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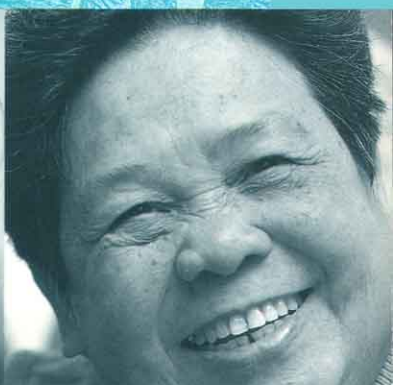
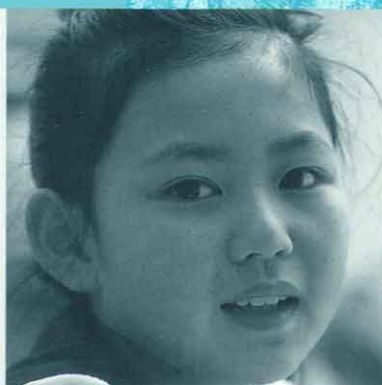
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THE HEALTH BELIEFS OF THE CHINESE COMMUNITY IN ENGLAND



*A qualitative
research study*

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1 The research: health beliefs among the Chinese community in England

1.1 Introduction

This study was commissioned by the HEA to explore the health beliefs of the Chinese community in England.

There has been increasing interest over the last decades in how notions of health and illness are constructed by different communities of people and in how this variation affects health-care delivery. Despite the dominance of the biomedical¹ model in the Western world, there is ample evidence that a variety of modes of health knowledge and practices coexist in any society. Attention to this plurality is crucial to improve the quality of health-care and to challenge patterns of communication between providers and users of health services. Recognising that issues of health and illness are grounded in cultural frameworks enables us to understand how people use, make sense of, and comply with health-care.

In multicultural societies, where different ethnic communities live side by side with the cultural system of the host society, cultural backgrounds and the corresponding representations they entail about health and illness emerge as key factors in the planning of health-care delivery. Awareness and sensitivity to cultural diversity produces medium and long-term gains at the level of both costs and quality of health care (Chi, 1994). Moreover, since the Thirtieth World Health Assembly in 1977, the World Health Organization (WHO) has officially recognised the importance of integrating traditional medicines into health-care systems. This policy change was based on the understanding that the traditional medical knowledge, which permeates lay thinking, can work as an added resource for health-care delivery (WHO, 1978).

¹Following Currer and Stacey (1986) we use the terms 'biomedicine' or 'biomedical model' to refer to the institutionalised system of health beliefs and practices which developed mainly in the West. It is based on a biological understanding of the human being, dominates the advanced industrial societies, and has now spread throughout the world. We prefer these terms to other frequently used adjectives such as 'modern' (which implicitly excludes the traditional beliefs and practices that survive in contemporary societies), 'scientific' (which may imply that other knowledge systems are less rational and less legitimate), or 'Western' (which does not fully acknowledge the diffusion and potency of biomedicine throughout the world), although these may also be used in particular contexts.

Besides, contemporary societies live in a period of increasingly rapid change. Very few societies, if any, have been immune to this pace of transformation. One of the most striking features of this process is the coexistence of different cultural backgrounds, different ways of life and different traditions within a single context. People, perhaps more than ever before, must face the displacement of taken-for-granted beliefs and open themselves up to other ways of life. These issues place new demands on health intervention related to ethnic groups. Sensitivity to such a context is one of the great challenges confronting health education programmes.

Yet there remains a tendency to ignore these factors, as if notions of 'culture' and 'beliefs' were too distant from the practicalities of everyday health care. In some cases lay knowledge stemming from cultural traditions is ignored; in others, it is considered an obstacle both to educational campaigns and to compliance with treatment; and in more extreme situations it is treated as pure 'superstition'. As Koo (1987: 405) has pointed out, to consider socio-cultural factors only as barriers to proper treatment can 'delay treatment by Western health-care systems, interfere with the patients' compliance in taking Western medication, or even cause and exacerbate existing health problems.'

Culture and traditional knowledge shape how people think, feel, perceive and socially represent questions of health and illness. This is not a trivial issue, considering that it is in the lay, popular, non-professional sector of society that the vast majority of health-related decisions are made. Indeed, it is estimated that between 70 and 90 per cent of all health-related decisions are made in the popular domain in Western and non-Western societies alike (Kleinman, 1986). The popular arena comprises mainly the family but it also includes social networks and community activities. Ill health is first recognised, defined, labelled and explained by lay members of society in the course of their everyday life. On this basis, health-care activities are initiated. These include all the therapeutic options that people utilise informally, without payment and without consulting folk healers or medical practitioners (Kleinman, 1986; Helman, 1994). All such decisions are based on socially-transmitted lay beliefs about the structure and function of the body, about the origin and nature of ill health, about the behaviours deemed appropriate to keep healthy and to avoid illness: they are based on social representations of health and illness.

The above considerations guided the study we report here. Perhaps more than any other minority ethnic groups in the UK, the Chinese can draw upon a long and well-established medical tradition in order to construct health beliefs and make choices related to health. And yet, as any other displaced community, the Chinese are exposed to

a tradition that differs from their own in fundamental ways. The clash between different ways of conceiving issues of health and illness produces a number of practical consequences, the most important one being the difficulty in communicating and, therefore, in implementing effective health-care. Do the Chinese maintain their traditional beliefs, do they reject Western biomedical systems, or do they combine both knowledge systems? In which ways do these different strategies guide health behaviours? Can they help us to make sense of the experience Chinese people have when using health services?

These questions become all the more important if we consider that there is ample evidence to suggest that Chinese people underutilise health-care facilities. The House of Commons Report (Home Affairs Committee, 1985) first alerted the nation to this fact. Since then, what little research there has been on the Chinese community in England reveals that the uptake of health services by Chinese people is still considerably lower than for the white and other minority ethnic populations, both in terms of GP and outpatient services (Smaje, 1996).

In a small-scale study conducted in Hull, Watt & Chui (1994) interviewed GPs with a substantial number of Chinese patients on their registers. The findings highlight three distinct issues. First, Chinese people were perceived as having higher and different expectations of the primary health-care services than the white and other ethnic populations. Second, doctors reported that Chinese patients tried to postpone or avoid consulting them altogether unless medical attention was absolutely necessary. This was manifest in the way Chinese people tried to keep consultations to a minimum by requesting repeat prescriptions both for themselves and for relatives and friends. And third, the GPs interviewed were agreed that their Chinese patients made very limited use of preventive care. Watt & Chui (1994) also report that uptake of ante-natal care among Chinese women in Hull is remarkably low in spite of a relatively high awareness of the ante-natal classes. Williams, Watt & Chui (1994) corroborate this: in the North of England, they found that 79 per cent of Chinese women were aware of the availability of such classes, but that only 21 per cent actually used the service (in comparison, only 56 per cent of Muslim Asian women were aware of the classes, but a considerable 43 per cent actually attended the classes).

While these findings are extremely useful in providing an initial diagnosis of the community's use of National Health Service (NHS), the need remains to make sense of these patterns of behaviour and to explain why they are produced and how they can be changed. In this sense, the present study had as its main objectives:

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- to explore the social representations of health and illness held by the Chinese community and to investigate how these representations affect health-related practices;
 - to examine how lay knowledge impacts on the acquisition and use of, and resistance to, new information and knowledge;
 - to identify the main concerns associated with the experience or use of health services in England.

To pursue these objectives we took as a starting point the larger social context that frames the life of the Chinese community in Britain and approached their health beliefs by placing emphasis on:

- the ways in which Chinese people handle concrete health issues in everyday life;
- the practical situations facing the Chinese community when using health resources (NHS or other).

This study focuses on the experience of being a Chinese person living in Britain, on the problems and difficulties associated with the use of health-care, and more generally on how Chinese people think and act in relation to health and illness. This focus aims to bring to light the variety of factors which constitute the overall situation of the Chinese in Britain as they are experienced, talked about and lived by the community itself.

1.2. A social psychological perspective on health and illness

Traditionally, research about health beliefs and behaviour has been informed by approaches that consider the individual person as the main focus of analysis and intervention. The limitations of such approaches are discussed extensively in the social scientific literature and it is not our intention to review them in here (for a comprehensive review, see Ogden, 1996). We want to note, however, that models such as the health locus of control model (Wallston & Wallston, 1982), the health belief model (Becker, 1966; Janz & Becker, 1984; Rosenstock, 1966), self-efficacy theory (Bandura, 1977; Schwarzer, 1992), and the theory of reasoned action (Ajzen, 1985; Ajzen & Fishbein, 1970; Terry, Gallois & McCamish, 1993), to cite but the most influential ones, all rest on a number of assumptions which are now recognised to be problematic. At the most basic level, they conceive of individuals as though they function in isolation, rather than as social beings engaging in group life and deriving their knowledge and values from the latter. Thus these models assume that knowledge is acquired in isolation and from direct experience, rather than through communication and social interaction. Furthermore, these models tend to endorse a somewhat limited

understanding of the complex relationships between knowledge, attitudes and behaviour. Put simply, it is assumed that the link between knowledge, attitudes and behaviour is direct and that, once proper information is given, the desired behavioural change will occur.

This dominant conception, which conceives health-related behaviour as the outcome of the joint effect of health-related attitudes and information, has yielded considerable knowledge over the years. It is readily amenable to systematic research and large-scale surveys which, in turn, generate valuable descriptive data. Yet we believe that it carries serious theoretical problems and may also have undesirable practical consequences. The assumption of an autonomous individual leads to a burden of responsibility being placed on the shoulders of people as though they could be made entirely responsible for their lifestyle choices and health (Crawford, 1977; Ichheiser, 1949). It also dangerously underestimates the larger societal, political, economic and cultural determinants of health. We now know, however, that such factors profoundly shape how individuals relate to their own body, how they deal with issues of health and illness, what sense of agency they have when facing health problems, which resources they will use in the case of illness or disease, and so on. And we also know that notions of health and illness are structurally bound up with how people think of themselves, of others and of society to which they belong, as well as with a range of moral issues, such as what is considered 'good' or 'proper' or 'natural' (Herzlich, 1973). Clearly the notion that greater and better individual knowledge will suffice to modify inadequate health-related behaviour is too simplistic to account for the complex psychological dynamics involved in the relations between knowledge and behaviour.

Successful health intervention must be geared towards the total environment in which people live. Social psychologists have made important contributions to developing this radical change in perspective. Indeed, in opposition to an individualistic approach, current developments in social psychological theory and research have produced a large body of evidence showing precisely that it is not individual knowledge, but social knowledge, which impinges on the ways in which individuals make sense of their environment and adopt strategies of behaving towards it (Campbell, 1997; Crawford, 1994; Farr & Marková, 1994; Herzlich & Pierret, 1986; Jodelet, 1984; Naidoo, 1986). These new perspectives focus on how culture, shared meanings and the social environment permeate individual experience, establishing the frameworks within which and against which people act. They show how knowledge is rooted in social life, expressing and structuring the identity and social conditions of those who share it. The theory of social representations, as developed by Moscovici (1984) and Jodelet (1984;

1991) is one such approach. Its theoretical and methodological assumptions have informed the study reported here.

Within the social representational approach, health beliefs and practices are constructed against a background of constant social interaction and negotiation, where allegiances to social identity, group norms and cultural traditions play a major role. In this context beliefs about health and illness express larger social psychological factors which shape the choices people make about health-related behaviours and practices. These factors range from concrete living conditions to the particular patterns of interaction and communication within any given community, via the lay and cultural bodies of knowledge that guide the interpretative frameworks used to make sense of what health and illness are.

Instead of an 'either, or' logic, the focus is both on individual and social reality simultaneously. The emphasis on the relationships between the individual and society enables us to uncover how social beliefs operate on a practical level, shaping personal choices and behaviour, as well as examining how individuals take on and manipulate these beliefs in everyday contexts. As Sapir (1967: quoted in Jodelet, 1991:16) has pointed out, health-related practices and beliefs are examples of the subtle interactions between the 'systems of ideas which have their roots in global culture and those which the individual creates for himself as a result of his special spheres of participation. The more we examine these interactions, the more difficult it becomes to distinguish between society as a cultural and psychological entity and the individual member of society whose culture he must espouse.' Thus a complete account of these beliefs and practices that is both theoretically and practically useful must explain, at one and the same time, the personal and social.

The recognition of these issues can enable health education campaigners to go beyond the imparting of information about health and illness to target populations. By considering health as a cultural system grounded in the shared meanings, values, representations and experiences of a particular community, and by acknowledging that what it is to be healthy is equally central to the identity of a culture and to that of an individual, health promoters can set and achieve more strategic goals. They can identify the knowledge and the cultural profile of a community as a resource they can engage with and develop. Instead of clashing with or discarding or, as in so many cases, simply ignoring existing beliefs, values and experience, health campaigners ought to take them into account and establish collaborative dialogues with their target populations.

No society could function adequately without common knowledge that makes sense of physical and mental well being and ill health.

This cultural system not only expresses the social context that shapes it, but itself plays a key role in shaping a community's social identity and profile. Current social psychological research on health highlights the fallacies of old individualistic approaches. It also proposes a strong vision according to which understanding health and health-related practices demands sensitivity to culture, context and ethnic group. Health beliefs and behaviours are largely dependent on cultural backgrounds and people carry with them the assumptions, values and knowledge that belong to their communities and give them a social identity. These cannot simply be transposed from one context to another: as with different languages, literal translations are often meaningless.

Drawing on this theoretical perspective, the present study will link representations of health and illness to the Chinese culture and way of life.