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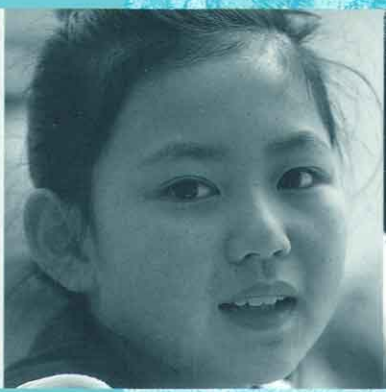
THE HEALTH BELIEFS OF THE CHINESE COMMUNITY IN ENGLAND



A qualitative research study

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2.1 Research design

Given the scarcity of research on Chinese health beliefs and practices in England, and considering the complexity of the issues involved, we favoured qualitative methods of data collection and analysis. Open-ended and flexible research methods – in this case, in-depth individual interviews and focus groups – are well suited to delineate how people think about their health or ill health *in their own terms*. They also generate valuable information to direct further research and intervention.

The present research design combines three different data sources: interviews with experts on the Chinese community in England, individual interviews with lay people and focus group discussions with lay people. All the interviews and group discussions were tape-recorded, translated when necessary and transcribed verbatim for analysis. The data were collected between December 1996 and April 1997.

The subjects in this study were not randomly selected so as to be 'representative' of the Chinese population in the statistical sense. Instead we approached potential interviewees on the basis of their typicality and diversity (Patton, 1980). However, the 1991 Census data (Cheng, 1996; Owen, 1992, 1994) in part guided the selection. (The reader can consult Appendix 1 for descriptive information pertaining to the countries of origin, the age distribution and the geographical distribution of the Chinese ethnic group in Great Britain.) We chose participants from the two main regions where the population is most concentrated – Greater London and the North-West of England – and from the age groups which comprise the bulk of the adult Chinese population in England. These age groups correlate with different waves of migration and modes of participation in British society. We did not include a third, older generation in this research because we assumed that the social representations of health and illness of the elderly population would have remained essentially traditional. There is sufficient literature on the health beliefs of the Chinese in traditional Chinese cultures.

We also selected participants of different national origins, the majority being from Hong Kong, Mainland China and Malaysia, in conformity with the Census (Cheng, 1996; Owen, 1992, 1994). UK-born subjects are somewhat under-represented, but this is due to to the age structure of the Chinese population itself. Indeed the age pyramid for the second generation shows that only a tiny proportion of this group are above age 20 and that virtually no one age 35 and over was born in the UK (Cheng, 1996). Diversity and typicality with respect to occupations suggested the selection of participants from four different groups: students, professionals, workers in the catering trade and unemployed respondents (often housewives). Tables summarising the socio-demographic characteristics of lay subjects can be found in Appendix 2.

Interviews with expert informants

In the initial stage of the empirical research we aimed to map out the key issues as perceived by Chinese expert informants who work closely with their community. To this end interviews with six experts were conducted (four in London and two in Manchester). This kind of interviewing is useful for tapping into reflexive knowledge, that is, the critical knowledge one possesses about oneself and one's community. The expert informants were initially recruited through associations dealing with Chinese health and social matters and then through snowballing. We ensured that informants had varied spheres of expertise. The resulting sample comprises respondents trained in biomedicine, either as doctors or nurses; trained researchers and social scientists; and managers of Chinese community centres and associations. The expert interviews were all conducted in English.

The themes addressed in the expert interviews included (see Appendix 3 for full details):

- the characteristics of the Chinese community: perceptions of homogeneity/heterogeneity, cohesion/fragmentation and integration/exclusion;
- the main health-related concerns of the Chinese community in England;
- the experience of health and illness in everyday life;
- the differences and similarities between Chinese and Western medicine;
- the availability and adequacy of service provision.

Individual interviews with lay Chinese people

We also conducted twelve in-depth individual interviews with lay members of the Chinese community. In-depth individual interviews are advocated to circumvent some of the problems traditionally associated with more highly-structured methods of data collection (Bourdieu, Passeron & Chamboredon, 1991). They enable us to gain access to the social representations of health and illness of the Chinese, as these are constructed in discourse, without imposing our own views, concepts and presuppositions on the population being investigated (Farr, 1993). Indeed, individual interviews provide subjects with a great deal of freedom to explore the issues that are most relevant to them, and the meanings which they themselves attribute to health and illness (Herzlich, 1973). Such interviews are ideally suited to our objectives. Four of the twelve individual interviews with lay Chinese people were conducted in Chinese with the mediation of an interpreter. The four subjects who spoke little or no English were all originally from Mainland China and belonged to the older age group. They were involved in the catering industry. Three of them were women.

The individual interviews with lay participants focused on the following themes (See Appendix 4 for full details):

- the experience of being a Chinese person living in Britain: dynamics of identity, integration/exclusion, advantages/disadvantages;
- general aspects of Chinese representations of health and illness;
- health and lifestyle: emphasis on working conditions;
- health beliefs and health-related practices;
- experiences of ill health: symptoms, resources, cure, explanations offered for the condition, effects on family, communication with health professionals, knowledge and use of resources, for example;
- relationship between Western (British) and Chinese health beliefs and practices: combination/separation.

Focus group discussions with lay Chinese people

Four focus groups with lay members of the Chinese community were also convened. Focus groups overcome some of the limitations associated with individual interviewing. They are an effective way of rapidly gathering a wide array of views and opinions and of providing information about both consensual and conflicting beliefs. Group interviewing makes use of group dynamics to generate data and insights which would otherwise be less accessible (Morgan & Krueger, 1993). It provides data on interactions, on realities as defined in a group context, and on interpretations of realities that reflect the group's dynamics; it

also shows how identities, social representations, beliefs, and shared cultural norms, all structure interaction and social communication (Burgess, Limb & Harrison, 1988). Focus groups aim to replicate, in so far as this is possible in a research design, the social settings in which people live and the conditions under which they would normally interact (Morgan, 1988; Morgan & Krueger, 1993).

Notwithstanding the considerable problems and costs encountered in setting up the groups in the first place, this method of data collection proved the richest. It revealed very specific patterns of communication among Chinese participants in terms of mutual respect, discipline in turn-taking, modes of conflict resolution, deference to authority and hierarchy, for example. The moderator hardly had to moderate at all since interactional patterns were so finely tuned. The groups were also an ideal means of eliciting latent beliefs and practices that are taken for granted. The very process of accounting for their private beliefs and habits in the common space of the group prompted the subjects to realise that what they had assumed to be their own isolated experience was in fact shared by most and grounded in cultural frameworks. Thus, by fostering a heightened self-awareness, the focus groups had an almost therapeutic nature and actually served to empower the participants.

The four groups were set up to reflect expected gender and generational differences (20–27- and 37–44-year-olds, male and female). The participants were recruited in the Greater London area. The two groups of young subjects comprised students of diverse nationalities and discussions were conducted in Central London. The two groups of older subjects included participants from a range of socio-economic backgrounds. The discussion with older women was held in a private home in Norbiton and the one with older men was convened in a Chinese restaurant in Greenwich. The discussions were in English which was often the only common language between the participants. Both researchers were present for all the focus groups, one moderating, the other mainly observing. No particular stimulus material was used.

The group discussions focussed on the following issues (See Appendix 5 for full details):

- the dynamics of mixed identity: being Chinese in England;
- characteristics of the Chinese community;
- health and lifestyle: health beliefs and health-related practices at home;
- attitudes towards Chinese traditional medicine and Western biomedicine;
- shared or particular experiences of contact with health services in England.

Data integration and analysis

The data were analysed according to two distinct but inter-related dimensions: content and processes. Bearing in mind the three-fold objective of our study, we extracted themes and sub-themes from the interviews and group discussion transcripts. This allowed us to identify the main issues emerging from the data and to establish how these are structured by identity and cultural processes. All the interviews and focus groups were content analysed in terms of their sequential structure. We identified the themes and sub-themes which evoked and generated one another (content), and stressed how these were linked by the reasoning and the identity positioning of the participants (processes). This strategy enabled us to derive deeper levels of belief and experience from the thematic content of the data, for as the interviews progressed and as rapport became more firmly established, the respondents felt more at ease in disclosing the complex reality of holding on to Chinese beliefs and cultural identity in British society. The quotations selected to appear in the report were chosen on the basis of their representativeness in relation to the entire corpus of data. The criterion was qualitative: quotations represent the overall trend of the analysis.

2.2 Researching the Chinese community

For a variety of reasons, Chinese people in England constitute a 'hard-to-reach' population (Li, 1992; Song & Parker, 1995; Tso & Chung, 1996). Barriers to access are not linked exclusively to the fact that the researchers are not Chinese. Even those most directly involved with the Chinese community (Tso & Chung, 1996) comment that elderly Chinese people in Manchester were 'very reluctant indeed to take part' in one of their studies and that they seemed 'quite unwilling to disclose information'. Experts recognise that the community is difficult to access. They are adamant that the solution lies in getting a strong footing in the community through its main organisations.

Accessing a 'hard-to-reach' population

We used existing community resources (see Appendix 6 for a list of Chinese community resources and associations in the UK) and worked closely with a Chinese research assistant. Of course this strategy entails many potential pitfalls and biases. It only allows access to people who use community centres and resources; they are a very distinct segment of the Chinese population. They tend to be more traditional and probably either less or more vocal than the average Chinese person. They may also end up being over-researched. Moreover, the pre-selection of subjects by community workers will often be made on the basis of unknown criteria. In our experience, these may range from sheer pragmatism – for

example, availability, previous acquaintance, geographic proximity, and so on – to the subtle, and perhaps unconscious, recruitment of people who conform to organisers' views about the needs of the community. Of course, the nature of the associations and organisations also reveals something about the subjects who attend them or use their services. However, in spite of these limitations, this seems to be the most viable way of approaching members of the Chinese community.

Advantages and disadvantages of using non-Chinese researchers

The two main researchers involved in this project are not Chinese themselves. The issue of whether or not they should be matching identity between researchers and the communities they investigate is a highly contentious and debated one among social scientists doing qualitative research. The requisite of matching ethnic and gender identity (among other possible sources of matching identification) between the researcher and the object of study is, in our view, a misguided conception. Difference does not preclude understanding, and empathy can go hand in hand with a critical stance. In fact, there are advantages and limitations in any choice one makes. The balance of these in relation to the objectives of the research is the real issue to be considered.

In our experience of researching the Chinese community we found that not being Chinese ourselves was a limitation in terms of gaining entry into the community. Being Chinese, or at the very least speaking Chinese, no doubt helps to overcome the reluctance to speak to outsiders. It was disadvantageous also in that interviews with only Chinese-speaking subjects had to be conducted through interpreters, a situation which fundamentally changes interactional dynamics and impinges on what is being expressed. More subtly, not sharing the same language and culture means, for example, that inter-cultural barriers could come into play during the interviews, that the interviewees could feel less comfortable in the interview situation and that some elements of the Chinese cultural universe which may not be easy to express in English could be lost altogether. Bearing such issues in mind, it is not surprising that the literature on minority ethnic health issues tends to stress the benefits of 'matched' interviewer-interviewees, both with respect to ethnicity (Blauner & Wellman, 1973; Stanfield & Routledge, 1993) and to gender (Stanley & Wise, 1983).

However, these very 'limitations' can also be advantageous. Song & Parker (1995) have devoted a paper to *rapports* between researcher and participant during interviews with UK Chinese subjects. The authors – one English-Chinese, the other Korean-American – showed how different identities came to the fore at different moments in the

interviews, with no predictable patterns. Each positioning, either as a 'pure' or 'mixed' Chinese person, made certain disclosures possible and impeded others. Generally however, the authors noted that assumptions of differences between interviewer and interviewee often prompted clarification, whilst assumptions of similarity tended to facilitate intimacy but also to engender anxieties if the subjects felt that they deviated from an assumed shared Chinese 'norm'.

Thus it would appear that the perception of cultural differences often compels interviewees to be more explicit about their beliefs. Non-Chinese researchers are also more likely to identify tacit assumptions in Chinese belief systems since they do not share them. It should also be borne in mind that the very reluctance or difficulties experienced by Chinese respondents in engaging with non-Chinese people are themselves part of the phenomena we are investigating; they give us insights into the reality of being Chinese in Britain.

It is perhaps in interviews with only Chinese-speaking subjects that the advantages and drawbacks of not being Chinese ourselves were most obvious. We had recourse to interpreters during the interviews and then, as a means of quality control, asked a Chinese research assistant to transcribe them, providing clarifications and, for example, noting erroneous translations, distortions, biases, uninvited interventions by the interpreter and segments of text which were edited out. This research strategy allowed us to gain insight into the power relations which are enacted during interpreter-mediated interviews: shifting allegiances are formed between the researcher and the interpreter, and between the latter and the interviewee, which shape the data in important ways. For instance, questions which may be interpreted as politically sensitive tended to be edited out. Answers which were thought by the interpreter to reflect badly on the Chinese community were either omitted by the interpreter or prefaced by some mechanism of distancing themselves. Often the two Chinese-speaking people would converse among themselves about health beliefs and practices, thereby blurring the boundaries between the interviewee's own views and those of the interpreter. There is no space to discuss these issues in greater detail; they ought to be researched systematically. However, this research strategy shows that the use of interpreters is no panacea. Interpreters ought to be fully trained and made aware of their potentially oppressive position.