatric sanatoriums were temporary facilities that replaced psychiatric hospitals, which had closed during the Korean War. After the war, administrators chose not to close these facilities and instead continued to develop their infrastructure. In 1970, the Park Chung-hee government passed the Social Welfare Act, which recognized psychiatric sanatoriums as legal welfare institutions. Sanatoriums specialize in accommodating people with mental

"*burangin*" (vagrant) is not a neutral category, as *burangin* are often associated with people with mental illness; women vagrants are an even more complex category, as they are often conflated as "*yullak yeoseong*" (prostitutes) in historical contexts.[4] Until the 1970s, the state definition of *burangin* was strongly linked to mental illness and associated with the inability to provide for oneself. In addition, as Ben-Moshe (2020) and many others point out, housing insecurity itself—that is, the very condition of living without a secure shelter and in constant anxiety and fear—can cause psychological and physical disabilities. In this context, the landscape of institutions this article refers to also includes accommodation facilities for vagrants.

Reconceptualizing Disability as Part of Biopolitical Population Management

Foucault (2011) showed that modern state power is characterized by regulation and control, forces of governance that allow people to live in certain ways while forbidding other ways of living. The biopolitical framework positions disability as an atypical body/mind whose self-evident deviance must be addressed in medical terms. Correcting or normalizing the pathological individual is the only appropriate solution to disability.

Disability politics emerged in Western societies in the 1960s to challenge how modern states treat disability as a medical abnormality. The focus is on redressing the medicalization of disability and the social segregation of disabled people and the discrimination against them it has led to. It argues that the disabled body is not a medical abnormality but a source

disabilities, regardless of the severity of their illness, but they not hospitals, meaning they do not have doctors or specialists on staff and therefore do not provide treatment. Because of the dubious nature of these institutions, psychiatrists have been calling for their closure since the 1960s (Korean Neuropsychiatric Association 2009).

4. Prostitutes were clearly the group most heavily pathologized as *mentally defective* in the 1950s into the 1960s, especially as eugenic concerns about deviant sexuality were added to the mix (Hwang 2023b).

of identity, and social barriers that discriminate against disabled bodies must be dismantled so that disabled people are included as subjects of human rights. However, scholars have criticized early versions of disability politics for being epistemologically based on white, male, middle-class, physically disabled subjects. Disability politics has since drawn on critical encounters with feminist and queer theory, critical race theory, postcolonial theory, and affective turn. Recent affect theory, particularly in its concern with undermining traditional anthropocentric views of cognition, agency, and action, calls for radically deconstructing the boundaries between "non-disabled" and "disabled" body/minds, and reconceptualizing disability in terms of biopolitical population management. Following Deleuze, scholars describe affect as the *capacity to affect and be affected* (H. J. Kim 2022, 90; K. W. Kim 2020, 44), insofar as bodies are inevitably related and connected to other bodies and environments in society, and thus have impersonal, pre-subjective properties. It is a socially produced and distributed force that "creates certain relationships...and thus gives rise to certain behaviors"(E. Kim 2019, 60).

Paying attention to affect leads to skepticism about societal forms of identifying and categorizing disability that divide disabled and non-disabled identities based on fixed levels of body/mind functioning. For example, identifying as able-bodied does not necessarily entail having a full range of bodily capacities. Distinguishing between disabled and non-disabled identities obscures that all bodies exist on a spectrum between capacity and debility. In this light, biopolitics can be theorized more precisely as a set of mechanisms for regulating and controlling the bodies of the population as a whole. Jasbir Puar (2017) stresses the importance of theorizing "debility" as central to biopolitics and as a way to move beyond the binary of non-disability/disability privileged by existing biopolitical theories. According to Puar, disability is not only congenital or the result of random events, as is commonly perceived, but is constantly regulated by the political and social environment. Those who are not interpellated or identified as "disabled" but who are also excluded from the privileges of capacity are debilitated, especially the countless members of the population around the world who are subject to transnational capitalism and imperialism, whose sexuality and

gender are regulated, and whose access to essential resources and healthcare is blocked due to their citizenship status, skin color, etc. "Debilitation as a normal consequence of laboring…exposes the violence of what constitutes 'a normal consequence.' By instrumentalizing the category of disability, state discourses of inclusion not only obscure forms of debility but also actually produce debility and sustain its proliferation" (Puar 2017, xvi). Attending to debility captures the complex and contradictory experiences of non-Western, racialized, poor, gendered populations who are not recognized as disabled within the framework of Western, middle-class, male, physical disability-centered politics.[5] Distinguishing between the identity category of disability and the biopolitics of debilitation allows us to rethink the concept of disability and capture the concrete reality of bodies, where death intersects with what is called "life"—"slow death" (E. Kim 2020; Berlant 2007) or "death wrapped in life" (Sakai 2011, 130). As a model of a politics that works against liberal notions of rights, Puar's theorization of the "biopolitics of debilitation" invites an intersectional analysis of disability that attends to class, gender, sexuality, nationality, and race. By moving beyond the dichotomy of non-disabled and disabled body/minds, it also reconceptualizes disability as a political, relational, and ongoing process of *becoming* (Erevelles 2011).

The preceding discussion offers a theoretical backdrop for understanding South Korea's history of variable and diverse categories of disability within the postcolonial geopolitics of the Cold War. It illuminates the analytical vacuum created when disability and non-disability are understood as binary and fixed categories. For example, until the 1970s, *burangin* (vagrants) and *bulguja* (cripples) were categorized as the same group, *bulgu* (crippled) in South Korea's national administrative system (Ministry of Health and Social Services, 1961–1979). No distinction was made between them. However, most academic discussions of Korea's history

5. Although four-fifths of the world's estimated 600 million people with disabilities live in the Global South, it has been argued that they are not captured by disability categories or disability rights regimes based on Western-centric epistemologies (Livingston 2006; Meekosha 2011).

of placing *burangin* in accommodation facilities have been based on fixed ideas about subjects and have overlooked how *burangin* include people with disabled body/minds. Meanwhile, psychiatric disabilities, which are not as immediately visible as physical disabilities and have complex politics surrounding their medical treatability (Mollow 2006), have long been unfairly excluded from the category of legal disability in South Korea. As a result, people with mental disabilities have been further excluded from access to the healthcare, employment, and welfare rights nominally afforded to people with legal disabilities and have effectively been the most targeted for institutionalization. At the same time, people with mental disabilities have long been excluded from debates about deinstitutionalizing people with disabilities.

The Rhetoric of Disability Rights and Institutions as a Field of Debilitation

Legalizing Disability Rights with Disproportionate Effect upon Mental Disabilities

In the early 1980s, the rhetoric of disability rights emerged in Korean society amid domestic and international changes, including the decision to host the 1988 Olympics and Paralympics in Seoul, and the United Nation's declaration of 1981 as the International Year of Persons with Disabilities. President Chun Doo-hwan, who came to power in a 1980 coup d'état, faced significant domestic and international changes in his early years in power and worked to introduce a legal system to support the welfare of disabled people. A key part of this legislative change was codifying institutional infrastructure, which until the 1970s had an ambiguous legal status, and imposing new meanings on institutional care, such as disability rights and welfare. On June 5, 1981, the government passed the Welfare of the Physically and Mentally Handicapped Act of 1981 (Law No. 3452), which detailed the legal categories of disabled persons. It classifies "physical and mental handicaps" as "limited mobility, impaired vision, impaired hearing,

speech and language disorders" and "mental defects such as feebleminded-ness," and defines a physically and mentally handicapped person as "a person who is substantially limited in daily or social activities for a long period of time." Including only "feeblemindedness" and not "mental illness" in the category of mental handicap is particularly notable. The act also divided the types of accommodation facilities. The government criticized the previous military dictatorship's policy of admitting people with disabilities into the same institutions, regardless of their status or type of disability, which made it difficult to guarantee the rights of people with disabilities (NASK 1981).[6] It also emphasized the importance of encouraging the private sector's active participation in establishing and operating facilities, rather than government initiatives.

Even though the Welfare of the Physically and Mentally Handicapped Act was enacted in 1981, the lack of state obligations to ensure the protection of rights and the emphasis on expanding private sector-led disability-specific facilities has not improved the living conditions of those with disabilities. Furthermore, people with disabilities are a heterogeneous group that varies in terms of class, gender, age, and type of disability. Yet a relatively small group of men—primarily, physically disabled or deaf men and physically disabled veterans—have coalesced around the identity of *disabled* and have been able to accrue the benefits attendant to the rhetoric of disability rights, receiving the lion's share of resources that are informally distributed through various government benefits projects (Ha 2020). At the same time, as in previous periods, most disabled people, who are systematically deprived of work, healthcare, welfare, education, etc., and disproportionately exposed to eugenic birth control and institutionalization (E. K. Choi 2022; So 2020), have become the largest group of long-term residents in *welfare* institutions for the mentally and physically handicapped. In the mid-1980s, facilities managers called for building more institutions for people with "mental retardation," including children, because the size of institutions had not kept

6. Minutes of the First Committee on Health and Social Affairs of the 11th National Assembly, May 13, 1981, 40–43; Minutes of the Seventh Plenary Session of the 11th National Assembly, May 19, 1981, 4.

pace with the needs of poor people with mental retardation (S. Cho 1985).

The most vulnerable group among these disability categories is the *mentally ill*, who were not included in the legal category of disability in the first place. Mental health professionals sought to construct a hierarchical relationship between mental illness and disability, emphasizing that people with mental illness should not be "treated as handicapped" but as people who require medical attention (Iyeong Kim et al. 1986, 257).[7] They therefore prioritized developing hospital infrastructure and medical staff, rather than reducing social inequality or increasing support for poor families, as a way to ensure the human rights of the mentally ill. However, people with mental illness make up a very heterogeneous group in terms of such categories as class and gender, and their access to healthcare has been very uneven. In the 1970s, there was a "strange phenomenon" (I. Kim 1991, 158) in which hospitals and hospital beds were grossly inadequate in relation to the population, and yet hospital beds remained empty because there were no patients to use them. Few people had easy access to hospitals and treatment infrastructures. It was not until 1977, at the end of the Park Chung-hee regime, that the Medical Protection Act (Act No. 3076, signed on December 31, 1977) was enacted to provide medical protection to the poor, but it was discriminatory in that it applied a "per diem" system to services related to psychiatric disabilities.[8] Under these circumstances in the 1960s and 1970s, the chronically mentally ill, who were frequently poor and untreated, came to make up the majority of the population in various institutions, either because they were involved in violent crimes such as murder or because they were caught up in government crackdowns on vagrancy. Poor people with mental disabilities continue to lack access to quality treatment and care.

7. Psychiatry expanded its influence as a dominant force in Korean society through US aid during and after the Korean War. For a detailed history of psychiatric institutions and professionals in the postwar era, see Yum (2014) and Hwang (2023b).
8. The per diem system is a payment system aimed at controlling the growth of health care costs. It pays a fixed amount per day for all the costs of outpatient and inpatient treatment. Fee-for-service, on the other hand, is a system that charges a separate price for each consultation, examination, treatment, medication, etc. Most medical bills are calculated according to the fee-for-service system (B. Choi 2018).

Excluded as they were from the category of persons with disabilities that received at least nominal rights protection in the 1980s, people with psychiatric disabilities were also sent to institutions as a blatant form of punitive control under the Chun Doo-hwan government. The difference in the 1980s, however, was that the government adopted a strategy of avoiding conflict with national and international public opinion regarding the human rights of people with disabilities. After Seoul was selected to host the Olympic Games in 1981, the government launched a series of crackdowns on vagrants, of which it was later revealed *mentally handicapped* people comprised the overwhelming majority. That same year, the government undertook an initiative called Measures for the Protection of Beggars under the Prime Minister's Office. This vaguely defined project did not explicitly refer to mental disability, but the government used it to crack down on and detain vagrants with mental disabilities. They did so by significantly expanding private accommodation facilities such as psychiatric sanatoriums for "professional rehabilitation" and "welfare" (Gungmu jojeongsil 2003). Using the rhetoric of welfare and rehabilitation, the government helped create institutions to control the mentally disabled that were in many cases places of debilitation.[9]

As mental health professionals have pointed out, the government also promoted the expansion of psychiatric hospitals. However, due to the inequities of the per diem system and a fundamental failure to address the multiple interlocking oppressions experienced by people with mental disabilities living in poverty, psychiatric hospitals have also become places of debilitation and long-term institutionalization. It was common for general hospitals to refuse to provide psychiatric beds or to treat patients under the Medical Protection Act at all. Because of the per diem system, the average revenue per bed was very low compared to other beds, and hospitals sometimes even lost money per patient. However, many large private

9. The history of inappropriate psychiatric treatment and control of residents through medication (so-called 'chemical restraint') in psychiatric and other institutions for vagrants has been vigorously investigated in recent years (J. Kim et al. 2021; J. Kim et al. 2023; Truth and Reconciliation Commission of Korea 2023).

psychiatric hospitals took advantage of loopholes in the system by simply confining the mentally disabled, effectively embezzling the government's flat-rate per-patient subsidy (B. Kim 1992; In-hyun Kim 1993).

As a result, regardless of their legal identity as disabled persons, members of marginalized groups at the intersection of gender, disability, and class, and people with psychiatric disabilities who were not even recognized as disabled, were debilitated by the lack of treatment and resources in the

Table 1. The National State of Vagrant Accommodation Facilities in the 1980s

Year	Total	Male	Female	Health status, type of disability						
				Normal	Mental illness	Physical	Visual	Hearing	Mental retardation	Others
1984	11,744	8,320	3,424	3,135	4,018	1,233	126	324	1,081	1,827
1985	12,033	8,572	3,461	3,195	3,540	1,445	150	477	1,211	2,015
1986	13,180	9,292	3,888	3,212	4,269	1,581	156	472	1,328	2,162
1987	8,571	5,262	3,309	421	3,401	1,034	149	502	1,049	2,015
1988	9,028	5,660	3,368	411	3,780	1,121	142	421	1,311	1,842

Source: Ministry of Health and Social Services (1984–1988).

Table 2. The National State of Psychiatric Sanatoriums in the 1980s

Year	Number of facilities	Male	Female	Type of symptom				
				Schizophrenia	Depression	Epilepsy	Mental retardation	Others
1982	26	3,238	2,196	-	-	-	-	-
1983	18	3,818	2,576	-	-	-	-	-
1984	40	5,024	3,325	6,920	588	207	267	367
1985	47	6,479	4,240	8,843	680	331	274	591
1986	52	7,504	4,944	10,379	650	400	379	730
1987	65	9,008	5,827	12,328	688	508	531	780
1988	71	10,053	6,197	13,657	622	534	390	1,047
1989	73	10,595	6,452	14,268	718	523	455	1,083

Source: Ministry of Health and Social Services (1982–1989).

1980s. As shown in Tables 1 and 2, the number of specialized institutions such as psychiatric sanatoriums gradually increased in response to the growing number of debilitated bodies. It is also noticeable that although facilities for vagrants still housed the largest number of people thanks to the government's crackdown on and internment of vagrants, the percentage of disabled people among inmates came to far outstrip that of "normal" inmates. Although the number of "normal" residents in accommodation facilities for vagrants has fallen sharply since democratization in 1987, the total number of mentally disabled people in different types of facilities has remained the same or steadily increased—a point that will be discussed below.

The state's recognition of the human rights of persons with disabilities in the 1980s was a process that simultaneously included some people with disabilities as subjects of rights and expanded a debilitated population. This debilitated population was *included* by being housed in organized institutions that imposed new meanings of welfare, rehabilitation, and treatment.

Familial Liberalism and Political Economies of Institutionalizing Care

Paying attention to the family alongside the discursive practices of government and professionals adds complexity to the understanding of institutionalization as a key field of debilitation that has been sketched out above. South Korea's long history as a state development system and the absence of a public welfare led to what has been called "familial liberalism" (Jang 2018), in which the *private* sphere of the family is the main source of citizens' welfare. Although the Chun Doo-hwan government was also indifferent to establishing a public welfare system, this period saw changes in family functioning and social risk. By the 1980s, the number of waged workers began to exceed agricultural workers in the total labor force, and real wages and public benefits—which were available mostly to full-time, highly educated male workers—began to grow the share of middle-class families. Whereas these families could rely on wages and private assets to manage risks in the absence of public welfare, a large group of poor workers

and self-employed small business owners were left without a social safety net (Yoon 2019). This trend encouraged poor working-class families to become reliant on two earners, and married women from poor families thus began to enter the precarious low-wage labor market in large numbers to help support their families. Because poor women had to carry the double burden of producing in the labor market and reproducing in the family, and were often the sole breadwinners in the family, they were more vulnerable to illnesses of both body and mind (H. Kim and Shin 1990; M. J. Cho 1986).[10] The mass entry of poor women into the labor market and their subsequent debilitation created a vicious cycle that also diminished the family's social reproductive function and increased economic inequality.

In a context in which the majority of citizens and families face increasing social risks while formal policies remain static, existing social protection is fundamentally constricted (Hacker 2005), making families who had already taken full responsibility for their members' well-being even more vulnerable. This constriction drove the large-scale institutionalization of people with disabilities in the 1980s. For example, the Medical Protection Act, introduced in the late 1970s to provide a minimum level of protection for poor families, already placed people with psychiatric disabilities in a discriminatory system. The law discriminates against people with mental disabilities to cut costs based on the fact that people exposed to poverty and inequality are more likely to develop mental illness.[11] A 1980 government

10. However, there is little data on the extent to which poor women workers were exposed to disability or illness in the 1980s. This is because married women are not typically recognized as formal workers and, even when they are, their work is usually irregular, so accidents and occupational illnesses among women workers are rarely formally recognized.

11. This logic that justifies excluding poor mentally disabled people from healthcare is evident in the 2017 decision in a lawsuit against the unconstitutionality of the per diem provision (2016헌마431 on July 26, 2018). The Constitutional Court noted that a fee-for-service system, which is suitable for acute illnesses, is inappropriate because most mental illnesses are chronic and patients are typically hospitalized for long periods, and because most medical expenditure is on hospital costs such as room and board, with a relatively small proportion on medical treatment. The Constitutional Court also noted that applying the per diem system to the mentally ill is necessary to prevent waste of state funds, as the average person benefiting from the Medical Protection Act has a higher proportion of

survey of people with disabilities demonstrated this logic, finding that "mentally handicapped" people and their families were the poorest among the people with disabilities surveyed (Korea Health Development Institute 1980).[12] However, the Chun Doo-hwan government maintained the discriminatory system and did not change any policies. The risks that psychiatrically disabled people and their families faced thus increased as socioeconomic conditions dramatically changed in this period.

What is perhaps more remarkable about the higher risks that families of people with mental disabilities faced is that the government used their vulnerable condition to encourage families to outsource care to institutions. In 1982, a year after the Measures for the Protection of Beggars were enacted, the Chun Doo-hwan government did not formally amend the Minimum Standard of Living Protection Act of 1961, which had been enacted to provide government assistance to those in need of protection, but rather revised the detailed provision to further systematize and strengthen the rules regarding family support obligations.[13] These measures exacerbated rather than mitigated the risks of social reproduction for poor families, yet at the same time the government covertly expanded the ways in which families covered by the law could send family members in need of care to institutions. In particular, the method of selecting beneficiaries under the act changed: previously, the state had unilaterally designated beneficiaries, but it started to allow third parties, such as facility managers, to apply for care. The government also increased the amount of state support provided for facility

chronic illnesses and mental illnesses, and their average cost of medical treatment is also higher.

12. This trend continues today, with people with mental disabilities accounting for the highest proportion of all people with disabilities covered by the National Basic Livelihood Security System (M. G. Kim 2019).

13. From its inception, the original Minimum Standard of Living Protection Act was based on the principle of the *duty of care*, which prioritizes family members over the state as responsible for supporting their families. However, the 1961 Act's principal obligation to provide for one's family was only enshrined in an executive order. In 1982, the government clarified the scope of family members' obligations to provide support by applying the standard of support obligor set out in the Civil Code to the Minimum Standard of Living Protection Act, enshrining it in law rather than in an executive order (Yoon 2019).

care compared to family care, as well as tax incentives and other privileges to help facilities efficiently attract private capital (Il-hwan Kim 2019; Yoon 2019).

Thus, the largescale production of a debilitated population on the streets and in various type of facilities was fundamentally caused by families being forced to take full responsibility for the reproduction of their daily lives in conditions of growing economic inequality. The state demanded that families and citizens, regardless of their class, gender, or disability, solve their own plights in the absence of public healthcare, labor rights, and wealth redistribution, and simultaneously created a hybrid and often invisible set of policy changes that bypassed public opposition and visible legal apparatuses to efficiently channel debilitated bodies into institutions. Faced with a binary choice between institutional and family care, the mentally disabled are the most debilitated group in this system, which minimizes state expenditure by cutting off social support to families and maximizing profits from the institutions that the government began cultivating as large-scale business in the 1980s. When the debilitated occupy beds in institutions rather than their own homes, the *unproductivity* of their debilitated bodies is made *productive* as a source of accumulating profits for the privately owned institutional industry.

Post-Democratic Opposition to Coercive Detention and the Reorientation of Institutionalization

The fall of the military dictatorship in 1987 initiated South Korea's transition to democracy. Anti-dictatorship and pro-democracy forces have been at the forefront of efforts to end the illegal practice of forced detention. Democratization put an end to the illegal practice of forced detention and led to abolishing or reforming various places of detention and anti-human rights laws. However, pro-democracy forces have not been able to challenge the shadow carceral state. With the rise of the international disability recognition in the 1980s, diverse actors including families and a subtle set of policy changes that refashioned existing institutional operations and goals converged to target bodies that fell *in between* the binary of disabled/non-

disabled that structures institutionalization. Debilitated by multiple layers of social oppression, including disability, poverty, and gender, the population is forced to turn to institutions as the only alternative to family care. Although democratizing currents have addressed the blatantly inhumane incarceration that is perpetrated by absolute power, they have not identified these invisible mechanisms of institutionalization.

Democratization has revealed the existence of various welfare institutions that forcibly housed various socially vulnerable groups, such as vagrants and prostitutes. In addition to the media coverage that led to the closure of Brothers Home in 1987, some feminist groups that emerged with democratization called for protecting women's human rights, strongly condemned the practice of forcibly interning poor prostitutes, and led to the closure of the Seoul Women's Reformatory in 1994 (Park 2011). However, as mentioned, the categories of "vagrant" and "prostitute" were state administrative terms that encompassed very heterogeneous groups in the first place. Historically, they were not perceived as abled-bodied, but neither were they identified as disabled subjects. As carceral facilities for vagrants, women's institutions such as Seoul Women's Reformatory were spaces that continued to house a mixed population of psychopathologized women as well as women who in many cases had actual disabilities (especially mental disabilities) as a material consequence of poverty and oppression (Hwang 2023a). However, the demands of civil society, based as they are on a monolithic disabled/non-disabled identity and a liberal human rights framework, do not address welfare institutions as a whole and their function as fields of biopolitical debilitation.

In this context, civil society's general opinion is that institutional infrastructure dedicated to treating and caring for certain populations, especially the mentally and physically handicapped, should be maintained, provided that the institutions' procedures, legal and otherwise, are corrected. Some organizations have criticized the debate for focusing on establishing legal procedures for institutionalizing people with mental disabilities and have emphasized instead the need to address the lack of a public healthcare system as a fundamental factor driving institutionalization (B. Kim 1992; Association of Physicians for Humanism 1990). However, a chain of events

that occurred around the same time reinforced public demand for democratizing these institutions and establishing due process. Incidents of people being misperceived as mentally ill, forcibly detained, and subjected to various human rights violation at various institutions and psychiatric hospital were reported and emerged as social issues. In 1991, for example, the media revealed that the Sinseongwon, a psychiatric sanatorium in Daejeon that housed "normal people with no mental or physical defects," had used forced labor, violated human rights, and embezzled government funds.[14] The "Tae Chon Pa case," in which a gang forcibly committed a member to a psychiatric hospital after he exposed crimes, also became a hot topic.[15] These incidents spread fear and concern that even "normal" people can be unjustly detained in institutions or hospitals. Similarly, a number of undemocratic and repressive institutions have been exposed across the country, including the forced incarceration and human-rights violations at Susimwon, a psychiatric sanatorium in Chungnam[16]; a fire and ensuing mass deaths at a closed psychiatric ward in Chungnam[17]; and forced labor and chemical restraint at Saehuimang, a psychiatric sanatorium in Busan.[18] In reporting on these cases, the media—as well as government officials, experts, and members of civil society in general—condemned the indiscriminate detention of people without any legal basis or objective criteria, and the violence and abuse in these facilities. Their response implies that if the accommodation process had been fair and the institution

14. "Jeongsangin 'gangje suyong' Daejeon sinsaengwon" (Normal People 'Forcibly Interned' at Daejeon Sinsaengwon), *Kyunghyang Shinmun*, August 3, 1991.
15. "Beomjoe sasil tuseohan buha jeongsin byeongwon-e gangje ibwon" (A Subordinate was Forcibly Admitted to a Psychiatric Hospital After Confessing to a Crime), *Chosun Ilbo*, August 23, 1990.
16. "Ingan-ui jogeon: Jeongsinjil hwanja suyongsiseol-ui siltae bogo" (The Human Condition: A Report on the State of Psychiatric Sanatorium), *SBS Geugeosi algosipda*, aired November 28, 1992.
17. "Hwanja-deul bal mukkyeo daepi motae" (Patients Stuck, Unable to Evacuate), *Hankyoreh*, April 20, 1993.
18. "Saehuimang yoyangwon gahokaengwi siltae: Beop·ingwon dujeoldoen hyeondaepan 'suyongso gundo'" (Saehuimang Sanatorium: A Modern-Day 'Camp Archipelago' Lacking in Laws and Human Rights), *Hankyoreh*, May 2, 1994.


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장부조작·국고보조금도 횡령

醫師진단없이 藥物 강제복용

工事場 동원

Figure 1. Newspaper coverage of "normal people" being forced into confinement

Source: *Kyunghyang Shinmun*, August 3, 1991.

democratic, then the existence of the institution itself would not be a problem. What is missing here is a diagnosis of the institutions' long-standing impunity for socially oppressing people based on their gender, class, and disability, as well as the government's neglect of the public health and welfare system. In short, the liberal human rights and identity-based framing of institutional reform during the period of democratization condoned unjust and unequal structures that continue to produce *abnormal* populations that are housed in institutions.

As a result, as Table 1 shows, *normal* people have all but disappeared from post-democratic institutions, and disabled bodies have taken their place. In addition, as shown in Table 3 below, both the institutional infrastructure and number of people with disabilities have steadily increased since democratization. In psychiatric sanatoriums, the proportion of "inmate[s] without family" has decreased since democratization, while the proportion of "inmate[s] accommodated by family" has increased (Ministry

of Health and Social Services 1987–1995). In other words, the trend of the authorities accommodating vagrants at a large scale has been reversed, as more families have turned to the facilities after democratization because they are unable to care for their families or have given them up. Table 3 also shows that while the facilities for vagrants stopped growing with the *choice* of the families to outsource the care of disabled family members to facilities, psychiatric hospitals have seen significant growth since democratization, with the number of psychiatric sanatoriums and psychiatric hospitals becoming equal in the 1990s. After democratization, discussions about the Mental Health Act (Act No. 5133, signed on December 30, 1995), which focused exclusively on preventing the unjustified detention of *normal* people and establishing procedures to ensure that people with mental disabilities could be effectively accommodated in treatment facilities, led to a proliferation of private hospital infrastructure.[19]

Thus, the invisible incarceration of a debilitated population that was established during the authoritarian period of the 1980s has only become more entrenched since democratization, with legal procedures for detention and laws clearly defining who can be placed in confinement. Since the first decade of the 2000s, public health and welfare systems have been introduced and spread through regime change, but the shadow carceral state constrains their full implementation and continues to (re)produce an "institutionalized society" (Women with Disability Empathy 2020).

19. As mentioned above, mental health professionals have called for expanding hospital infrastructure as a human rights measure that would allow them to treat "mental illness" as a medical condition. Beginning in the 1960s, they also called for enacting the Mental Health Act to facilitate the efficient admission of the mentally ill to hospitals. In response to the post-democracy incidents of *normal* people being forcibly detained in psychiatric hospitals and mental institutions, mental health professionals pressed for a law that would provide a detailed procedure for admission based on a doctor's diagnosis. The Mental Health Act, which was finally passed in 1995, details the due process for involuntary hospitalization, but omits important content such as the state's responsibility for the welfare of people with mental disabilities and their families.

Table 3. Size of Welfare Institutions Before and After Democratization, by Type

Year	Facility for the disabled		Facility for vagrants (mentally disabled inmates)		Psychiatric sanatorium		Psychiatric hospital	
	Number of facilities	Residents	Number of facilities	Residents	Number of facilities	Residents	Number of facilities	Residents
1985	92	9,326	27	15,337 (3,540)	47	10,719	6	3,919
1990	150	12,759	29	9,728 (4,556)	74	17,432	24	9,310
1995	216	13,936	32	8,890 (5,102)	75	18,639	27	15,197

Source: Ministry of Health and Social Services (1985–1995); Y. Lee (2005).

Conclusion

Scholarly discussions about the institutionalization of socially disadvantaged people in the 1980s have thus far analyzed how it was produced by undemocratic dictatorships and the economic interests of private institutions. As these studies have shown, the state remains an important actor, and much remains to be understood about the connection between state power and institutional capital. However, this paper argues that such analysis ignores the ways in which institutionalization was embedded in the intersecting structures of oppression and exploitation that sustained capitalism, familial liberalism, sexism, and ableism during the 1980s and even after democratization. It argues that to fully uncover the history of institutionalization in South Korea, we need to pay more attention to the body itself (rather than the subject or identity) and the biopolitical management of the population as it operates through multiple layers of power, such as class, gender, race, and disability.

Rather than including or excluding identities, the biopolitics of capacitation/debilitation has allowed institutions to proliferate as key sites of debilitation without the coercion and violence of authoritarian governments,

even under the rhetoric of human rights. This shadow carceral state has survived and even been strengthened by democratization and regime change. Despite the defamiliarization of care, the strengthening of public welfare, and the creation of social services for people with disabilities promoted by democratic regimes since the 2000s, the shadow carceral state has continued to flourish. During this period, South Korea was placed under the management of the International Monetary Fund and economic inequality worsened. Low-wage labor, which is not covered by the social safety net, proliferated, and the infrastructure for care and welfare was marketized. In this situation, many people are consistently forced to choose between family and institution.

Since 1999, *mental illness* has been recognized as a legal category of disability in Korea. The Welfare of Persons with Disabilities Act (Act No. 5960, signed on March 31, 1999), which amended and restructured the entire Physically and Mentally Handicapped Act, included "mental illness" as a legal category of disability for the first time. Today, everyone in contemporary Korean society is at least aware of the human rights of people with disabilities, including the mentally disabled. However, the conflation of disability rights and neoliberal transformation continues to produce bodies that are debilitated regardless of their legal identities. And a population that is consistently marginalized and debilitated based on intersecting layers of class, disability, race, and gender is institutionalized entirely by the *choice* of the individual and their family. Care responsibilities for people with mental disabilities (including the power to institutionalize them) have historically fallen entirely on families. These same people have been systematically excluded from access to social resources and are currently the most likely to be placed in institutions (Ministry of Health and Welfare 2019). These findings demonstrate the need for Korean society to create a political coalition between the disability studies, gender and sexuality studies and the transitional justice movement.

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