A place to be well: an ethnographic study of health and wellbeing at a Chinese community centre in the north of England.

A thesis submitted to The University of Manchester for the Degree of Doctor of Philosophy (PhD) in the Faculty of Biology, Medicine and Health

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Abstract

Research demonstrates that perspectives of health and illness vary by social and cultural context. This has implications for the ways in which people experience and respond to health and illness and becomes particularly important when people face major social and cultural change through migration. This is explored in this study through the relationship between health and place. The location for the study is a Chinese community centre, in which the centre members are first generation migrants from Hong Kong, China and Vietnam, aged 50 and over, who have spent the larger part of their lives living in the UK. The study uses the concept of therapeutic landscapes as an analytical lens through which to explore understandings of health and illness, issues of identity and belonging, and practices of wellbeing as they are enacted outside of formal healthcare settings.

As an ethnographic study, the primary means of data collection has been through participant observation. This included regular attendance at the community centre to participate in activities and events over a period of ten months from August 2013 to May 2014. Twenty one formal interviews were also conducted with members of the community centre, the majority in English, and several in Cantonese.

The migration stories of the participants in the study are explored as gendered experiences; that is, that the men and women experienced, and spoke about, migration differently. For the women in particular, their experiences of migration were recalled as a time of profound loneliness and isolation. Understandings of health and illness among the centre members are also explored. A shared understanding of health as a holistic and collective concept was expressed. In particular, they spoke about maintaining a positive attitude in the face of difficulties, about their own health in terms of family and social relationships, and the importance of being together and being active. The choices that they make around the use of Chinese and/or biomedicine are also explored within the context of this understanding.

The experiences of migration and the understandings of health and illness are further explored through a consideration of the everyday practices, and associated materialities, that constitute the day-to-day life of the centre. These are explored as ways of re-connecting with the past and maintaining a sense of identity, but also as ways of negotiating both continuity and change at the same time. The role of the community centre in the lives of its members, and the ways in which they interact with one another in this particular place, is approached through the concept of therapeutic landscapes. The day-to-day activities, and the ways in which the centre members participate in these are presented as everyday practices of care; as the enactment of a particular understanding of health and wellbeing that helps to create a sense of identity and belonging at the community centre, which in turn contributes to the health and wellbeing of the centre members.

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Declaration

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Dedication

For Maddy, my beautiful girl;
for all the time I spent writing when I should have been with you.

And in memory of Mum.
Acknowledgements

This PhD has been a rollercoaster of personal and academic challenges and a massive test of determination and perseverance. Through the ups and downs there have been a number of people who have been instrumental in supporting me through this PhD.

Firstly, I would like to thank my research participants, who made me so welcome at the community centre and took such good care of me and my bump. I am indebted to them for their generosity in sharing their time and energy with me and for trusting me with their stories. I would particularly like to thank Mrs Z for her time, encouragement, professional support and friendship.

I owe much gratitude to my supervisors, Dr Caroline Sanders and Dr Julia Segar, both of whom inherited me along the way as my studentship fell apart. Thank you to both for sticking with me and pushing me to do the best I can. I am especially grateful to Caroline for her personal support above and beyond the remit of an academic supervisor, and to Julia for continuing to offer support even through her own difficulties. Thank you also to both for being excited (rather than alarmed) when I told them that I was pregnant in the middle of all this.

On a personal note, I would like to thank my family for their ever present support and encouragement over the last 4 years; especially Mum, for taking such good care of Maddy so that I had extra time to write. Mum died, very unexpectedly, shortly before I was able to finish writing this thesis. She told me so many times that she didn’t know how I was managing to write and look after a baby, but always in the same breath that she knew I could do it. I am deeply saddened that she did not see my completed thesis; not just because she would have read it, given me a pat on the back and said well done (because that’s what mums do), but because I think she would have found the stories of my research participants, and the ideas about therapeutic landscapes and practices of wellbeing and care, genuinely interesting. I hope, above all, that this thesis would have made her proud.

Lastly, and most of all, I would like to thank my husband Darin, for so much more than there is space to write here; but particularly for his unwavering faith in my ability to do this, and for all the time that he has spent looking after our beautiful daughter so that I could write. I would not have been able to do this without his support and encouragement.
Chapter 1: Introduction

1.1 Introduction

This PhD began as something quite different; I came to Manchester to take up a studentship to do a study around diabetes self-management as part of a multi-national research project. However, half-way through the first year the original supervisors and the multi-national project moved to another university, and I was faced with the challenge of creating a new project for my PhD. Although daunting, this was a challenge to think beyond the constraints of a pre-defined larger project, and an opportunity to return to my academic roots in sociology and anthropology, which I welcomed. This thesis is the outcome of that challenge. Although the study has changed considerably, the interest that I began my PhD with none-the-less remains within the present study; that is, an interest in social and cultural influences on the ways in which people learn to live with long-term illness.

1.2 Long-term illness - self-management - migration

The remit of the original studentship was constructed around self-management and self-care for long-term conditions\(^1\). In the context of the increasing prevalence of chronic disease and the associated concern with rising healthcare costs, self-management for long-term illness has become a major focus for health policy in the UK\(^2\) (Newbould et al., 2006; Taylor & Bury, 2007). In this respect, the majority of the day-to-day care for those with long-term illnesses is undertaken by patients and their families away from hospitals or formal health care services (Department of Health, 2005a; 2005b). Self-management is promoted in terms of improved health and quality of life for patients and in terms of

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\(^{1}\) Long-term condition is understood here, very broadly, as ‘a condition that cannot, at present, be cured but is controlled by medication and/or other therapies’ (Department of Health, 2012, p.3).

\(^{2}\) The Department of Health defines self-care and self-management in the following way: ‘Self-care is about individuals taking responsibility for their own health and well-being. Self-management is about individuals making the most of their lives by coping with difficulties and making the most of what they have. It includes managing or minimising the way conditions limit individuals’ lives as well as what they can do to feel happy and fulfilled to make the most of their lives despite the condition.’ (Department of Health, 2008, p.9).
empowerment for individuals to be able to care effectively for themselves in their day-to-day lives (Department of Health, 2005a; 2005b). The Department of Health frames this in terms of building a ‘person-centred health service’, such that self-care aims to ‘put people at the centre of the planning process’ and ‘recognise that they are best placed to understand their own needs and how to meet them’ (Department of Health, 2008, p.8).

However, this discourse around ‘person-centred’ health services becomes problematic in the context of contemporary multi-cultural society; in particular, with the effects of migration - for many different reasons - and the associated processes of cultural change and adaptation in this respect (Bartram et al., 2014). This adds complexity to discourses about health and illness, which is reflected in the scope and scale of research around experiences of health and illness within the disciplines of medical sociology and medial anthropology. This also raises important issues around the provision of culturally sensitive healthcare services for multi-ethnic populations. In particular, it creates a need for extending understandings of care in this context; that is, thinking about what care can be taken to be mean, the ways in which it is practiced in day-to-day life, and where it takes place.

The interest in migration in this study came from reading qualitative literature about the experience and management of long-term illness; in particular, studies that addressed aspects of culture, or a person’s cultural background, in relation to their approach to, and understanding of, long-term illness. It was notable within this literature that whilst there are studies focussed on aspects of long-term condition management for ‘migrant’ or ‘immigrant’ groups, this is for the most part used only as a descriptive label (often muddled up with refugee, ethnic minority, and second/third/fourth etc generation migrants). The experience of migration, what it actually means to be a migrant living in another social and cultural context, and how this contributes to (or complicates) experiences of health and illness, is often not the main focus of such studies. This was used as the focus for developing a new project, whilst retaining the interest in the social and cultural contexts within which health and illness are experienced and managed.
1.3 Health and place: therapeutic landscapes

These areas of interest are approached in this study through the relationship between health and place. In terms of the relevance of a consideration of place in relation to experiences of migration, Relph (1976) writes that:

‘There is for virtually everyone a deep association with and consciousness of the places where we were born and grew up, where we live now, or where we have had particularly moving experiences. This association seems to constitute a vital source of both individual and cultural identity and security, a point of departure from which we orient ourselves in the world.’ (Relph, 1976, p.43).

Within this study, this association with place is addressed in the context of migration. As Relph suggests, the movement between places (through migration) raises important issues about identity and belonging. In this study, these are also issues that are shown to be important in terms of health and wellbeing. This is therefore a study about health and place. More specifically, it is a study about health in place; about how health and wellbeing are experienced within - and in relation to - particular places.

In this respect, the literature around therapeutic landscapes shapes the conceptual orientation to the study. This concept - and the way it has been used in other studies to explore processes of healing in many different places - has helped to bring the study together in several ways. Firstly, it enabled me to consider the community centre not just as the place where I did my research, but as a key element of the story, and to think more critically about the part that it plays in the lives of the research participants and about their interaction in this particular place. It also helped to refocus this from a study of illness to a study of health and wellbeing, which better reflects the responses of the research participants. Although my intention was to undertake an exploration of long-term illness (management) among first generation migrants, the project evolved to become a study of health and wellbeing in the context of belonging and identity in place. The focus of therapeutic landscapes on processes of healing as they unfold in different places also helped to think more critically about care. This enabled me to think about what can be considered as healing or therapeutic for different people in different places, and the ways in which this contributes to understanding and approaching care. In this study, this is not
specifically about treating illness, but more broadly about everyday practices that contribute to the maintenance of health and wellbeing in day-to-day life.

In terms of the relevance of a study of Chinese migrants in particular, there are some studies of the experiences of Chinese migrants in the UK, and some studies of Chinese approaches to health and wellbeing (reviewed in Chapters 2 and 3), but very few that put both of these together. This is a reflection, in part, of the fact that there is only a limited amount of research available on the health of the Chinese population in the UK (Long et al., 2015). This study therefore makes an important contribution to this area of research, by bringing both of these things together, but also by bringing a new approach to this area of study through the use of the concept of therapeutic landscapes.

As noted above, this began as a study specifically about diabetes (as opposed to other long-term conditions). However, when I made contact with the Chinese community centre and discussed the feasibility of undertaking my study there, it made more sense to broaden the focus from diabetes to any long-term illness so as not to exclude members of the community centre from the study. This did not detract from the research questions that I set out with; rather, it allowed for a more in-depth exploration of those questions and enabled me to engage more thoroughly with the migration stories of the centre members in relation to their views about health and wellbeing.

This is therefore a study about a particular group of people in a particular place. The focus of the study is on the migration experiences of this group of people, they ways in which they interact with one another in the community centre, and how their understandings of health and wellbeing are enacted in this.

1.4 Outline of the thesis

Chapter 2 outlines the conceptual orientations of the study. This provides an overview of the literature around therapeutic landscapes, used in this study as a conceptual lens through which to explore the relationship between people, place and health. It also outlines the approach taken to migration in this study; firstly in relation to some of the main themes
within literature on migration, and secondly in relation to some of the key issues that are raised in qualitative studies of the experiences of Chinese migrants in the UK (and elsewhere). This chapter also addresses the question of culture in relation to health, through a discussion of culturally competent health care. This is followed by the rationale and research questions for the study.

Chapter 3 outlines the context of the study in terms of the Chinese population in the UK. This provides an overview of the history and circumstances of Chinese migrants in the UK, highlighting in particular the wave of migration associated with the takeaway and restaurant industry in the 1970s and 1980s which many of the participants in this study are part of. It also gives an overview of the health of the Chinese in the UK; this includes the approach to health and illness within Traditional Chinese Medicine (TCM), the use of both TCM and biomedicine, and mental illness within TCM.

Chapter 4 outlines the methodology for the study. This focusses on the understanding of ethnography as it is applied in this study, the theoretical and conceptual orientations that underpin this, the activity of fieldwork, and the process of analysing and ‘writing up’ the data. It also includes a discussion of the ethical considerations in the conduct of this study, including the need for reflexivity in ethnographic research. A description of the participants in this study is also provided in this chapter.

Chapter 5 describes the community centre at the heart of this study. This sets the scene for the unfolding study, through a description of the physicality of the centre - the layout of the building, the sounds, smells and the movement of people - and by locating it as part of a larger organisation with a particular ethos around the value of the elderly in the Chinese community.

Chapter 6 deals with the migration stories of the research participants. These are discussed as gendered experiences; that is, that the men and women in the study experienced, and talked about, their migration stories in different ways. For the women in particular, their experiences of migration are recalled as a time of profound loneliness and isolation. In this respect, they are also stories that concern issues of health and place; this is discussed in terms of the experience of homesickness, interpreted as a loss of - or disruption to - place.
Chapter 7 explores the participants’ understandings of health and illness. This was expressed in terms of social and family relationships, being active and keeping busy, and the importance of being together rather than being alone. This is shaped by generational characteristics around maintaining a positive attitude and dealing with problems in a positive way. This chapter also addresses the experiences of those participants who spoke about coping with mental health problems - depression and anxiety in particular.

Chapter 8 explores the decisions made about the treatment and management of health problems in day-to-day life (i.e. about specific conditions, or episodes of illness) in the context of the above understandings of health and illness. This demonstrates that although the participants shared a similar understanding of health and illness, this was manifest in different choices about health care and treatment.

Chapter 9 explores some of the regular activities at the centre and the ways in which the centre members participate in these. These are discussed as collective - and embodied - practices that attend to health and wellbeing. The role of memory and reminiscence is addressed within this; that through these day-to-day activities the centre members re-connect with previous times and places in their lives. This is important in terms of identity and belonging, and in turn to the health and wellbeing of the participants in this study.

Chapter 10 returns to the concept of therapeutic landscapes in order to address what can be considered as healing, or therapeutic, in the context of this study - for this particular group of people, in this particular place. This is discussed in terms of practices of care; through ideas about the nature of healing, fields of care, embodied memories of place, and continuity and change. The day-to-day activities, and the ways in which the centre members participate in these are presented as everyday practices of care; as the enactment of a particular understanding of health and wellbeing that helps to create a sense of identity and belonging at the community centre, which in turn contributes to the health and wellbeing of the centre members.
Chapter 2: Orientations - Health, Place and Migration

2.1 Introduction

The purpose of this chapter is to set out the conceptual orientations that shape the approach to the exploration of the three key elements of the study; the people, their understandings of health and illness, and (their participation in) this particular place.

The first section of the chapter outlines the concept of therapeutic landscapes, which is used in this study as a conceptual lens through which to explore the relationship between people, place and health. This concept comes from within the discipline of medical geography and has been used to explore processes of healing and the maintenance of health and wellbeing in a wide range of places; from spas and thermal baths, to hospitals and clinics, to neighbourhoods and cities. This literature offers a conceptualisation of place that raises issues of identity and belonging as they are implicated in the relationship between health and place.

With this in mind, the second section of the chapter addresses migration as a further way to explore issues related to health and place; or rather, health in place. Although the literature on migration and health (or more accurately, migrant health) primarily addresses issues of health inequalities, the approach to migration in this study is in terms of experiences of migration as they influence and shape understandings of health and illness and the enactment of everyday practices of wellbeing. Migration is conceptualised as a major change in social and cultural context; in essence, this is a change in place, which raises important issues about identity and belonging. This section also highlights some key issues that are raised in qualitative studies of the experiences of Chinese migrants, in the UK and elsewhere. This helps to contextualise the approach to migration, to show how it also concerns issues of identity and belonging, and in turn to show how these are important for health and wellbeing.

The third section offers a discussion of culture and health. This concerns the ways in which culture can be seen to shape and influence understandings - and practices - of health and
illness. This is important in terms of setting out the understanding of culture that is applied in this study, and will be addressed through the idea of culturally competent healthcare, which has particular relevance for thinking about the provision of health care services in multi-cultural and multi-language societies.

The final section of the chapter presents a rationale and specific research questions for the study.

2.2 Health and Place: Therapeutic Landscapes

The concept of therapeutic landscapes emerged from within the discipline of medical geography as a new way of looking at the relationship between health and place (Smyth, 2005, p.488-489). Gesler introduced the term in his influential paper in 1992, suggesting that the notion of therapeutic landscapes should be a ‘geographic metaphor for aiding in the understanding of how the healing process works itself out in places (or in situations, locales, settings, milieu)’ (1992, p.743). Fundamental to this is an understanding that ‘meaning is the key to the importance of places, and it is the subjective experiences that people have within places that give them significance’ (Gesler, 1991, p.164 - emphasis added). Writing about place in the late 1970s, Relph (a humanist geographer) suggested that there are three basic elements that constitute the identity of places; ‘the static physical setting, the activities, and the meanings’ (1976, p.47). These are reflected in the concept of therapeutic landscapes, which also encompasses three elements of landscapes: physical elements, such as location, internal design or architecture; social elements, i.e. ‘the people interacting within these settings’; and symbolic elements, such as ‘objects, artefacts and language’ (Smyth, 2005, p. 490).

The combination of these three elements generates a conceptualisation of landscape as ‘a product of the human mind and of material circumstances […] reflecting both human intentions and actions and the constraints and structures imposed by society.’ (Gesler, 1992, p.743). The concept of therapeutic landscapes applies this specifically to the study of processes of healing as they unfold in different kinds of places.
2.2.1 Landscapes of healing

In its simplest construction, therapeutic landscapes was interpreted as ‘landscapes associated with treatment or healing’ (Gesler, 1992, p735-736). As such, this body of work began with an interest in landscape in a traditional sense, with a focus on physical or natural environments that were reputed to contain healing properties (Gesler, 1992, p.736). This included studies of places of natural beauty, such as the Denali National Park, Alaska (Palka, 1999); places associated with spiritual or religious healing, such as Lourdes, France (Gesler, 1996, 2003); and other places such as spa towns and thermal baths reputed to have healing properties, such as Bath, England (Gesler, 2003). The central focus of these studies was to explore the interplay of the various factors that were seen to play a part in creating, and sustaining, a reputation for healing in particular places (Gesler, 2003).

The early work around therapeutic landscapes also includes studies of places of formal health care, such as hospital and clinics; places which Smyth refers to as ‘the constructed spaces of health’ (2005, p.490). This has encompassed an interest in the design and physicality of hospital buildings, in the particular social relationships that are played out within those formalised spaces, and in the social structures and power relationships that also play a part in shaping the construction of these kinds of places (Gesler & Kearns, 2002).

Gesler (2003) proposes that consideration of these different aspects of environments can be used to (re)construct hospitals, or other institutions of healthcare, as places of healing. Kearns & Barnett (2000) also explore some of these issues in their work on the Starship Children’s Hospital in Auckland, New Zealand. They emphasise the design of the hospital (the colours and materials used in the wards and waiting areas) and the use of the Starship metaphor as attempts to minimise the associations with ‘institutionalised medicine’ and to ‘normalise the place for children’ (p.84). However, as well as being designed to be appealing to its patients - i.e. children - Kearns & Barnett argue that the design was also a marketing strategy, attempting to attract financial donors, as a way to make up the shortfall in public funding for hospital care in New Zealand at the time (p.84).
2.2.2 Everyday landscapes

Alongside studies of specific practices of healing in formal places of healthcare, the concept of therapeutic landscapes has also been applied in studies of everyday places; that is, to places that are not primarily associated with processes of healing, or formalised health care, but that are none-the-less considered to contribute to health and wellbeing. This includes, for example, towns and cities (e.g. Wakefield & McMullan, 2005), neighbourhoods (e.g. Liamputtong & Suwankhong, 2015), communities (e.g. English et al., 2008), parks (e.g. Plane & Klodawsky, 2013) and communal gardens (e.g. Milligan et al., 2004). Taking this step away from a consideration of formalised places of health care, Wakefield & McMullan (2005) use the idea of therapeutic landscapes to explore what they describe as ‘ordinary places and commonplace processes of healing’ (p.299). Their study of the city of Hamilton in Ontario, Canada, explores the idea of unhealthy places. They argue that healthy and unhealthy places can exist together and they explore the ways in which the residents renegotiate and live with(in) the unhealthy image of the city. Although this is different in its application, the conceptual basis of therapeutic landscapes remains; the relationship between people and place. Within the context of this relationship, Wakefield & McMullan explore notions of ‘wellbeing’ (or health) in relation to living in particular places, as opposed to participating in specific health care practices. In this way they are using the concept of therapeutic landscapes as an analytical tool to explore the relationship between the city and its inhabitants. In particular, the concept enables an understanding of what it means to be healthy, or to live healthily.

These themes are also picked up in other studies of neighbourhoods and communities. Plane & Klodawsky (2013) explore aspects of neighbourhoods that are perceived to make them healthy or unhealthy places to live. They present a case study of a small group of women living in a supported housing development in Ottawa, Canada, and explore their experiences of a local park which they view as a meaningful place in relation to their health. One of the aspects of the park that is highlighted in this study is the perception of it as a space for social and communal activity; as such, community is defined in terms of participation (in activities) that in turn promotes a sense of belonging within, or attachment to, a particular place (2013, p.5). Milligan et al. (2004) also adopt a similar approach to the idea of community in their study of communal gardening among older people in the UK. They combine a discussion of gardens as healing places with a consideration of place as
‘community’. Like Plane & Klodawsky (2013), they explore community in terms of social activity and engagement. As such, participation in the community (as ‘place’), is found to contribute to health and wellbeing through the activity of communal gardening.

2.2.3 Landscapes of health and wellbeing

There is also a body of work in which the concept of therapeutic landscapes is used to explore health and wellbeing outside of biomedical approaches to health and illness. Williams (1998) argues that in the context of holistic medicine, which she defines broadly as healing practices outside of the ‘formalized canon of scientific western biomedicine’, that therapeutic landscapes can be seen as ‘not only healing places, but those landscapes associated with the maintenance of health and wellbeing’ (p.1195). Although there are movements within biomedicine that also promote holistic (or patient-centred) healing (see for example Checkland et al., 2008; Goldstein et al., 1988; Wolpe, 1990), Williams discusses this specifically in relation to non-biomedical healing practices. She makes particular reference to the view, within holistic medicine, of health and illness as part of the same continuum, rather than as separate states (1998, p.1195). This approach to therapeutic landscapes makes space for different understandings of health and wellbeing, or what might be experienced as therapeutic, and the ways in which this might be enacted, or played out, in specific places.

In terms of non-biomedical practices of healing, Bignante (2015) uses the concept of therapeutic landscapes to explore traditional healing practices that take place outside of the formal health care system in Northern Senegal. Bignante considers the space in which these healing encounters take place (in the traditional healer’s room), the process of talking with the healer and the use of specific material objects that are associated with healing, such as herbs, prayers and music (p.709). She argues that in these healing encounters, patients find ‘physical and emotional wellness’ and that this is ‘mediated by place, specific actions and material objects’ (p.709).

In terms of place, Wilson’s (2003) study of a group of First Nations people in Canada offers an alternative approach to the consideration of the therapeutic properties of physical/natural landscapes. In her study, place is interpreted as ‘land’, and Wilson
contends that it is the relationship with the land that shapes both the health and identity of the people in her study. She calls for the inclusion of cultural and symbolic aspects within the concept of therapeutic landscapes; what she terms as ‘other (non-physical) dimensions of therapeutic landscapes…[that] are embedded within the beliefs and value systems of different cultural groups’ (p.85). This has implications for the ways in which both health and place are conceptualised. For the people in Wilson’s study, both of these are tied to the land, and to a particular way of living or ‘being’, which is in turn shaped by a particular understanding of wellbeing that sits outside of the biomedical approach to health and illness. This resonates with a more phenomenological approach to place, as something that is lived or ‘acted’ (Andrews et al., 2014, p.210) in distinct ways for different social groups.

In a contrasting study, Laws (2009) challenges the implicit assumption that therapeutic landscapes are places that are pleasant or comfortable, as well as the idea of what ‘therapy’ looks like and from where and whom it might come (p.1828). The respondents in her study are members of a self-help group who meet regularly in several locations that are renowned as dangerous places. However, in these particular places, group members are able to create and participate in a particular kind of ‘therapy’ that is meaningful for them. Laws explores the connection that the members of the group feel with the places in which they meet, and argues that it is this connection that is important in the process of healing (p.1828-1829). The approach that Laws takes is a challenge to consider different ways in which the process of healing might be understood and made meaningful, as well as different places within which this might take place.

Taking the concept of therapeutic landscapes beyond an interpretation of landscapes as physical places, Andrews (2004) explores the use of imagined landscapes in complementary and alternative medicine. He argues that the use of imagined landscapes in processes of healing and treatment challenge the notion that physical presence in a particular place is necessary in order to experience its therapeutic effect (p.315). Following this idea, Andrews & Shaw (2010) explore the creation of ‘safe places’ (as imagined places) in the treatment of needle phobia and propose that these can offer a kind of ‘refuge’ from (unpleasant) bodily feelings and distress (p.1805). While this reflects ideas within the early studies of therapeutic landscapes as places of ‘escape or retreat’ (Gesler, 1992, p.735-6), the idea of imagined landscapes, as places that are recalled or recreated in the mind,
highlights the power of the connections that people have with particular places, even without being in those places.

Considering this in a different way, Hoyez (2007) explores the ways in which therapeutic landscapes may be reproduced from one place into another, through a study of the practice of yoga in both India and France. She argues that the processes of globalisation and the transfer of knowledge from one place to another, enable the reproduction of landscapes, or practices, that are associated with health and wellbeing, across different places. Although this is about physical places, it reflects the idea of imagining, or recreating landscapes, from the connections felt to/with particular places.

Gastaldo et al. (2004) also build on the challenge to the traditional understanding of therapeutic landscapes as physical places, and the requirement of physical presence in particular places in order to experience their therapeutic effects. Also considering imagined, or recreated places, Gastaldo et al. explore the notion of ‘therapeutic landscapes of the mind’ in the experience of migration. They propose that therapeutic landscapes of the mind are ‘non-traditional landscapes, the ones constructed and experienced in one place but that refer to another location’ (p.171). The accounts of migration experiences in this study highlight the role of (selective) memory, nostalgia and reminiscence, in recalling and talking about places of ‘home’. Gastaldo et al. argue that the process of ‘evoking memories of home’ functions as a ‘therapeutic coping mechanism for ‘missing’ the places of home’ (p.160). In this sense, the therapeutic effect of imagined landscapes (in this case, specifically related to migration), is such that they enable the ‘reconstruction of the individual’s self in relation to a new place’ (p.172).

2.2.4 Conceptualising place

Within the literature on therapeutic landscapes, there are several useful ideas about place that shape the approach to health and place in this study. Plane & Klodawsky (2013) propose that a relational approach to place requires an ‘understanding of the dynamic interactions between individuals and contexts, rather than simply the effect of a particular physical environment on health’ (p.3). They highlight that places are interconnected and exist in relation to one another, rather than as ‘fixed’ and ‘separate’ (p.2). Similarly,
Cummins et al. (2007) contend that a deeper understanding of health and place requires consideration of people in a variety of places; that people move in and out of different places over time, and that people are therefore ‘embedded in multiple health damaging and health promoting environments, across time and space’ (p.1835). This builds on what Dyck (1999) describes as a ‘recursive constitution of place and people’ that is concerned with ‘how behaviour and ideas are deeply embedded in place’ (p.247).

Conradson (2005) adds to the idea of a relational approach to place with the term ‘therapeutic landscape experience’ which he describes as ‘a relational outcome, as something that emerges through a complex set of transactions between a person and their broader socio-environmental setting’ (p.338). With this, he proposes that it is interaction within a place, rather than simply being present, that has the potential to make places therapeutic. This suggests that to experience a place as therapeutic therefore requires some sort of interaction or engagement within that particular place. This also resonates with a conceptualisation of place as constituted through ‘social relations and practices’ (Laws & Radford, 1998, p.81) and Gesler’s assertion (as above) that it is meanings and experiences that make places significant (1991, p.164).

Other conceptualisations of place in this literature approach place as something that is ‘lived’ (Andrews et al., 2014) or that ‘comes into being’ through the processes of engagement and interaction of people with(in) place(s) (Gesler, 1991, p.166). In this respect, Andrews et al. (2014) take a phenomenological approach to place, suggesting that ‘health and health care unroll in places that are acted, felt, felt about and represented’ and that ‘experiences of places, and the knowledge gained from being part of them or learning about them, gives rise to their intentionality (what places are about) and essences (how places feel)’ (p.210). Davidson & Milligan (2004) also suggest that places are ‘felt’, but draw on the role of emotion in order to explore this. They propose that emotion and place exist in a reciprocal relationship; that emotions play a central part in making sense of places, but at the same time that particular places contextualise - or make sense of - emotions (p.524). They relate this to identity and to a phenomenological sense of being (in particular places):

’[Emotions] have tangible effects on our surroundings and can shape the very nature and experience of our being-in-the-world. Emotions can clearly alter the way the
world is for us, affecting our sense of time as well as space. Our sense of who and what we are is continually (re)shaped by how we feel’. (Davidson & Milligan, 2004, p.524 - emphasis in the original).

2.2.5 A note about place and space

Although a distinction is made between place and space within the discipline of human geography, the terms are used somewhat interchangeably within the literature on therapeutic landscapes. Andrews (2008) highlights that traditionally, place has been approached as a ‘bounded phenomenon’, albeit one that may exist on a range of scales. In contrast, space is conceptualised in more relational terms, such that space can be seen as ‘coming into existence because of social processes and phenomena’ and occurring within places such as cities, neighbourhoods, or buildings (p.627). The idea of a relational approach to place within the literature on therapeutic landscapes, as discussed above, would seem to collapse this distinction to some extent. Within this approach to place, the emphasis is on exploring the ways in which people interact with their surroundings and with one another, in particular places, and in a recursive relationship. As such, this contains elements of the concepts of both place and space; that this (social) interaction occurs within particular places. The range of studies that use the concept of therapeutic landscapes to explore health and place, show that although there is a perhaps a lack of clarity in the way that these two terms are used interchangeably, the relational approach to place, as developed within this literature, can nonetheless be critically applied in a variety of different places.

2.2.6 Place, identity and belonging

The notions of ‘evoking memories of home’ and the ‘reconstruction of the individual’s self in relation to a new place’, that Gastaldo et al. (2004) discuss (as above), clearly raise issues about belonging and identity; specifically, about the connections that people feel within and to particular places. This resonates with Gesler’s emphasis that it is the meanings and experiences associated with particular places that make them significant (1991, p.164). It also resonates with a relational approach to place, such that people are involved in multiple places within their everyday lives (Cummins et al., 2007) and
therefore those places are experienced in relation to each other (Plane & Klodawska, 2013). Relph (1976) writes that places are ‘a fundamental aspect of man’s existence in the world’ and that they are ‘sources of security and identity for individuals and for groups of people’ (p.6). He discusses attachment to, and rootedness within, particular places, and suggests that ‘to be attached to places and have profound ties with them is an important human need’ (p.38). He describes this attachment as ‘a familiarity that is part of knowing and being known here, in this particular place’ and states that ‘it is this attachment that constitutes our roots in places’ (p.37 - emphasis in the original). He goes on to say that ‘to have roots in a place is to have a secure point from which to look out on the world, a firm grasp of one’s own position in the order of things, and a significant spiritual and psychological attachment to somewhere in particular’ (p.38). This clearly concerns both belonging and identity as they are experienced within particular places.

2.3 Health and Place: Migration

The migration stories of the research participants in this study add an important contextual layer to the relationship between health and place. Their stories and experiences play an important part in shaping their shared understandings of health and wellbeing, their motivation for being part of the community centre and the particular ways in which they engage with each other in this place. In this way, their stories also raise important issues around identity and belonging that resonate with the ideas about health and place that are reviewed above.

2.3.1 Migration and health

Increasing population movement world-wide has put migrant health on the global public health agenda (Ghent, 2008). The International Organisation of Migration positions migrant health within human rights discourse, as well as an issue implicated in social and economic development (Davies et al., 2009). In particular, it emphasises that a greater focus on migrant health enables migrants to become better integrated and more productive members of host countries, both socially and economically (Davies et al., 2009, p.6). Aligned with this perspective, much of the research around migrant health is focussed on
health inequalities; that is, the health of migrant and ethnic minority groups as compared to the host country population (see for example Bécares, 2013). In addition to changes to living and working conditions, Davies et al. (2009) state that migrants are particularly vulnerable to discrimination, social exclusion and stigmatisation; issues that they suggest are implicated in an increased vulnerability to disease and ill health (p.9-10). Issues around access to, and the use of, health care services are also reported to present particular problems for migrant groups. This includes the availability of appropriate services, lack of knowledge about how the healthcare system works and expectations about interactions between patients and healthcare professionals (Ingleby, 2009, p.12). Studies of health inequalities among ethnic minority and migrant groups also draw attention to the particular social environments in which people live and the ways in which these also contribute to health and wellbeing. This includes issues of poverty, poor quality housing, deprived neighbourhoods, isolation and the availability of health services in particular areas (Alegria et al., 2011; Karlsen & Nazroo, 2002; Scambler, 2007).

2.3.2 Qualitative studies of migration and health

Although the focus of much of the literature around migrant health is on health inequalities, as above, there are also some qualitative studies that address aspects of culture - or at least the change in social and cultural context that comes with migration - in terms of the relationship between the experience of migration and health.

In terms of differences in health care systems and the expectations that come with that, Borovoy & Hine (2008) present a study of elderly Russian Jewish migrants with diabetes in the USA. In order to contextualise the health care choices and practices of this particular migrant group, the study explores both the political context and the structure and ideological orientation of healthcare in the country of origin, as well as in the country of settlement. Guell (2011) also picks up this thread in her study of Turkish migrants with diabetes in Berlin, suggesting that the nature of the healthcare system in Germany constitutes a structural factor in the marginalisation of this particular ethnic group. Although there is a strong healthcare system in Germany, Guell highlights the limitations of this towards migrant populations, particularly in cases where migrants also live in areas with high levels of poverty and social deprivation (p.381). In this respect, she suggests that
the response to living with diabetes is also a response to living as marginalized citizens as migrants in a foreign country.

Lawton et al. (2007) highlight migration as an important influence in shaping understandings of health and illness. They look at differences in causal understandings of diabetes among White and South Asian people in the UK. Within this study, many of the South Asian respondents gave their migration to Britain as the cause of the onset of diabetes; that the stress and pressure of migration, including the interruption to their social and family networks, caused their ill health (p.899). The outcome of the study is not to simply say that White people and South Asian people view health and illness in different ways because they have different ethnic and cultural backgrounds, or that all South Asian people view diabetes in this particular way. Rather, the participants of South Asian origin in this study, who had migrated from another country to the UK, perceived the event of migration as having a significant effect on their health. In this sense, the experience of migration contextualises - and complicates - differences in understandings of health and illness that might simply be labelled as ‘cultural’ differences.

In terms of the disruption to social and family networks, and the availability of support in the host country, Elliot & Gillie (1998) highlight experiences of loneliness, homesickness and depression among South Asian Fijian migrant women in Canada. They note that where family support systems in the host country were not strong, problems associated with loneliness and depression were intensified (p.334). They also note changes to the traditional roles for the women in their study. For many of the women, economic pressures as a result of migration meant having to work outside the home for the first time in their lives, as well as continuing to care for their families (p.336). Dyck & Dossa (2007) draw attention to different routes of migration in terms of the level of interruption to support networks and the availability of support in the host country. They compared a group of Afghan-Muslim refugee women with a group of South Asian Sikh women who had migrated to Canada to join family. They showed that the route of migration had implications for the availability of financial and material resources, as well as social support, and that it also had a significant influence on the experiences of the two groups of women.
2.3.3 Qualitative studies of Chinese migrants

Chapter 3 sets out a detailed context of the history and circumstances of Chinese migrants in the UK. This includes contextual information about the particular generation of migrants that the participants in this study are part of. However, the purpose of this next section is to give a brief overview of the main themes within qualitative studies of Chinese migrants, in the UK and elsewhere. These focus particularly on the experiences of women, highlighting issues around family structure and traditional gender roles, and demonstrating how migration is experienced differently by Chinese men and Chinese women. This also serves to contextualise the migration stories of the research participants in this study, which will be explored in Chapter 6.

2.3.4 Gendered experiences of migration and the traditional Chinese family

Chan et al. (2006) state that: ‘Confucian teachings place the family at the centre of an individual’s entire life’; according to this, ‘the family is the basic unit in the Chinese community’ (p.306). In terms of family relationships, the notion of filial piety is particularly important. This concerns ‘respect and care for elderly family members [and] family reciprocity’ (Chappell & Kusch, 2007, p.30), and ‘the continuity of the family through generations of parents and children’ (Liu et al., 2000, p.213). Chappell & Kusch (2007) highlight the gendered nature of filial piety; that despite the relationship between father and son being central to the notion of filial piety, the task of caring for elderly family members tends to fall to women. They highlight that this is particularly the case for daughters-in-law whose ‘responsibility transfers to her husband’s family upon marriage’ (p.30).

Also writing about the traditional role of Chinese women, Tang et al. (2002) note that Chinese women are ascribed subservient roles according to Confucian teachings. These require a woman to ‘subject herself to the authority of her father when she is young, her husband when she marries, and her son when she is widowed’ (p.976). These teachings also set out the four virtues of women as ‘fidelity, tidiness, propriety in speech, and commitment to needlework’ such that the value of women is measured in terms of their ‘capacity to fulfil the domestic roles of being a supportive wife and nurturing mother.’ (p.976). Yuen (2008) suggests that for Chinese women migrants (in the UK), such beliefs...
about traditional gender roles are internalised, and shape their experiences as migrants (p.304).

Lee et al. (2002) explore the experiences of Chinese migrant women in the UK in the context of their involvement in family-run catering businesses. Experiences of loneliness and isolation of women in these situations are highlighted (as others such as Baxter & Raw (1988) also note), particularly where the only family network is with the husband’s family. However, Lee et al. (2002) also highlight differences in the experiences of different generations of women, as well as different routes of migration. Also writing about the context of Chinese family catering businesses, Song (1995, 1997a, 1997b) suggests that the involvement of women and children in family businesses is an important part of social and economic adaptation, and at the same time a key part of establishing and maintaining Chinese identity in the UK. In particular, she suggests that children ‘helping out’ in the family business is a ‘norm’ and an enactment of the values of family collectivism and solidarity in the context of migrant family life.

Ho (2006) explores the experiences of contemporary Chinese migrant women (from Hong and China) in Australia. She notes that although this generation of migrant women are typically highly skilled and educated, it is common for them to leave paid employment, or change from full to part time employment following migration. She notes the role of extended family and paid domestic support in China, allowing women to work outside the home, even when they have young families (p.503). Post-migration, the lack of family networks and the higher cost of domestic help, causes what Ho calls an ‘escalation of women’s “mothering” roles’, such that ‘the act of migration itself often results in an escalation in women’s roles as wives and mothers, and a concurrent reduction in their role as income earners’ (p.503).

Cooke (2007) also highlights the interplay of traditional gender roles in the experiences of the younger generation of highly educated professional women migrants coming to the UK from China in the 1990s onwards. The women in her study all had successful professional careers in China but in coming to the UK, had sacrificed their careers for their husbands’. Cooke notes that ‘It appears that these highly educated Chinese women with advanced career achievements have not managed to break the chains of traditional gender roles […] They not only assume their childcare responsibilities but also assist their husband’s career
in every possible way in order to maintain a harmonious family environment’ (p.62). In both cases - for Chinese migrant women in the UK and in Australia - being a migrant in another country changes the circumstances in which gender roles are fulfilled, and shows that traditional gender roles continue to shape the experiences of Chinese migrant women.

2.3.5 Generational change and the Chinese migrant family

Within the literature on Chinese migrant families, tension between different generations and the notion of the family as a site of change is highlighted. In terms of identity, Kuah-Pearce (2006) notes that for second generation migrants (i.e. those who are ‘locally-born’) the ‘reference point is the host society rather than the original hometown’ (of their parents) and that this can lead to ‘clashes over ideological orientations, social values and behavioural traits’ (p.228). Kwok-bun (2005) suggests that children play a vital role in immigrant families in terms of negotiating social and cultural change. He writes that ‘Children act as cultural brokers, shuttling between the private and the public to bring society’s values into the family, and the family’s values into society’ (p.132). However, like Kuah-Pearce, he notes that this is not without tension, and states that ‘some of the fiercest battles fought within Chinese immigrant families are between generations, between tradition and change’ (p.132).

Chiu and Yu (2001) highlight the tension between ideal family values, for example around caring for older family members, and the reality in which this is played out. They note the perception that Chinese families traditionally value ‘filial piety and family care’; however, they caution that this is often exaggerated, and suggest that economic and migratory factors play a part in ‘shaping the care-giving and care-receiving process in Chinese families’ (in the UK) (p.682). In their study of family care within Chinese families in London, they report that although traditional values about the obligation to look after elderly family members still had some influence, the position of the elderly within the family was also determined by ‘the family’s caring capacity and older people’s contribution to the family’ (p.696).

Tan et al. (2010) also note this changing perception of family support, particularly for older family members, among Chinese immigrants in Australia. The Chinese immigrants in their
study expressed the importance of financial security as part of successful ageing, because they did not want to be dependent on their children. Similarly, Chen and Lewis (2015) report a generational change with regard to the position of older Chinese people in the family, in their study of Chinese grandparenting in the US. In particular they note a shift in attitude towards the notion of filial piety, and the concurrent need for older Chinese people to take up new roles in the family setting. Also writing about Chinese immigrants in the US, Chun et al. (2011) highlight the impact of changing family values in terms of self-management for long-term illness. The participants in their study expressed distress over the ‘highly acculturated American-born Chinese youth’, and worried about the effect of this on the care they might receive from their families (p.260).

2.3.6 Conceptualising migration: identity and change

Writing in relation to Chinese migrants in Thailand, Singapore, Hong Kong and Canada, Kwok-bun (2005) proposes a conceptualisation of migration that goes beyond the assimilation/segregation (either/or) dichotomy inherent in other theories of acculturation. He is concerned with a ‘hybridisation’ of identity among (Chinese) migrants, in which ‘pluralism and a variety of multiculturalisms’ generate ‘multiple faces of ethnicity’ (preface, xiii - emphasis in the original). He goes on to say that ‘Ethnic actors are forever mixing and mixed, forever crossing, traversing and translating linguistically, culturally and psychically’ (preface, xiv), and proposes the idea of identity as ‘positionality’ in the face of (modern) heterogeneous society.

This conceptualisation mirrors some of the ideas around ‘place’; in particular, places as relational (that they exist, and are experienced in relation to other places), and the multiplicity of places in peoples’ everyday lives. What Kwok-bun suggests is that identity is negotiated and articulated in different ways in different places; that it is never just one thing that is fixed and static, but is changeable and fluid. Furthermore, the challenges of migration within contemporary heterogeneous society necessarily create an articulation of identity as multiple and fluid.

In this study, the migration stories of the research participants are explored as significant life events, and as shared experiences, that influence the enactment of identity within a
particular place (i.e. the community centre). This is an approach to identity that sees it as relational, as multiple (and sometimes partial) and as situated within a particular place. The migration experiences constitute an important context within which to explore the collective (re-)construction of identity that in turn creates a sense of belonging and wellbeing that makes the community centre a meaningful place for its members.

2.4 The question of culture

As well as the issues connected to health and place, as reviewed above, research around migration and health also raises the question of culture. It is widely acknowledged that cultural context is important in relation to the ways in which health and illness are understood. However, culture is a somewhat malleable concept, used in many different ways to mean different things.

Central to the discipline of anthropology, the concept of culture has been applied and developed through the study of human diversity; in particular, in the exploration of questions about ‘how and why human beings differ in their forms of life’ (Ingold, 1994, p.329). In its early use, culture was associated with notions of civilisation, progress and development (Ingold, 1994, p.329; Wagner, 1981, p.21). In this view, culture was understood as singular - as the culture of mankind (Wagner, 1981, p.1) - and humans were seen to differ in their level of advancement along ‘a universal scale of progress’ (Ingold, 1994, p.329). This also encapsulated an understanding of culture as something that is possessed and that can be acquired (Barnard & Spencer, 2002, p.136), so that culture is ‘something which everyone had, but which some people had more or less of’ (Barnard & Spencer, 2002, p.138). Equally, some things were seen to be more cultural than others, for example, art, music and literature (Ingold, 1994, p.342; Barnard & Spencer, 2002, p.136).

Alongside this, the idea of culture as plural and relativistic was also developed (Barnard & Spencer, 2002, p.136). In this view, the world was understood to be divided into separate and distinct groups of people, that were bounded and homogenous (Barnard & Spencer, 2002, p.136-138). These cultural groupings - or ‘cultures’ - were each seen as ‘a traditional way of life, embodied in a particular ensemble of customary behaviour, institutions and
artefacts’ (Ingold, 1994, p.329). Within this view of culture, people were understood to be ‘products of the particular culture in which they have lived’ with differences between them being explained by ‘differences in their cultures’ (Barnard & Spencer, 2002, p.136).

More contemporary conceptualisations of culture move away from these ideas of ‘culture’ as singular, and of ‘cultures’ as distinct and separate groups. Rather than being something that can be seen, or encountered, in a tangible or measurable sense, Ingold (1994) suggests that:

‘What we find are people whose lives take them on a journey through time and space in environments which seem to them to be full of significance, who use both words and material artefacts to get things done and to communicate with others, and who, in their talk, endlessly spin metaphors so as to weave labyrinthine and ever-expanding networks of symbolic equivalence.’ (Ingold, 1994, p.330).

This is purposefully set apart from an understanding of culture as something that is ‘neatly bounded and mutually exclusive’ and that is ‘perfectly shared by all who subscribe to [a particular culture]’ (Ingold, 1994, p.330).

Writing specifically about culture in relation to health and illness, Helman (1994) suggests that culture can be understood as ‘a set of guidelines’ that tell people ‘how to view the world, how to experience it emotionally, and how to behave in it’ (p.2, emphasis in the original). He goes on to suggest that culture is ‘an inherited ‘lens’, through which the individual perceives and understands the world that he inhabits, and learns how to live within it’ (p.3). This is about ways of being in and understanding the world around us. Like Ingold, this view moves away from an understanding of culture as something that is acquired or possessed, or that exists ‘apart from the people who possess it’ (Gesler & Kearns, 2002, p.12), and towards a conceptualisation of culture in terms of ‘shared ideas and practices’ (Gesler & Kearns, 2002, p.13).

Ormrod’s (2003) conceptualisation of culture adds an important dynamic to this. She proposes an understanding of culture as ‘enacted’, ‘emergent’ and as ‘embedded in ongoing and fluctuating practices’ (p.231). She suggests this as a ‘third way’ between the ‘has/is dichotomy’ of more traditional understandings of culture (as discussed above) (p.230). Like the idea of culture as shared practices, Ormrod emphasises an understanding
of culture as ‘action in context’; of ‘processes’ and ‘practices among particular groups in specific contexts’ (p.230). In the context of the provision of healthcare for ethnic minorities in the US, Borovoy & Hine (2008) call for an awareness of culture ‘in motion, galvanised by processes of assimilation, accommodation to new technologies, social transformation, and generational conflict’ (p.4). This suggests a more fluid and dynamic understanding of culture as something that is lived, and like Ormord’s conceptualisation, of something that is emergent through everyday practices. In this vein, Ingold usefully suggests that ‘it might be more realistic […] to say that people live culturally rather than that they live in cultures’ (1994, p.330, emphasis in the original).

This study reflects the idea of culture as practice; as enacted and emergent through everyday practices. Rather than being about inherent or ascribed characteristics associated with where people come from, this is about ways of living, according to what is meaningful. In turn, it is understood that what is meaningful is shaped within the circumstances and conditions of life; through places, through relationships, through families, through the everyday and extraordinary events of life. This is explored in this study through the migration stories of the research participants, as experiences of living in different places in different ways. The approach to culture taken in the study enables an exploration of how these different experiences, in different places, are brought together - not always easily - and made meaningful in the context of the research participants’ lives, here and now. This provides the contextualisation for the understandings of health and illness that are expressed by the research participants, the ways in which they interact in this particular place, and the ways in which these are connected. As Ingold suggests, this is about living culturally rather than living in culture. In the context of this study, this is understood as a way of living in response to the conditions of life; of (re)creating and enacting meaning, as well as negotiating change, through everyday practices. It is in this sense that culture is understood as emergent through everyday practices.

### 2.5 Research questions and rationale for this study

Borovoy & Hine (2008) make the point, with reference to cultural competence in healthcare, that it is important to ask the question of what health actually is; how it is understood
and what it means for different groups of people (p.18). A consideration of place helps to ask this question; how health might be understood and enacted outside of formal healthcare settings, and about places where such practices might take place. In this study, I am asking what health and wellbeing mean, but more specifically what health and wellbeing mean for this particular group of people in this particular place. This is contextualised by the migration stories of the research participants, and is shaped by an understanding of culture in a context of change; as an inquiry about the ‘meaning of actions and events to the people we seek to understand’ (Spradley, 1980, p.5). The literature on therapeutic landscapes and the ideas about place also give shape to this study of people in place, through a consideration of the three elements of place outlined at the beginning of this chapter; the physicality of the community centre, the activities that take place there, and the ways in which people interact with one another in this place. This also draws on the conceptualisation of places as relational, and as ‘acted’, and as ‘lived’ (Andrews et al., 2014).

As discussed in Chapter 1, this PhD began as a study of long-term illness management. In this regard, as I began my fieldwork, my intention was to undertake an exploration of long-term illness (management) among first generation migrants, with migration conceptualised as a major change in social and cultural context. However, through the processes of fieldwork, analysis and writing, and in response to the field site and research participants, the project has evolved to become a study of health and wellbeing (as opposed to a study of illness) in the context of belonging, identity and community, within a particular place. In this sense, the development of the project has been ‘iterative-inductive’ (O'Reilly, 2009, p.3). Having said this however, it is important to state the research questions that I set out with, in order to show where the study began. The interests that underlie these research questions have remained at the heart of this project and have driven the development of the study.

With this in mind, the overarching research question for this study was:

How is long-term illness management negotiated and enacted in this particular social and cultural space, where migration is a common experience in the life history of the members of the centre?
And the specific aims of the study were:

i. To explore the migration histories of the members of the centre;

ii. To explore members’ understandings of their long-term conditions and their choices about treatment and management;

iii. To explore the involvement of family and others in long-term illness management;

iv. And to put the above in the context of the daily activities and services of the centre as the site of the study.
Chapter 3: Context - The Chinese in the UK

3.1 Introduction

There is limited information about the health of the Chinese population in the UK and it is noted that in general this is an understudied section of the population (Long et al., 2015). However, within the research that is available, low levels of illness (Bécares, 2013) and limited use of health services are reported (Chau, 2008; Sprotson et al., 2001). The nature of the Chinese population - geographically dispersed across the UK, rather than concentrated in one area (Chan & Chan, 1997; Chau & Yu, 2010; Tran et al., 2008) - and the issues highlighted in the literature around the experiences of Chinese migrants (in Chapter 2), both raise implications for health and wellbeing. Both also provide an appropriate and relevant context within which to pursue the particular interests of this study; that is, the relationship between health and place, in the context of a conceptualisation of migration as a major change in social and cultural context. With this in mind, the purpose of this chapter is to set the context of the study, as a study of health and wellbeing amongst a group of first generation Chinese migrants in the UK.

The first section of the chapter gives a brief overview of the Chinese population in the UK, followed by a more detailed account of Chinese migration into the UK. This focusses on the particular circumstances that relate to the experiences of the participants in this study, most of who came to the UK in the 1970s and worked in and/or owned Chinese takeaways and restaurants. This sets the context for the migration stories of the participants, as gendered experiences of migration, which are discussed in Chapter 6.

The next section gives an overview of the health of the Chinese population in the UK, outlining some of the problems associated with this population, particularly around social isolation and loneliness, and issues of access to healthcare. These are issues that are also reflected in the migration stories of the participants in the study, particularly the women,
and will be addressed in Chapter 6 as part of the discussion of the migration stories, and in Chapter 8 in terms of the use of Traditional Chinese Medicine (TCM) and biomedicine.

This is followed by an overview of TCM; as a holistic medical practice influenced by Chinese philosophy, that views health and illness in terms of balance and harmony. The conceptualisation of mental illness within TCM is discussed, as part of this holistic view of health and illness. In particular, this raises issues of stigma and shame, that in turn impact on help-seeking and treatment for mental health disorders, particularly for Chinese communities outside of China. This discussion of TCM provides an important contextual background for the understandings of health and illness among the participants in this study, including those with mental health problems (discussed in Chapter 7). It also provides a foundation for the exploration of the use of both TCM and biomedicine among this group (discussed in Chapter 8), and as it is reported among other Chinese groups in the UK.

Lastly, a cautionary note is given about the use of the label ‘Chinese’ for the participants in this study.

3.2 The Chinese population in the UK

According to UK Census data, in 2011 the Chinese in the UK accounted for approximately 0.7% of the total population, making them a small but significant part of the UK population (Office for National Statistics, 2012). It is widely noted that the Chinese population in the UK is diverse. Included under the label of ‘Chinese’ are people from different countries of origin, different social and cultural backgrounds, speaking different languages and dialects, who have come to the UK for different reasons, as well as a growing UK-born migrant generation (Chau & Yu, 2010; Li et al., 1999; Long et al., 2015; Wong, 2006; Yu, 2000; 2006;). It is also noted that although there are clusters of Chinese people, for example in London and the North West, the Chinese are widely dispersed across the UK (Chan & Chan, 1997; Chau & Yu, 2001; 2010; Tran et al., 2008). This is

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3 Biomedicine is used here to refer to medical practices based in biological sciences and developed through clinical and laboratory research (Kroker, 2008).
attributed primarily to economic competition amongst Chinese restaurant and takeaway businesses (Chan et al., 2007; Tran et al., 2008). In this respect, Chau et al. (2011) suggest that the Chinese in the UK experience a ‘double social exclusion’; that through their employment in predominantly Chinese family-run businesses, they are geographically separated from one another due to economic competition, but also isolated from the mainstream UK society (p.120). Chan et al. (2007) note that a common perception of the Chinese community in the UK is of a ‘silent and self-sufficient community’ that is ‘perceived by statutory bodies as having sufficient resources to meet their [own] needs’ (p.510). However, at the same time, there is also the perception that the ‘UK Chinese people's caring practices [operate] mainly at family level, while mutual help at the community level is minimal’ (p.510). Chan et al. highlight that both of these perceptions have implications for the provision of services, such as health and social care services, to the Chinese in the UK (p.510).

3.2.1 Chinese migration to the UK in the post-war 20th Century

In the post-war 20th Century, there were three major waves of Chinese migration into the UK (Wong, 2006, p.8). The first of these, in the 1950s and 1960s, was predominantly men from the rural villages in the New Territories of Hong Kong. These were young men with little education and speaking little English, who came to the UK to earn money and worked first in Chinese laundries and then later in Chinese restaurants and takeaways (Wong, 2006, p.8; Skeldon, 1995, p.54; Chau & Yu, 2001, p.108). Following this, the next inflow of migrants in the 1970s and 1980s, was made up of the dependents and family members of those who came in the 1950s and 1960s (Wong, 2006, p.8). The immigration laws at that time required the arrangement of employment prior to entry into the UK, meaning that many of these came to work in Chinese-owned restaurants and takeaways through family and kinship ties (Baxter & Raw, 1988; Pang & Lau, 1998; Watson, 1974; 1977). The end of the Vietnam War also brought refugees from Vietnam into the UK during the late 1970s and early 1980s (Tran et al., 2008; Wong, 2006). These were ethnic Chinese from North Vietnam, who fled Vietnam in large numbers by boat (Robinson & Hale, 1989, p.1). Many of these refugees, known as the ‘Boat People’, died at sea; those who survived the journey were placed in refugee camps in Hong Kong, Thailand and Malaysia, before being dispersed to other countries, including the UK (Robinson & Hale, 1989, p.1).
From the 1990s onwards, the pattern of migration began to change, meaning that the Chinese population in the UK became increasingly diverse. The return of Hong Kong to Chinese sovereignty in 1997 and the issuing of British citizenship to 50,000 families was a major factor influencing immigration out of Hong Kong in the 1990s (Skeldon, 1995; Tran et al, 2008). Skeldon (1995) notes that in contrast to the earlier waves of migration from Hong Kong, in the 1990s it was predominantly highly skilled and educated people migrating from urban rather than rural areas (p.54). In addition to the changing demographic characteristics of migrants from Hong Kong, migration since the 1980s has also been shaped by increasing numbers of students and other highly skilled migrants coming into the UK from mainland China (Cooke, 2007; Zhang, 2003), as well as the increasing number of UK-born Chinese (Chan et al., 2007, p.512, Gervais & Jovchelovitch, 1998, p.716). In addition, the Chinese population in the UK also includes people from other Chinese-speaking countries such as Taiwan, Singapore, and Malaysia (Chan & Chan, 1997).

3.2.2 The Association of the UK Chinese with the catering industry: the success of the family business

Chinese migration into the UK is associated with the development of the catering industry in the 1960s and 1970s (Baxter & Raw, 1988; Pang & Lau, 1998; Skeldon, 1995; Wong, 2006; Yu, 2000); in particular Chinese restaurants, takeaways and fish and chip shops. Pang (1996) notes that ‘[the Chinese] have carved out a niche for themselves in the Chinese catering industry, which has provided the majority of post-Second World War Chinese migrants to Britain with social and economic security’ (p.891). These restaurants and takeaways were predominantly small, family-run businesses in which the women and children in the family typically ‘helped out’ and provided cheap, and often unpaid, labour (Baxter & Raw, 1998, p.67; Song, 1995, p.287). The shift from restaurants to takeaways, in the late 1970s, arose through economic competition and the need to manage rising setup and running costs for these businesses (Baxter & Raw, 1998, p.67).

It is noted that the Chinese work ethic and entrepreneurship in running these businesses meant that a generation of self-employed migrants in a niche market achieved economic success and upward mobility in a relatively short space of time (Pang & Lau, 1998).
However, there are also important structural factors that shape this trajectory, so that what is described as the Chinese work ethic is also contextualised by the particular social and economic circumstances of the generation of migrants who fuelled the growth of this industry. In terms of employment opportunities in the UK, Pang & Lau (1998) suggest that ‘rather than take the low-paying jobs rejected by indigenous people and perhaps [facing] racism and discrimination in the wider labour market, [the] Chinese typically choose to set up business ventures if possible, in areas where they face least competition from indigenous people’ (p.868). As such, they suggest that ‘entrepreneurship is the means whereby most people achieve or believe they will manage to achieve socioeconomic advancement’ (p.868).

However, Chau and Yu (2001) suggest that the economic success associated with this preference for business ownership came at a price for those migrants of the 1970s and 1980s, and by extension, the Chinese community in the UK more generally. As noted above, the dispersal of the Chinese population through the UK has been a result of competition between restaurant and takeaway owners. In order to maximise business potential, these family businesses spread themselves out, meaning that despite some clustering of Chinese people in urban centres, such as London, Manchester and Liverpool, the Chinese have been widely dispersed throughout the country (Tran et al., 2008; Chan & Chan, 1997). In addition, the fact that most of these businesses were owned as well as staffed by Chinese people, meant that they were also isolated from the mainstream economic market (Baxter & Raw, 1988, p.58). Chau & Yu (2001) argue that because of the nature of the Chinese catering trade, the Chinese in the UK experience a ‘double social exclusion’ in that they are ‘not fully integrated into the social mainstream and (for financial reasons) maintain a distance from each other’ (p.120).

There has also been research focussing on these Chinese family businesses as sites of oppression and exploitation, particularly for Chinese women and children. Baxter & Raw (1988) highlight that although the long opening hours and hard physical labour of running a takeaway affected both men and women in these businesses, it was the women who experienced the social isolation to a greater extent. They state that: ‘whether as dependent wives of workers or themselves working in the family takeaway, the monotony and alienation of life in the Chinese fast food industry for all women is striking’ (p.69). Song (1995) challenges the perception that working in the family business is necessarily
oppressive and exploitative for Chinese women however, by showing that it can also be a space in which Chinese women can ‘assert their skills and initiative’ (p.292). She explores the different experiences of Chinese women working in family businesses in order to show a diversity of experiences, as well as highlighting the fact that ‘these families are running businesses in the context of migration and ethnic identities’ (p.294). Song reports that the women in her study stated a preference for working in the family business rather than in outside employment, despite the gendered division of labour and the hierarchical roles within the businesses.

The association of the Chinese population with the catering industry is changing with the new generation of migrants coming to the UK and with the growth of the generation of UK-born Chinese (Chau, 2008, p.1). Pang & Lau (1998) note that unlike the previous generation of migrants who worked predominantly in the catering industry, the younger UK-born Chinese tend to pursue a different path in terms of education and employment: ‘where possible, the younger Chinese aim towards obtaining academic qualifications to gain entry into bureaucratic careers as a means to gain socio-economic advancement’ (p.864). Pang & Lau (1998) reflect on this in terms of the values and aspirations of social advancement and suggest that the older generations also strive for this generational change, and view it as their children ‘consolidating [their own] success’ (p.866).

3.3 Health of the UK Chinese population

There is limited information about the health of the Chinese population in the UK and it is noted that in general this is an understudied section of the population (Long et al., 2015). The focus on ethnic minority groups and health tends to stress the inequalities experienced across different ethnic groups, and suggests that ethnic minority groups fare worse than the general population in terms of health (Long et al., 2015). However, according to UK Census data, the Chinese population are reported to have significantly better health than both the white and other ethnic minority populations in the UK (Bécares, 2013). This is noted particularly in relation to long-term illness; that of all the ethnic groups included in the 2011 Census, the Chinese reported the lowest level of limiting long-term illness (Bécares 2013). (In the 2011 census ‘limiting long-term illness’ was interpreted in terms of
limitations to day-to-day activities because of a health problem or disability lasting more than 12 months (Bécares 2013: 2)). Within the Chinese population however, the rates of long-term illness are noted to increase with age, and it is the older Chinese who are more likely to self-report their health as ‘bad’ or ‘very’ bad (Sprotson et al., 1999, p.45). In terms of specific illnesses, the National Health Survey in 2004 reported that the Chinese were less likely than other ethnic groups to have cardiovascular disease or diabetes (Sprotson & Mindell, 2006, p.6-7). The survey also reported that the levels of overweight and obesity were significantly lower among the Chinese than the general population (Sprotson & Mindell 2006, p.10). In a health and lifestyles survey of the Chinese population in the UK, Sprotson et al. (1999, p.45) suggest that the most commonly reported long-term illnesses among the Chinese community are musculoskeletal disorders, respiratory complaints, and heart and circulatory problems.

It is noted that the Chinese in the UK are relatively low users of healthcare services (Chau, 2008; Sproston et al., 2001). This has been explored in terms of the barriers to accessing and using healthcare services, particularly around issues of language (Chau, 2008; Chau et al. 2011; Fang et al. 2015; Li & Logan, 1999; Li et al., 1999; Liu et al., 2015; Long et al., 2015; 2009; Rochelle & Marks, 2010; Sprotson et al., 1999; 2001; Yu, 2000). Language presents a problem in terms of both accessing health care services and in terms of communication with General Practitioners (GPs) and other healthcare providers. Tran et al. (2008) suggest that it is the older/elderly Chinese, who have more limited English language ability, who are more likely to experience problems in accessing health care services (p.16). Many of these would rely on family members, particularly younger generations, to accompany them to medical appointments, to act as translators and interpreters, and to pass on information about health services (Chau & Yu, 2010, p.389; Green et al., 2006, p.1504; Liu et al., 2015, p.134). As well as needing family members to be available, this has implications for the nature of family relationships, where people may be uncomfortable being dependent on younger generations for help, and involving them in details of their health problems (Li et al., 1999, p.79). In addition to this, there are issues around the availability, competence and trustworthiness of professional interpreting services (Li et al., 1999, p.79). There are also issues of communication that concern shared cultural knowledge and the interpretation and understanding of particular health problems or symptoms (Chau, 2008, p.4; Yu, 2000, p.16; Liu et al. 2015, p.138). Even in cases where language proficiency is not an issue, communicating a culturally specific concept of illness
can be difficult without a shared understanding between doctor and patient (Yu, 2000, p.16; Green et al., 2006, p.1504). Tran et al (2008) suggest that this may deter or delay seeking help, particularly with regard to mental health issues (p.35).

Social isolation is highlighted as a significant issue in relation to the health of the Chinese in the UK, particularly the elderly Chinese (Chau, 2008; Li et al., 1999; Tran et al., 2008). Tran et al. (2008) highlight the breakdown of extended family networks as a source of distress for older Chinese people. In their study of the mental health needs of older Chinese people living in London, the majority of participants either lived alone or with a spouse, rather than in extended family units (p.37). Li & Logan (1999) also highlight social exclusion in relation to mental health issues among the elderly Chinese and suggest that this challenges what they describe as the ‘stereotypical image of caring and supportive extended families in this [Chinese] group’ (p.1). In a study of the health and lifestyles of the Chinese in England, Sprotson et al. (1999) report that the Chinese are significantly more likely to have low levels of social support than the general population (p.159). In this respect, Yu (2000) suggests that, due to the dispersal of the Chinese community in the UK (as discussed above), the ‘cohesiveness of the Chinese community is overstated’ (p.10).

Alongside the focus on barriers to accessing and using health care services for Chinese people in the UK, is the call for culturally sensitive health care services (Chau et al., 2011; Chau & Yu, 2010; Green et al., 2006; Rochelle & Marks, 2010, 2011; Yu, 2006; 2009). Rochelle & Marks (2011) state that the increasing diversity of the UK population, and the corresponding diversity of health care needs within the population, make the need for culturally sensitive health care services vital (p.390). However, Yu (2009) argues that the provision of culturally sensitive services for Chinese people is complicated by assumptions about ethnic minority groups; in particular that ‘all members of the same ethnic minority group organise their health and social care according to their cultural principles, and that these cultural principles are monolithic’ (p.58). Similarly, Chau et al. (2011) caution against imposing mainstream health services on ethnic minority groups, but at the same time suggest that ‘it may be equally insensitive to take for granted the fact that all members of ethnic minority groups prefer to organize their health according to their heritage’ (p.385).
3.4 TCM: a holistic view of health and illness

TCM is a range of practices that ‘systematically addresses ailments as life-energy (or Qi) imbalances’ (Yang et al., 2009, p.207). It includes the treatment of illness with practices such as acupuncture, herbal medicine, moxibustion, massage, foot therapy, and physical exercise⁴ (Tang et al., 2008, p.1938; Yang et al., 2009, p.207). Influenced by the Chinese philosophies of Taoism and Confucianism, TCM incorporates the notions of balance and harmony as represented by Yin and Yang, and a concern with ‘social ethics, moral conduct, and the importance of maintaining harmonious relations among individual, family, community, and state’ (Scheper-Hughes & Lock, 1987, p.12). Unlike biomedicine, which separates illness into physical and mental forms (Yang et al., 2009, p.207), TCM is based on a holistic view of health and illness in which ‘no single part [of the body] can be understood except in its relation to the whole’ (Kaptchuk, 2000, p.7). In this respect, Kaptchuk emphasises that ‘If a person has a complaint or symptom, Chinese medicine wants to know how the symptom fits into the patient’s entire being and behaviour. Illness is situated in the context of a persons’ life and biography’ (p.7). As a holistic approach to health and illness, TCM therefore encompasses not just the ‘healthy working of the [human] body’, but the whole person, as it is situated in social and family relationships, and in relation to the ‘natural and supernatural environment’ (Jovchelovitch & Gervais, 1999, p.251). In this way, the notions of harmony and balance represent bodies as situated - or as in place - in the world. To this effect, Jovchelovitch & Gervais (1999) state that:

‘Harmony within the family and respect for its hierarchy and fundamental values, the primacy of collective goals over individual needs and desires, obedience to authority and self-discipline, all maintain the self in balance with society and give to the Chinese definition of health a breadth that goes far beyond bodily conditions’ (Jovchelovitch & Gervais, 1999, p.251).

Rather than being a system built around the reactive treatment of illness and disease, this is a way of living to maintain health.

⁴ Acupuncture is the practice of inserting very fine needles into the acupuncture points on the surface of the body; moxibustion is a practice of applying heat to acupuncture points (Kaptchuk, 2000, p.107-108).
As a fundamental element of TCM, Qi is understood as ‘the vital energy and the source of life’ (Hwu et al., 2001, p.631). Hwu et al. explain that Qi occurs in various forms and from different sources: ‘Nutritious food, clean water and fresh air are the external sources of Qi. On the other hand, self-cultivation can facilitate the nourishing of the spiritual and moral aspects of Qi.’ (p. 631). This highlights a tangible sense of Qi, as related to food and water as the fundamental sources of human life, but also encompasses something of the moral and spiritual elements of life - of bodies in the world - that are also vital in maintaining balance and harmony. Kaptchuk (2000) emphasises that there is no single English word that properly captures the meaning of Qi and explains that:

‘One can say that, for the Chinese, everything in the universe, inorganic and organic, is composed of and defined by its Qi. Mountains, plants, and human emotions all have Qi. Qi is not so much a force added to lifeless matter but the state of being of any phenomena. For the Chinese, Qi is the pulsation of the cosmos itself’. (Kaptchuk, 2000, p.43-44).

Yin and Yang represent ‘two opposite, complementary, interdependent, and exchangeable aspects of nature’ (Tang et al., 2008, p.1939) that are contained in all things (Hwu 2001, p.631). Kaptchuk (2000) explains that:

‘The character of Yin originally meant the shady side of a slope. It is associated with such qualities as cold, rest, responsiveness, passivity, darkness, interiority, downwardness, inwardness, decrease, satiation, tranquillity, and quiescence.[...] The original meaning of Yang was the sunny side of the slope.[...] Yang is associated with qualities such as heat, stimulation, movement, activity, excitement, vigour, light, exteriority, upwardness, outwardness, and increase’. (Kaptchuk, 2000, p.8).

Health (and illness) is intrinsically linked with Yin and Yang, such that ‘Health is a manifestation of when Yin and Yang are in harmony and balance. Once the harmony and balance is broken, pathological changes appear.’ (Hwu et al., 2001, p.631). In this way, health is represented in terms of the maintenance of the Yin Yang balance and the flow of Qi through the body (Chan et al., 2006). Correspondingly, illness and disease are understood in terms of imbalance, disharmony, or excess and deficiency (Hwu et al., 2001,
Food is another important element in TCM, both in terms of maintaining health and treating illness. Ho (1985) states that ‘Besides sustenance, the [Chinese] belief in foods’ importance also lies in their innate properties in preventing, ameliorating or curing illness’ (p.223). Therefore, different types of food, for example those categorised as ‘hot’ or ‘cold’, or ‘wet or ‘dry’, ‘should be eaten in proper balance, taking into account the seasonal variations and the individual’s body constitution, his temperament and his state of health’ (p.223). Koo (1984) also discusses the properties of food and the use of food, such as soups and teas, to prevent and treat disease, and in terms of restoring balance and harmony within the body (see also Anderson, 1987). Wong & Richman (2003) highlight that ‘part of having a regular lifestyle (for health) includes avoiding excessive food or drink’ (p.15-16). Green et al. (2006) report that in their study of Chinese women migrants, ‘Dietary management was explicitly used to maintain bodily balance and harmony and often there was no clear-cut division between food and medicine’ (p.1503).

3.4.1 Mental illness in TCM

As noted above, as a holistic medical practice, TCM does not recognise Cartesian dualism (the separation of body and mind); as such, there is no ‘separate and distinctive category of mental illnesses’ as they are understood within western biomedicine (Wong & Richman, 2003, p.14). However, Wong & Richman (2003) state that as well as maintaining the body in harmony with nature, ‘the mental and physical, must [also] be in harmony. For example, excess emotions have a deleterious effect on the body’ (p.14; also see Kleinman 1980, p.135; 1991, p.286-7). In this respect, they suggest that despite different terminology and language, conditions interpreted within biomedicine as mental illnesses, can be recognised within TCM (p.14). This can be understood as a ‘cultural patterning of illness’ in which the
experience of particular illnesses and the ways in which symptoms are reported and interpreted differ among different populations (Kleinman, 1980, p.138).

Kleinman has written at length about this, highlighting the tendency within Chinese culture(s) for symptoms that might be understood as psychological (in the USA) to be reported (by patients) in terms of physical complaints (1977, p.5; Green et al., (2002) also report this in terms of the Chinese in the UK). He states that:

‘In many parts of Chinese society, the experience of depression is physical rather than psychological. Many depressed Chinese people do not report feeling sad, but rather express boredom, discomfort, feelings of inner pressure, and symptoms of pain, dizziness, and fatigue.’ (Kleinman, 2004, p.951).

Kleinman (1980) describes this process - of somatisation - as a coping strategy which reduces ‘the intensity of anxiety, depressive feelings, fears, and the like’ and which helps to ‘both distance [those feelings] and to focus concern elsewhere’ (p.148-149). This provides a culturally acceptable way to talk about the experience of illness, focussing concern on physical rather than psychological symptoms. Kleinman shows that this is partly contained in the use of language, and the construction of particular words, for describing symptoms of mental illness. He gives the example of the Chinese word mên as a term for depression:

‘The character for this term includes the heart radical enclosed within a doorway radical. Patients and informants told me they picture this character when they used the term. Their hearts were “locked in”, “closed off”, or “suffocating behind a door”. They pointed to their chests to locate the feeling there. To them mên meant this physical sensation and its associated psychological state. The metaphors communicate how they feel in physical imagery in which the affect is inferred. The idiom makes the experience primarily somatic.’ (Kleinman, 1980, p.140-141).

He also looks to the process of socialisation of the individual into Chinese family life (in Taiwan), as a way of explaining this form of somatisation. In particular he emphasises the importance of control over personal feelings for the greater good of maintaining family relationships. In this respect, the expression of strong emotions is understood to ‘endanger
close interpersonal relationships whose harmonious arrangement is more important [to individuals] than their own psychological status’ (1980, p.133). Personal wellbeing therefore ‘depends on these finely balanced relationships’ (1980, p.133). To this effect, children are taught that ‘Achievement is not only for them, but also for the family. Shame falls on them and on their families together. Misfortune, including sickness, affects both’ (1980, p.134).

Both of these examples help to understand a concept of health and illness that is fundamentally linked to family and social relationships (as discussed above) and the idea of excess emotions causing illness. It also contextualises the association of stigma and shame associated with mental health in Chinese culture(s), which is widely reported both in Chinese countries and among Chinese populations outside of China (Green et al., 2002; Kleinman, 1977; Li & Logan, 1999; Yang et al., 2008; 2014; Yang & Singla, 2011). Kleinman (1988) states that ‘the family with a mentally ill member is regarded as carrying a hereditary trait of moral failure and constitutional vulnerability’ (p.109). This conceptualisation of stigma as ‘a person’s loss of moral standing’ has a significant impact on the ‘opportunities for individuals to marry, have children, and perpetuate the family structure’ (Yang & Kleinman, 2008, p.406). Understood in this way, the stigma associated with mental illness is not limited to individual people with mental health problems, but also affects their families and social groups (Kleinman, 1988, p.108; Yang et al., 2007; Yang et al., 2013).

In the context of Chinese immigrants in the US, Kleinman (2004) stresses that the diagnosis of depression is ‘morally unacceptable and experientially meaningless’ (p.951). This has implications for Chinese migrant communities in terms of the provision of healthcare services in the context of biomedicine, for example the National Health Service (NHS) in the UK (Green et al., 2002; Li et al., 1999; Li & Logan, 1999; Tran et al., 2008; Yang et al., 2014). In this respect, Yang and Singla (2011) report that as well as being associated with the diagnosis and labelling of mental health, stigma and shame are also associated with the use of western psychiatric services. They explore the use of local idioms for mental health disorders, such as ‘excessive thinking’ as a culturally acceptable label for schizophrenia. They stress that whilst the use of such idioms may have protective effects for patients and their families, this can be problematic in terms of help-seeking and treatment for these kinds of illnesses. This helps to illustrate the problems of morally
unacceptable and meaningless diagnoses; this is particularly important in the context of Chinese communities outside Chinese countries (such as the UK and the US) where there are multiple, and often competing, cultural and social influences that shape responses to illness and treatment.

3.5 Medical pluralism: TCM and Biomedicine

Various studies report the combined use of TCM and biomedicine among the Chinese population in the UK (see for example Gervais & Jovchelovitch, 1998; Green et al., 2006; Jovchelovitch & Gervais, 1999; Liu et al., 2015; Long et al., 2015; Yu, 2006). Such studies of medical pluralism focus primarily on health care choices concerning the use of TCM and/or biomedicine. However, they are also concerned with the social representations of health and illness and how these shape the ways in which people understand and respond to health and illness more generally (Jovchelovitch & Gervais, 1999). Jovchelovitch & Gervais (1999) state that ‘health beliefs and behaviours are constructed against a background of constant social interaction and negotiation where allegiance to social identity, group norms, and cultural traditions play an influential role’ (p.248). They add that ‘the factors which shape the choices people make about health-related behaviours and practices […] range from concrete conditions of living, to the particular patterns of interaction and communication within any given community, to the lay and cultural knowledges that guide the interpretative frameworks used to make sense of health and illness’ (p.248). This suggests that whilst cultural factors are important within decisions about health care choices, this is also a matter of making practical choices. To this end, Green et al. (2006) show that the Chinese women migrants in their study made pragmatic choices about health care, drawing on both TCM and biomedicine and expressed a ‘willingness to use whatever therapy was available’ (p.1503). Similarly, alongside a consideration of cultural factors, Rochelle and Marks (2011) highlight other factors that influenced choices about health care among the Chinese people in their study, such as cost, convenience, speed of recovery, availability of medicine and accessibility of health services (p.401).
Although TCM and biomedicine are perceived as oppositional, and even clashing, medical systems, Kaptchuk (2000) suggests that there is a complementarity between them. He demonstrates this by saying that despite different descriptive language and terminology, each system can treat conditions of the other. For example, he states that:

‘…the Chinese refer to certain diseases as being generated by “Dampness,” “Heat,” or “Wind.” Modern western medicine does not recognise Dampness, yet can treat what Chinese medicine describes as Dampness of the Spleen. Modern western medicine does not speak of fire, but can, from a Chinese perspective, stoke the fire of the Kidney or extinguish excess fire raging out of control of the lungs. In western medicine, Wind is not considered a disease factor; yet western medicine is able to prevent Liver Wind from going to the head, or to extinguish rampaging Wind in the skin. The perceptions of the two traditions reflect two different worlds, but both can affect and often heal human beings regardless of their cultural affiliation.’ (Kaptchuk, 2000, p.3).

Similarly, Jovchelovitch & Gervais (1999) suggest that ‘Chinese and western knowledge combine to construct a mixed representational field wherein these two types of knowledge co-exist and complement each other’ (p.253).

This complementarity is also shown in the understanding that TCM and biomedicine work in different ways to treat different kinds of illnesses. For example, Rochelle & Marks (2011) report that in their study, TCM was perceived to deal with the cause of illness (rather than just treating the symptoms), to be gentle on the body (because it is derived from natural substances) and to work more slowly than biomedicine (p.396). Conversely, biomedicine was viewed as more convenient and working more quickly, but also as being more toxic to the body (p.397). These are views that are also reflected in other studies (Gervais & Jovchelovitch, 1998; Green et al., 2006; Jovchelovitch & Gervais, 1999; Liu et al., 2015; Prior et al., 2000; Rochelle & Marks, 2010).

Jovchelovitch & Gervais (1999) link this perception of the complementarity of TCM with biomedicine (working in different ways to treat different kinds of illness) and choices about healthcare in the face of this (and other structural factors) with the discourse around cultural adaptation and identity. They argue that more than simply being choices about
health care, the mixing of TCM and biomedicine is integral to ‘the struggles over identity experienced by the Chinese people in England’ (p.248). They add to this that the mixing of TCM and biomedicine among the Chinese in England is fundamental in the ‘maintenance of a cultural identity’ (p.253).

3.6 A note about the participants in the study

Long et al. (2015) caution against the uncritical use of the term ‘Chinese’ within studies of Chinese populations in the UK. They contend that the label ‘Chinese’, as it used to describe a diverse minority population, lacks both clarity and complexity, and they call for an engagement with the migration patterns which have shaped the nature of the Chinese population in the UK (p.116). In this study, the community centre is identified as a Chinese community centre, and the participants are identified as Chinese (from different origins). However, as Long et al. (2015) highlight, there is clearly diversity among the members of the centre, in terms of the countries of origin, the languages spoken, and the routes of migration. Whilst acknowledging that using the term ‘Chinese’ to describe the centre and its members may be problematic, this study focusses on this group of participants as a particular generation of migrants, who have lived their lives in different social and cultural circumstances than both the younger UK-born generation of Chinese people in the UK, and the more contemporary generation of Chinese migrants coming into the UK. The migration experiences of the research participants are approached as experiences of migration that are shaped by gender and that are historically, socially and culturally situated. In the day-to-day activity of the community centre, there is a sense of belonging and community, rather than an emphasis on difference. Although the research participants told me their individual stories, there was a collective sense of these experiences that drew people together, rather than emphasised their differences, and that also played an important part in the enactment of a particular understanding of wellbeing at the centre. The focus of the study is to explore the sense of community and belonging - as it is linked to these shared/collective experiences of migration - that is enacted at the centre, and that is at the heart of what makes it a therapeutic place.
Chapter 4: Methodology

4.1 Introduction

Whilst ethnography is increasingly being used in health research (O’Reilly, 2012, p.24), this is often with some ambiguity, and it is noted that the terms ethnography and participant observation are often used interchangeably (Green & Thorogood, 2009, p.150). O’Reilly (2009) makes a clear distinction between these; that ‘ethnography is a methodology’ and ‘participant observation is a method’ (p.3). Madden (2010) makes this distinction in a different way; that ‘methods are what tools you use; a methodology is an explanation of why you use those tools’ (p.25). As an ethnographic study, this project reflects this distinction; ethnography in this study is not just a means of data collection, but a particular kind of inquiry about everyday life in a specific social and cultural setting. The interests at the centre of this project are about people, about their day-to-day lives, about their experiences and their views of the world, and the ways in which all of this influences their understandings of health and wellbeing. These are questions about human nature and about the ways in which people live and experience the world. Rather than things that can be measured in a quantifiable sense, these are things that concern meanings. In this sense, they are also things that can be difficult to uncover and to articulate; the ‘common sense’ (Brewer, 2000, p.14), or ‘the unspoken, unsaid, not seen, but sensory, and known elements of everyday life’ (Pink & Morgan, 2013, p.353), that help to explain why people act and think in certain ways. With this in mind, this chapter will outline and discuss the undertaking of this project as an ethnographic study; the understanding of ethnography in this context; the theoretical and conceptual orientations that underpin this; the activity of fieldwork; and the process of analysing and ‘writing up’ the data.

4.2 A note about reflexivity

Like all qualitative research, ethnography is not a neutral activity; rather, it is a ‘disciplined form of observation’ that is ‘historically, theoretically and personally defined’, requiring a critical reflection in order to understand ‘how it is our own ways of seeing, that produce
ethnographic representations’ (Madden, 2010, p.111-112). With this in mind, the importance of reflexivity in ethnographic research concerns the ‘inevitability of the ethnographer’s influence on the research process’ (Madden, 2010, p.2). This is about the presence of the researcher in the field site and their role in the process of collecting and interpreting data (Green & Thorogood, 2009, p.223) as well as the a priori assumptions that shape particular research projects. Encapsulating both of these elements, Van Maanen (2011) describes ethnographic writing as ‘the peculiar practice of representing the social reality of others through the analysis of one’s own experience in the world of these others’ (p.xiii). The purpose of reflexivity is therefore to critically account for the process of doing ethnographic research; to account for the context in which research takes place, as well as the ‘acts of research and writing’ (O’Reilly, 2009, p.189). Green & Thorogood (2009) suggest that ‘good practice’ approaches to reflexivity should include: methodological openness, theoretical openness, awareness of the social setting of the research, and awareness of the wider social context (p.223). These will all be addressed in this chapter.

With particular reference to conducting research with multi-ethnic or ‘other’ groups, Adamson and Donovan (2002) highlight reflexivity as an essential component in terms of the validity and rigour of qualitative research. Their concern is with the impact of social factors on the research process; in particular, issues of language and social status within multi-ethnic settings, as they impact on the relationship between researcher and research participants, and in terms of the understanding and interpretation of research data (p.823). These are issues that are relevant to this study; the research participants are Chinese migrants, mostly (but not all) women, aged 50 and over, who speak a mixture of Cantonese, Mandarin and English. I am a white British woman in my late 30s. I have no previous involvement with Chinese communities in the UK and I do not speak any Cantonese or Mandarin. What follows is a reflexive account of my approach to this research project with these issues in mind; particularly, critical reflections on my experiences during fieldwork, the relationships that I built with my research participants, my use of a key informant (who was also an interpreter), and the way that these have influenced the conceptual and analytical development of this thesis.
4.3 Ethical considerations

Ethical considerations in the conduct of qualitative research concern responsibilities and values towards the people involved in the research (Green & Thorogood, 2009, p.62-63). The basic principle of codes of ethical research practice is the responsibility to ‘do no harm to the people or the community under study’ (Fetterman, 2010, p.133). In terms of values, this is about the ‘right way to treat other human beings in a research context’ (Murphy & Dingwall, 2001, p.339). The particular nature of ethnographic studies - based on close contact with the research participants over a prolonged period of time - makes these responsibilities and values particularly pertinent (O’Reilly, 2009, p.57). In this respect, the primary ethical consideration in this study is around the responsibility to the research participants, and concerns issues of trust, confidentiality and representation. Whilst these are issues in their own right, collectively they also require a critical consideration of the conduct of the researcher more broadly. My conduct as a researcher in this study will be addressed in the following sections of this chapter; however, the more formal elements of ethical conduct are discussed here.

4.3.1 Procedural aspects

Approval from the University of Manchester Research Ethics Committee was granted for this project in May 2013, prior to the commencement of the fieldwork period (see Appendix A.1). Two amendments to the study methodology were also approved to include participant observation (see Appendix A.2) and focus groups (see Appendix A.3). This reflects the development of the study design in response to the study site and research participants (as discussed in Chapter 1).

I also attended Lone Worker Training, provided by the University of Manchester, prior to starting fieldwork. In terms of the potential risks presented by the particular circumstances of my fieldwork, these were minimal. The study site is an easily accessible public space and I was never there alone; there were always several members of staff and other centre members when I was there. Three of the formal interviews were undertaken at the research participant’s home, however I did not go alone to those. I was accompanied on all three

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3 The ethical approval letter gives the original project title. The change in title (to the title of this thesis) was also approved by the University of Manchester Research Ethics Committee (see Appendix A.4).
occasions by Mrs Z (my contact at the community centre) who had arranged those particular interviews on my behalf and who also acted as an interpreter during those interviews. At all times when I was on site conducting fieldwork I left full contact details with colleagues at the University.

4.3.2 Consent

The issue of consent for participation in research activities rests on the premise that participation in research should be voluntary, and that ‘individuals should not be coerced, or persuaded, or induced into research’ (Green & Thorogood, 2009, p.68). For the formal interviews in this study, participant information sheets and consent forms were used. These were translated into Cantonese and provided in either English or Cantonese as appropriate (see Appendices B and C). Those who chose to undertake a formal interview were asked to sign a consent form prior to the interview taking place.

In terms of gaining consent for observations, it can be difficult in a field site in which different people come and go throughout the fieldwork period, to gain consent from each and every person (Green & Thorogood, 2009, p.70). Different people used the community centre on different days, and at different points throughout the day, and it was therefore not possible to obtain written consent for observation from each individual at the centre every time I attended. However, a number of things were done to make sure that members of the centre knew who I was, that I was undertaking a research project at the centre, and that they could request not to be observed as part of my study if they wished to do so. I was given permission by the centre to undertake my research study there and to do so by observing and taking part in activities, as well as conducting formal interviews with the members of the centre. This was discussed and agreed at the centre team meeting with the manager and staff. A poster was displayed at the centre, in both English and Cantonese, with my photograph on it and details of my project (see Appendix D). Members of the centre were also informed verbally by the staff of who I was and that I was there to conduct a research project. They were told that I would be taking part in activities, observing, and making notes whilst at the centre, and that if they did not wish to be included in any of my notes or observations to tell either the centre staff of myself.
4.3.3 Anonymity and confidentiality

Issues of anonymity and confidentiality are about ‘protecting the privacy of those we are researching’ (O'Reilly, 2012, p.68). To this end, pseudonyms have been used in this thesis instead of participant’s real names. Excerpts from formal interviews are labelled with the pseudonym for the participant, their age and country of origin (Hong Kong, China or Vietnam). Excerpts from fieldnotes are labelled with FN and the date the notes were recorded. It is important to note that it is difficult to guarantee complete anonymity when research takes place in a setting such as this; even if privacy is ensured external to the site, it may still be possible to identity individual participants within the site (Murphy & Dingwall, 2001, p.341). In this respect, I have also removed other personal details from interview and fieldnote excerpts that I think would make the research participants potentially identifiable.

With regard to protecting the identity of the community centre, it is also difficult to guarantee complete anonymity. Although I have not used the name of the community centre in this thesis, I acknowledge that it is a well-known centre within the Chinese community in this region, and that it is easy to find with a simple internet search. My main priority however, has been to protect the identity of the individual people who are members of the centre and who took part in this study.

4.3.4 Representation

The issue of representation - what is written about research participants - is also a possible source of (indirect) harm to research participants; that they may be hurt or offended by what is written about them, not only by what is included but also by what is left out (Murphy & Dingwall, 2001, p.341). This is also part of the responsibility towards research participants, and particularly concerns the trust built up between the researcher and research participants. What I am presenting in this thesis is my understanding and interpretation of what was said to me, and of the things that I experienced, observed and heard during my fieldwork. My interpretation is drawn from my experiences, from my own theoretical and conceptual interests, and from the literature that I have drawn on in shaping this project (as outlined in Chapters 2 and 3). The interpretation presented here is therefore
what makes sense in terms of the topic of study that I started out with, in terms of my own experiences in the field site, and in terms of what has been written in other relevant studies.

4.4 Ethnography

As a research methodology, with its roots in anthropology and sociology (O’Reilly, 2009, p.3), ethnography is concerned with the study of everyday life and the ways in which people interact with one another in ‘routine or ritualised ways’ (Madden, 2010, p.16). In traditional anthropological studies, the researcher was expected to live amongst the people being studied and to be part of daily life as it was lived. It was thought that conducting fieldwork in this way, by ‘being there’, and by being immersed in the ‘field’, was essential for in-depth inquiry into the ebbs and flows of everyday life and for the detailed documentation of the people, place, or culture being studied (Emerson et al., 2011, p.2-3; Green & Thorogood, 2009, p.150-151; Silverman, 2006, p.71). In this respect, ethnography is a practice that ‘values the idea that to know other humans the ethnographer must do as others do, live with others, eat, work and experience the same daily patterns as others’ (Madden, 2010, p.16).

In terms of contemporary ethnography, used in the study of people and places closer to home (O’Reilly, 2009, p.110), the principle of immersion in the society that is being studied remains. Emerson et al. (2011) describe this as a commitment to ‘going out and getting close to the activities and everyday experiences of other people […] in order to grasp what they experience as meaningful and important’ (p.2-3). Immersion in this sense requires ‘both being with other people to see how they respond to events as they happen and experiencing for oneself these events and the circumstances that give rise to them’ (p.3).

4.4.1 Step-in-step-out ethnography

Madden (2010) uses the term ‘step-in-step-out ethnography’ to describe circumstances in which ‘ethnographers work in familiar settings, and they [may] spend only portions of days
‘in the field’ and return to their homes at the day’s end to write up notes and debrief’ (p.80). Although this may be seen to be a departure from the traditional mode of anthropological fieldwork - of complete immersion in the field site over a long period of time - Madden argues that step-in-step-out ethnography is based on the same fundamental principle; that ‘the ethnographer wants to get as close to the participants as they can in the time given, and yet maintain their critical ethnographic position’ (2010, p.80).

The idea of step-in-step-out ethnography reflects the way that I conducted the fieldwork for this study. The community centre is open 4 days a week, from 9.30am to 4.30pm, and is within easy travel distance from my home. On my fieldwork days, I spent part of the day ‘in the field’ and part of the day writing up my fieldnotes, either at the University or at home. This also reflects the way that the participants in this study used the centre; they do not live there, they go to and from the centre regularly (some more often than others) to do specific things and to be with each other. It is part of, but not the entirety, of their day-to-day lives. As Madden suggests, my aim was to take part in day-to-day life at the community centre, in the same way that the centre members do, to observe and to be there as far as I could in the time that I had available for fieldwork in this project.

4.4.2 Studying place

Writing about the study of place, Gelser (1991) argues that ‘one can study a given place properly only by becoming immersed in the environment and activities of, and the interactions among, the people who live in that place. One has to see for oneself, walk the streets, perhaps even live with one’s subjects’ (p.182). He adds that ‘only in this way can one understand the values, feelings, and intentions of people, and the meanings they ascribe to localities’ (p.182). This reflects the orientation to ethnography in this study; being in this particular place with these particular people in order to explore their understandings of health and wellbeing as they are enacted within this place. The aim is not to present life in this Chinese community centre as a definitive account of Chinese culture, but to explore it as a place where people of the same generation, with similar social and cultural backgrounds and with similar migration stories come together as a community, and where a particular understanding of health and wellbeing is enacted through their interaction with each other, within this particular place.
4.5 A note about language in cross cultural research

Language is an important issue in terms of conducting cross-cultural and cross-language research (Adamson & Donovan, 2002; Bradby, 2002; Brämberg & Dahlberg, 2013; Caretta, 2015; Williamson et al., 2011). On a practical level, this concerns being able to build relationships with research participants and being able to talk with them, both in general day-to-day conversation, and in formal interviews. It also raises issues around meaning and understanding, and about the validity and reliability of the data that is generated.

The main language spoken at the community centre is Cantonese; some centre members also (and in some cases only) speak Mandarin, and some also speak English, to varying levels, including the centre staff. I did not learn Cantonese or Mandarin either before or during the process of fieldwork (apart from coming to recognise a few words). This was primarily because the timescale of this project did not allow for a period of language training prior to fieldwork, or for the fieldwork period to be long enough to learn the language as well as collecting data. Given that the study site is a specifically Chinese community centre, and that the centre members are all Chinese, this could be seen as a limitation to the study. However, day-to-day life is not conducted only in Cantonese, Mandarin or other Chinese dialects at the community centre, and the focus of the project was to explore the experiences and views of the centre members in the context of their lives in the UK. Most of the centre members have lived in the UK for the larger part of their lives and many of them have children and grandchildren who speak (in some cases only) English. This means that communicating in English, at least to some extent, is part of their day-to-day lives. This is not unproblematic however; many of them told me that they experienced considerable difficulties with language when they first came to the UK and many spoke about the changing use of language within their families.

A central interest in this project is the sense of ‘in-between-ness’ in the community centre; between life as it was in the country of origin then and life as it is in the UK now. The way in which day-to-day life is conducted in this ‘in-between’ space - sometimes in English, sometime in Cantonese or Mandarin, sometimes in a mixture of both - is part of the process of negotiating meaning within this place, and within the centre members’ lives in the UK. This is not to say that language is therefore not a difficulty in the context of this
study; however, it is a relevant one, and one that is not insurmountable. Issues around the practicalities of fieldwork in a multi-language setting, about meaning and understanding, and about the validity and reliability of the data, will be addressed in the following sections on participant observation and ethnographic interviews, as the two elements of fieldwork in this study.

4.6 In the field: participant observation

Participation and observation are generally viewed as two different but connected activities. Put very simply participation is about ‘being with people’ and observation is about ‘observing people’ (Madden, 2010, p.77). The point of making this distinction is that with participation and observation, the position of the ethnographer, with regard to his or her relationship with the field and those being studied, is different. As a participant, the ethnographer ‘joins in with the normal activities and routines of the participant group’ (Madden, 2010, p.77); however, observation requires ‘an element of standing back intellectually and reflecting on things, writing them down, and thus objectifying them’ (O’Reilly, 2009, p.152). O’Reilly (2009) suggests that participation and observation occur along a continuum between ‘full immersion in the setting or culture to very minimal participation’, and that the position of the ethnographer along this continuum shifts in response to the practicalities (as well as other considerations) of conducting fieldwork (p.161). This movement, between participation and observation, is reflected in the nature of my fieldwork in this study; I was able to switch between joining in and standing back as appropriate, and in response to what was going on at the centre whilst I was there.

4.6.1 My fieldwork

The fieldwork for this study was conducted over a period of ten months between August 2013 and May 2014. I regularly attended the community centre twice a week to learn Tai Chi and to eat lunch with the centre members. I also joined in with the dancing group on a number of occasions and towards the end of the fieldwork period I also took part in the calligraphy group. In addition to these regular activities, I also took part in a World Tai Chi Day event and a Tai Chi and cultural exchange day at another (non-Chinese) community
centre with the Tai Chi group. I also observed two health consultation sessions that took place at the centre, and I attended an AGM (in 2014) of the organisation that the centre is part of. I did not take an active part in either the health consultation sessions or the AGM; for these I was purely an observer. In addition to the above, I also conducted 21 formal interviews and a focus group with centre members (to be discussed later in this chapter).

Both my entry to and my exit from the study site were relatively straightforward. My entry was negotiated through Mrs Z, the key informant in this project, who is a member of staff at the community centre (discussed later in the chapter), and who I met with on several occasions at the centre prior to starting fieldwork. Although I began fieldwork in August 2013, I did not conduct any formal interviews until January 2014. This was deliberate; I wanted to spend time there, to become an ‘expected participant in group life’ (Fine, 2003, p.53), for the members to get used to me being around and to begin conversations without the formal arrangements of an interview setting. However, I was from the very beginning, open about why I was there. When I was asked, I explained that I was a student at the University, that I was doing a research project about migration, health and illness, and that Mrs Z had invited me to the centre to do my project there. Each new group or activity that I joined in with, I was introduced by Mrs Z, in this way. In this sense, I tried to be at all times throughout the fieldwork period, an ‘overt’ participant observer (O'Reilly, 2009, p.49).

For the majority of the time that I spent at the centre, I took part in what was going on alongside the centre members. For some events, I was purely an observer, sitting to one side, watching, listening, and sometimes taking notes. On other occasions, I joined in with part of a group or activity, but also spent some of the time sitting and watching.

Leaving the study site was unproblematic; I was due to go on maternity leave so I left the study site in order to have my baby. There was no further explanation needed and most of those with whom I had the most contact knew that I would be returning to the University following a period of maternity leave; that my departure from the centre was not the end of my project.
4.6.2 Building relationships in the field

The nature of the relationships that are established with research participants in the field are a major factor with regard to the quality of the data that is collected and the ethnographic account that is produced (O’Reilly, 2009, p.175). The need to build rapport and trust with research participants is particularly important in ethnographic research where the researcher may be in the field for a long period of time; this is not just about generating rapport in order to gain access to the field, but is about building and maintaining relationships, based on trust and mutual understanding, throughout the fieldwork period (O’Reilly, 2009, p.174-175). This requires building trust, over time, by ‘being there day in, day out’ (O’Reilly, 2009, p.175) and becoming an ‘expected part of life’ (Fine, 2003, p.53).

This was particularly important given that several of the participants said to me that the Chinese community is a ‘closed’ community. Mrs E, who goes to the community centre regularly, explained to me that it is the Chinese way to stick together and to keep things to themselves. She held her hands together over her chest when she said this, indicating that she meant emotional, or personal, things. Mrs Z also made the same comment; that it would be difficult to conduct a research project at the community centre with this particular group of people without spending time there and building up a relationship with them before attempting to ‘research’ them.

As is to be expected, I got to know some centre members better, and more easily, than others. Those who I got to know particularly well spoke good English and we were able to talk together easily. The women in the Tai Chi group always gathered at one of the tables to drink tea and chat before class began. When I realised this, I started to go to the centre earlier so that I could also sit and drink tea with them before class. Mrs E was usually the first one to arrive and we had many conversations in those half hours before the class started when no one else was around. As I continued to talk with and get to know her, I also got to know others; there were many times when she involved me in the conversations over lunch, translating for me, asking my opinion, or drawing me into the banter, and introducing me to other centre members.
Becoming an ‘expected part of life’ (Fine, 2003, p.53) and ‘being there day in, day out’ (O’Reilly, 2009, p.175) also means that there are other ways of building up relationships that do not rely on language (particularly in a multi-language site). There were a number of women at the centre who spoke very little English but with whom I felt I had managed to build a genuine relationship by the end of the fieldwork period. This was in part facilitated by my pregnancy (as discussed below) but also by being there ‘day in day out’. One lady, who spoke very little English, always greeted me with a smile and a nod of the head, but as I continued to regularly attend the centre, this gradually turned into grasping my hands or arms, then greeting me with a hug. Although we were not able to talk together, her actions towards me made me feel part of the centre and included in the care with which the centre members treated each other.

*I held the door open for Mrs AX and another lady too, and when Mrs AX went through the door, she sort of skipped up to me with a glint in her eye, bent her head down to my bump, said ‘hello baby’ and then carried on walking through the door!* [FN39-09.4.14]

4.6.3 Embodied participation: pregnancy and fieldwork

Madden (2010) suggests that embodiment is an important element of ethnographic fieldwork. He is interested in the way that the ‘subjective experience of being in the field write[s] itself onto the ethnographer’s body and into ethnography’ (p.82). The point here is that participation in ethnographic research also involves a ‘bodily presence’ (Gesler & Kearns, 2002, p.42). Madden approaches this in terms of the process of becoming ‘comfortable with, and comforting to, the people around you’ and suggests that the ‘ethnographer’s body needs to acquire some competence relevant to the participants he or she is working with’ (2010, p.83). A large part of my fieldwork involved learning to use my body in the same way as the centre members; for example in the Tai Chi and dancing classes (see Figure 1. below), learning to eat properly with chop sticks, and learning to use a brush and ink to write Chinese characters.
Thinking about the idea of embodied participation, as a bodily presence in the field site, also allows for a critical reflection of my experience of being pregnant whilst conducting fieldwork in this study. Becoming pregnant during my fieldwork period changed the way that I experienced being a part of the community centre. Family was an important topic of conversation throughout my fieldwork, both before and during my pregnancy. It was one of the first things that people asked me every time I met someone new, and was often discussed in subsequent conversations as I got to know people better; if I was married, if I had children, and where my family lived. As a first conversation, these things seemed to be important in establishing who I was. I came to understand that for the women at the community centre, family and children are the main priorities for Chinese women of their generation; this was expressed explicitly by several of the women I spoke to and got to know, both in informal conversation and in formal interviews. I had many conversations about babies and children and was advised (by the women in particular) that I should get on and have babies as soon as possible if I wanted to. It is in this respect that I think that becoming pregnant was a turning point in my relationships with the centre members. Prior to becoming pregnant I was somewhat of an oddity; I was not Chinese, I was not the same age as the other centre members, I was not a member of staff, I was not in any way part of the broader Chinese community, and I was a married woman without children.

Being pregnant changed this; it meant that I became something more recognisable, and it gave me something that I could share with the centre members, which they could easily relate to. For the women especially, they were able to advise me, to express concern, and to show me care in the way that they would have done with a woman in their own families or social groups. They could be part of my experience, and they could share their experience, knowledge and wisdom about pregnancy, birth, motherhood and families with me. I had...
many conversations that began with someone asking me about my bump that lead to talking about other things that were directly relevant to my study. They also gradually became more and more tactile with me; they often wanted to (and did) touch my bump, or talk to it, or put their ears to it to listen, and they commented on my figure and changing shape and the growing size of my bump. Being pregnant opened up a space between myself and the centre members in which we could talk about family and babies, as well as other things; personal things about their lives, their experiences and their views on life that we might not otherwise have talked about, or that they might not otherwise have shared with me. Being pregnant made me not just a researcher, but a younger woman they could advise, guide and take care of. This is the space in which my fieldwork took place.

In terms of understanding the nature of participation in ethnographic research, this highlights the difference between participation as joining in, or doing the same things alongside research participants, and participation in a different, more integral way. This is about gaining acceptance and gradually moving from ‘outsider’ to ‘insider’ (O’Reilly, 2009, p.110). This also highlights the need for reflexivity; that is, a critical reflection on the ways in which the experiences in the field shape the subsequent analysis and writing of an ethnographic account. In this respect, it is important to note that it was not until I returned from maternity leave and began to re-engage with my data and to draw on theoretical ideas and relevant literature that I began to understand what I had experienced in the field. The process of stepping back from those experiences and engaging critically with relevant theory allowed me to ask questions about and understand the relevance of my experiences for the development of this thesis.

4.6.4 Fieldnotes

On the whole, I wrote fieldnotes elsewhere; either at home, at my desk at the University, or somewhere in between. Where possible, these were written immediately after a period of fieldwork, as a sort of debrief at the end of each day. Occasionally, I wrote notes at the centre, if I was observing rather than joining in, but not often. This was mainly out of practicality; it was hard to join in with a Tai Chi class, or to eat lunch, whilst also writing notes at the same time.
The content and nature of my fieldnotes changed throughout the fieldwork period. My notes began as mostly descriptive as I became accustomed to the centre; to what went on, to the people that came and went, to the sounds and smells that were a regular part of everyday life there. This was a process of familiarising myself with the place and the people, and of coming to know what was expected or usual activity at the centre. Gradually, I began to note the things that were different as well as what was usual. With this understanding, I became more critical in my observations and began to ask questions about what was going on, rather than just recording it (see Appendix E for examples of fieldnote excerpts).

As well as providing a detailed record of the fieldwork period the fieldnotes also show that analysis is not a separate activity that takes place at the end of fieldwork, but is part of the whole process of ethnography (Fetterman, 2010, p.93). The fieldnotes - and the process of writing them - form the beginnings of analysis through the engagement with the data collected, so that coming to formally analyse and write was more of an extension of writing done in the field than a separate activity (although in my case, this was separated by my maternity leave).

**4.7 Mrs Z**: Gatekeeper and collaborator

Mrs Z is a member of staff at the community centre. She has been involved with the centre since 1993, and has had various roles; she began as a volunteer, and later became a mental health development worker before her role changed to community development worker. Her current role (as community development worker) involves organising and facilitating activities and events at the centre, making home visits and providing care in the community for elderly Chinese living in the area. She is very committed to her work supporting the local Chinese community and often spoke about funding opportunities that she was pursuing and projects that she wanted to set up at the centre. She was open about this being her motivation for getting involved in my project when I first got in touch with her; that she saw it as an opportunity for the centre to benefit from my research and to gather evidence that might help her to find extra funding for the centre. Mrs Z trained and

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6 As with all other participants in this study, this is a pseudonym, and not Mrs Z’s real name.
worked as a nurse in Hong Kong and has undertaken her own research with the Chinese community in the UK as part of her MPhil. She was also undertaking training to be a counsellor during the time of my fieldwork. She has a good understanding of the health needs of this community and was able to articulate this to me in terms of both Chinese and western orientations to health and illness.

As noted above, it was through Mrs Z that I was able to negotiate access to the community centre. She was the first person that I had contact with at the centre and she was involved in the entire fieldwork period in a variety of ways. She invited me into the centre, introduced me to the centre members and staff, involved me in events and activities, arranged interviews for me, translated my research materials and also acted as an interpreter in several interviews (to be discussed later in this chapter). In this sense, she was very much a gate keeper; she granted me access to the centre and gave me permission to be there (O’Reilly, 2009, p.132).

She also acted as a ‘cultural broker’ (Fetterman, 2010, p.50) and was a source of knowledge about the centre members’ lives and world views. She was able to explain things to me about Chinese understandings of health and illness and about the upbringing and generational traits of the centre members. She included herself in these explanations, saying ‘this is how we were brought up’, ‘this is a concept that we have in Chinese’, so that it was clear that she sees herself as part of this community as well as working to support it. Whilst this was hugely beneficial in terms of her involvement in my project, it is also a reflection of her role at the centre; that she needed to be able to articulate the needs of the Chinese community she works with in order to find ways of providing support to them. This also resonates with the idea of ‘enculturated informants’ as people who ‘know their culture well’ (Spradley, 1979, p.47) and who are ‘consciously reflexive about their culture, and either enjoy sharing local knowledge or are in a status position where this is expected of them’ (O’Reilly, 2009, p.133).

Although Mrs Z was a key informant (O’Reilly, 2009, p.133) in this project in terms of access and cultural brokering, she was primarily a collaborator and a source of advice and support, rather than a research participant. She had a good understanding of the research process (from her own research) and I felt that we were able to communicate clearly about what I wanted to do. She was able to advise me on how to go about things appropriately in
the centre, and I was able to discuss my progress, thoughts and plans for my project and data collection with her throughout the fieldwork period. I did not collect her migration story or speak specifically to her about her health in the way that I did with other centre members; some of these things arose naturally in our conversations, but I did not interview her in this way. The formal interview that I did conduct with her was focussed on discussing my ideas for analysis of the data. I saw this as an opportunity to cross-check my understanding of the data that I had collected and to seek her thoughts about my conceptual orientation to this. Although I am aware that some caution is needed with this level of input from an informant, and that she had her own interests in being involved in my project, this was an important step in the analysis of my data, in terms of ‘put[ting] the whole situation into perspective’ (Fetterman, 2010, p.94).

4.8 In the field: ethnographic interviews

As noted above, alongside participant observation, I also conducted 21 formal interviews with centre members. Heyl (2001) makes a distinction between qualitative interviews more generally and ethnographic interviews, which she describes as interviews that take place within already established and on-going relationships (p.369). Although Heyl’s emphasis is on the establishment of relationships with participants prior to conducting interviews, O’Reilly (2009) argues that ethnographic interviews are also part of building those relationships, because they seek to understand the views of participants from their own perspectives (p.128). Alongside this, Fetterman (2010) highlights the use of interviews in ethnography in relation to issues of validity and rigour. In this sense, the purpose of conducting interviews in ethnography is about comparison and representation; that is, ‘comparing responses and putting them in the context of common group beliefs and themes’ (p.40). Similarly, Madden (2010) suggests that the purpose of ethnographic interviews is to elicit descriptive, structural and comparative responses from research participants (p.73).
4.8.1 Conducting interviews in this study

As already described, the interviews in this study were conducted part way through the fieldwork period. This meant that the majority of interviews were conducted in the context of already established relationships (as Heyl describes), which were also maintained after conducting interviews, as I continued to attend the centre. With regard to language - in terms of meaning and understanding - this was particularly important; partly in terms of allowing participants time to feel comfortable speaking with me in English (as a second language), and partly in terms of generating a context in which to place my understanding of what was said in interviews.

The interviews were semi-structured and an interview schedule containing questions concerning the three main areas of interest within the study was used: migration experiences, understandings of health and illness, and family (see Appendix F). The schedule was not used rigidly, but as a flexible guide, and a prompt where needed. This allowed for an approach in which although the same broad topics were covered in each interview, the participants were free to speak more or less about each of those as per their own interests. To this end I tried to use mostly open questions, such as ‘can you tell me about….?’ or ‘can you explain that to me….?’. In some instances it was difficult to ask open questions, for example ‘Do you use Chinese medicine?’. These were followed up with more open questions, about the choices that the participants made and the reasons they gave for those choices, such as ‘can you tell me why you think that?’.

For the part of the interview that concerned the participants’ family, I drew a (very rudimentary) genealogy as a means of prompting discussion about the composition and the relationships within the families; who the members of the family were, where they lived and the means of communication between them. The intention was not to reproduce these as genealogies, but to use this as an aid to discussion; so that we could easily identify members of the family in order to talk about the relationships and connections between them.
4.8.2 Participants in this study

The members of the community centre in this study are predominantly first generation Chinese migrants, from Hong Kong, China and Vietnam. Most of the centre members are retired, although a few still work part-time or help out in their children’s takeaway shops, and they range in age from late 50s through to early 80s (and some older than this). Most have children and grandchildren in the UK (or somewhere other than their country of origin) and most have a few relatives (parents, siblings) in their country of origin (with some exceptions).

Among those who I formally interviewed, the most common reason for migration to the UK was marriage; either to get married in the UK, coming to the UK with their spouse having got married in their home country, or coming to join their spouse who had come over to the UK before them (see Appendix G for a summary of the participants who were formally interviewed in this study). Most of them arrived in the UK in the 1970s (with a few exceptions), meaning that all the centre members who were formally interviewed had been in the UK for at least 30 years. Many of them had come to the UK to join other family members (mainly on the husband’s side) and had owned and worked in family-run restaurants and takeaways reflecting the association with this wave of Chinese migration into the UK (as discussed in Chapter 3). Three of the members formally interviewed were refugees from Vietnam and the remaining interviewees stated the main reason for migrating to the UK was to join family or to earn money/get a job. There was a range of health problems among the group of interviewees. These included diabetes, arthritis, high blood pressure, high cholesterol, heart trouble, depression and anxiety. Some had one of these, some had a combination, and some reported no health problems at the time of the interview.

The research participants that were formally interviewed represent a proportion of the members of the community centre who were physically active, who were able to come to the centre on their own, and who were engaged in the regular activities at the centre (to

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7 In this study first generation migrant refers to people born outside the UK, but permanently settled and residing in the UK. This does not include UK-born members of Chinese families (i.e. children and grandchildren). In the literature around the Chinese population in the UK (and around migrant communities more generally) the differences in experiences of different generations is noted with regard to the diversity of migrant communities, and particularly around issues of cultural adaptation and identity.
different extents). There were other members who were older and less physically able, who relied on the minibus service to come to the centre and whose participation in the centre was mainly through the communal lunch and through playing mahjong, rather than through the more physical regular activities (i.e. Tai Chi, dancing and ping pong).

Of the 21 interviews that I conducted, 19\(^8\) were with centre members, one was with the Tai Chi Master and one with Mrs Z\(^9\). I had already had some contact with most of the participants prior to conducting interviews with them; some I had had many conversations with and some less so. Mrs Z arranged seven of these interviews on my behalf and was present at those interviews as an interpreter. For one of those participants, the interview was the only contact we had; I did not see her on any other occasion during fieldwork, although she had regularly attended the community centre in the past. Three interviews took place in the participant’s home; Mrs Z was present at these. All other interviews took place at the community centre. All of the interviews (except one\(^{10}\)) were audio recorded and all were transcribed (issues around the process of transcription will be discussed later in this chapter).

Not all of the centre members that I asked were willing to be interviewed. Several declined, saying that they did not want their (personal) business to be discussed. However, I did have ongoing informal conversations with those people during the fieldwork period, sometimes about the topic of the study. In this way, they are also part of the data collected and the views that are represented in the following chapters, even though they did not take part in a formal interview.

4.8.3 Focus group

In addition to the formal interviews, Mrs Z facilitated an informal focus group on my behalf. This was intended as a way of further exploring some of the key ideas that had been

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\(^8\) This included 18 individual interviews and 1 interview with 2 participants, making a total of 20 interviewees.

\(^9\) The interview schedule was not used in the interviews with the Tai Chi Master and Mrs Z. The interview with the Tai Chi Master was focussed specifically on her experiences and knowledge of Tai Chi, and the interview with Mrs Z was focussed on the nature of the community centre, and my analytical approach to the data that I had collected about the centre and the centre members.

\(^{10}\) One participant said that she did not want the interview to be recorded. Detailed notes were taken during this interview and written up immediately after the interview had taken place.
raised in the formal interviews. This took place at one of the regular sessions of the calligraphy group and followed the same format as their usual sessions; that they would discuss and practise writing about a specific topic. Mrs Z had announced at the session the previous week that they would be discussing the topics relevant to my study in this session; health, wellbeing, happiness, family and migration. Thirteen centre members, two members of staff, myself and another student were present at the session. Mrs Z made the introductions at the beginning of the session; reminding them who I was, that this was for my PhD study and asking them to sign a consent form for the session to be audio recorded. Mrs Z did this in Cantonese but we had discussed beforehand what she would say. The size of the group, spread out around several large tables pushed together, with enough space for everyone to write, made it difficult to hold one group discussion across the table. However, slowly people started to discuss the topics with the people they were sitting near to, and it settled into their normal pattern for the session; writing and talking amongst themselves. Although this did not work particularly well as a structured focus group, and the individual conversations were not picked up in the audio recording, I was able to speak at length to a number of the people with whom I had not previously had much contact. In this respect, it was a very useful exercise.

4.8.4 Using an interpreter

The use of an interpreter in cross-cultural interviews raises additional issues around the validity and reliability of research data (Brämberg & Dahlberg, 2013, p.246). These centre on the question of meaning and understanding and have both practical and theoretical implications. Collectively, this is about the role of the interpreter in the generation and interpretation of interview data, and the relationship between the researcher(s) and interpreter(s) in this respect (Bradby, 2002; Caretta, 2015). The preparation of interpreters prior to conducting interviews and the involvement of them in post-interview discussion are advocated as ways of mitigating some of these issues (Adamson & Donovan, 2002; Brämberg & Dahlberg, 2013; Williamson et al., 2011). These strategies are discussed here with regard to Mrs Z’s involvement as an interpreter in this study.

Seven of the formal interviews for this study were conducted in Cantonese with Mrs Z present as an interpreter. These participants relied on Mrs Z to interpret to varying degrees;
some relied on her entirely, some understood the questions that I had asked in English but replied in Cantonese, others used a mixture of English and Chinese using Mrs Z to explain things that I had said that they did not understand, or to explain things to me that they could not say in English themselves.

Mrs Z is not a trained interpreter; however, as noted above, she is a member of staff at the community centre, and is known to the centre members in this capacity, as an advocate and a source of support. It was clear throughout the fieldwork period that Mrs Z is a person that the centre members trust and respect, and with whom they talk easily and comfortably. In terms of the focus of the study, she has a good understanding of the centre members’ migration experiences, the particular health problems among the group and their attitudes towards health and illness. In this respect, where she may not have the language skills to translate word for word what was said, she has an implicit understanding, through her similar background and experiences, and through her ongoing work with the centre members, to be able to convey the meaning of what was said. Brämberg & Dahlberg (2013, p.245) advocate this approach - of focussing on meaning rather than reproducing a word for word account - in the three way interpretation of data that occurs when an interpreter is involved in the interview process.

In terms of including the interpreter more fully in the research process, Mrs Z’s involvement in this study was considerably more than just being an interpreter. She was an integral part of the process of conducting fieldwork and a valuable source of cultural knowledge. With regard to preparation prior to conducting interviews, we discussed what her role as interpreter should be. She was clear that she was not speaking on behalf of the participants but that her role was to report, as faithfully as she was able, what had been said by the participants. During interviews, she often checked with the participant that she had understood correctly what had been said before, or in the midst of, communicating that to me. Equally, she was careful not to speak on my behalf, repeating questions participants had asked for me to answer rather than answering on my behalf. There were occasions where she added to what the participant had said, or offered an additional explanation, for my benefit, but she made it clear when this was the case; that they were her words, not the participants’. In this respect, I felt able to trust her understanding of her role in the interview process. Adamson & Donovan (2002) also suggest that interpreters should be involved in post-interview de-briefs and discussions, in order to clarify meanings and
Multiple translations, back-translating and cross-checking are also suggested as ways of ensuring the validity of the data generated in cross-cultural interviews (Williamson et al., 2011). I did not have the resources in this project to cross-check the interview data in this way. However, as I conducted all of the interviews myself - some with Mrs Z as an interpreter, but most without - I was able to check for consistency across the interviews. Whilst there were differences in the dynamics of the interviews, there was little discrepancy in terms of the ‘essential meanings’ (Brämberg & Dahlberg, 2013, p.245); these resonated across all the interviews, with similar ideas expressed in similar ways. All the interviews were not of course the same; participants recounted different experiences and different views, in varying degrees of detail, but in terms of the central meanings, there was enough consistency for me to feel confident in Mrs Z’s skills in interpreting.

Brämberg & Dahlberg (2013) note that the presence of an interpreter presents a challenge to ‘the desired openness and immediacy’ of the interview process, because ‘immediate contact between the interviewer and informant is frequently interrupted’ (p.242). In terms of the dynamics of the interview, there was a difference between the interviews where Mrs Z was present as an interpreter and the interviews that I conducted on my own. Some degree of variability is expected here; in what the research participants want to talk about, what they choose to disclose and how candid they choose to be. It is also to be expected that some participants are naturally more open, or more guarded, than others, because they are different people. The nature of the relationship with research participants also has a bearing on the interview dynamics; as noted above, I had had contact with most, but not all of, the interviewees prior to interviewing them. With the interviews that Mrs Z arranged on my behalf, the trust was placed in her rather than in me; this was about her relationship with them, and at the same time, her relationship with me. Although it has been suggested that a prior relationship between an interpreter and research participants may potentially negatively affect the interview situation (Williamson et al., 2011, p.383) in the case of this study, this was a significant benefit. Research participants were willing to talk to me, through their trust in Mrs Z.
4.8.5 A note about transcription

The majority of the interviews in this study were transcribed professionally; the remaining few I transcribed myself. This was a decision that was made mainly in terms of time; as I came to the end of conducting interviews and the end of my fieldwork period, I was due to go on maternity leave and did not have time to transcribe the interviews myself before going on leave. However, on my return to study, I spent a considerable amount of time reading through the interview transcripts and checking them against the recordings. This was partly a process of re-familiarising myself with the data, but also an important process of checking the accuracy of the transcripts against the recordings.

Despite none of the interviewees being native English speakers, the majority of interviews were conducted in English, and the remainder were conducted in Cantonese with an interpreter, who was also not a native English speaker. Most of the interviewees, and the interpreter, had distinct Chinese accents which were, in place, difficult to decipher on the recordings. Whilst the flow of conversation was good, in terms of what the interviewees were talking about, there were many sections of speech where the interviewee stumbled, or hesitated over particular words, or where the grammar and sentence structure were not fluent. This raised issues about the way in which I wanted to represent the conversations that I had had with my research participants. In this respect, I made the decision to do some tidying up of the transcripts; for example, by removing ‘ums’ and ‘ers’, mispronunciations of words, or stuttering whilst participants searched for the right words. I made this decision because I felt that in some places the thoughtful and intelligent way in which the research participants spoke about their views, opinions and experiences, was lost in the sections of stumbled speech, as they were represented on paper. I acknowledge that this is in effect another layer of translation - from spoken to written word, or from voice to page - and that the concern here is that in this additional process of translation the meaning of what was said is not lost or altered.

One of the benefits of conducting fieldwork over an extended period of time, as described above, was that I was able to build up relationships with my research participants that allowed me to have a deeper understanding of their lives, their experiences and their viewpoints. It also enabled me to get used to the particular ways in which they expressed themselves in English; for example, the turn of phrase, the tone of voice, the mannerisms
and non-verbal communication that go alongside speech - a lot of which is lost in the process of transcription. This meant that where participants did speak falteringingly in an interview, or stumble for particular words, I had other conversations with them (and others at the centre) that enabled me to understand what they were trying to express. This is an understanding that I would not have had from only conducting a single interview with each participant, and which mitigates some of the issues of accuracy (as above) within the transcripts. Conducting fieldwork over an extended period of time also means that there is additional data, in the form of fieldnotes, with which to check what was expressed in interviews. The detailed record of observations, conversations (often repeated, in terms of topic/subject) and my own experiences, help to contextualise the formal interviews. This enables me to represent the views and experiences of my research participants with confidence, and to ensure that the meaning and understanding of what was said is not lost in the processes of transcription.

It is also worth noting here that the way in which I have recorded conversations in my fieldnotes raises similar issues around accuracy and representation. In most cases, I have not recorded conversations word for word, in the way that an interview is formally recorded, but from memory (usually immediately after a period of fieldwork). It could be argued that this is not an accurate recording of a conversation/interaction, but I would apply the same principles as above; that these are not one-off interactions, and that my understanding is contextualised by other data and by the depth of the relationships that I built up over the period of fieldwork. As such, the meaning and understanding of conversations is not lost despite not being recorded exactly word for word.

4.9 Analysis

4.9.1 Making sense

The aim of analysis is to ‘make some sense of it all’; that is, to ‘[move] from a jumble of words and pictures, to something less wordy, shorter and more manageable, and easier for an outsider to understand’ (O’Reilly, 2009, p.93). This task is twofold, and requires ‘simultaneously ‘telling the story’ from the point of view of the research participants, and
unpacking that story in such a way that the broader meanings can be elicited’ (Green & Thorogood, 2009, p.197). This is about the tension between emic (insider) and etic (outsider) perspectives in ethnographic research; ‘between representing the world views of participants in the research and analysing the accounts they provide in order to explain something more general about the phenomena we research’ (Green & Thorogood, 2009, p.215). This is also about the potential for generalisability from a small scale specific study; so that although the research takes place in a particular setting with a particular group of people, it is still possible to learn something about the guiding interests and research questions at the heart of the study. These are the more generalised insights that might also be applicable to other places and to other groups of people, so that what we learn in one particular study might also help in asking questions about and explaining the same phenomena in other places and for other groups of people.

4.9.2 Sorting and organising data

Issues of rigour and validity are important with regard to both the data that is generated and the interpretations that are drawn from it. This requires ‘openness’ (Green & Thorogood, 2009, p.223) about the means of data collection as well as the means of analysis and writing. In practical terms, O’Reilly (2009) describes the process of analysis and writing as:

‘organising and presenting the data in a form that is both accessible to the reader and which provides them with detailed information and some general observations, usually of a theoretically relevant nature, regarding the significance of what is uncovered’ (O’Reilly, 2009, p.14).

The organisation of data is done primarily through coding as a process of sorting and labelling sections of data - of fieldnotes, interview transcripts, or other research materials. This requires looking very closely at the data in order to identify recurrent themes and important issues within research participant’s accounts (Green & Thorogood, 2009, p.198; O’Reilly, 2012, p.188). This also allows for comparison of the data across those themes, which Fetterman (2010) argues is an important form of ‘ethnographic reliability’ (p.97-98).
Madden (2010) suggests that the aim of coding is to find the ‘best fit’ for the particular research interests that guide the generation of data, and that ‘generic or first order themes should be constructed with reference to the overall aim of the project; thinking about the reason you started the ethnographic research in the first place’ (p.143-144). Bearing this in mind, Emerson et al. (2011) make a useful distinction between two types - or stages - of coding: open coding, ‘to identify and formulate any and all ideas, themes, or issues they suggest, no matter how varied and disparate’, and focussed coding, around ‘a smaller set of promising ideas and categories to provide the major topic and themes of the final ethnography’ (p.172).

In terms of analysis as an integral part of fieldwork, and as a way of looking for patterns or themes in the data, analysis in this study began during fieldwork. As discussed earlier in this chapter, this was part of the process of becoming familiar with the people and place in the study; of coming to know the regular patterns of behaviour and interaction at the centre and among the centre members. I gradually became aware of having similar conversations about the same topics, but with different people; for example, about family and about my pregnancy. I also started to see patterns of behaviour, such as the particular way that food was shared, and the way in which people behaved in the Tai Chi class. These observations, as the sorting, organising and processing of data in situ, form the beginnings of the later, more formal stages, of analysis.

As already noted, the end of my fieldwork period coincided with the start of ten months of maternity leave. This meant that as I returned from leave to continue working on my PhD, the first thing to do was to re-familiarise myself with my data. I did this by reviewing the interview summaries that I wrote immediately after each interview. These were written as a record of my first impressions of the significant themes that were raised by research participants in the formal interviews, around the three sections of the interview (migration, health, and family). These summaries provided a point of comparison across all of the interviews and a means of building up a picture as I went of what the participants spoke about and in what ways, and of the similarities and differences across the interviews. These were used to compile a list of themes as a preliminary framework for organising and coding my data (see Appendix H.1). This was used as a way to get started with thinking constructively about the data, so that the analysis was driven by the research interests in the first instance (through the interview structure).
At this point, all of the fieldnotes, interview transcripts and other notes were coded electronically using QSR NVivo 10 software. The main reason for doing this electronically was for ease of handling the data; it was used simply as a tool for systematically organising the data, by ‘sorting, comparing [and] searching for patterns’; what Fetterman (2010) says that ‘ethnographers do in their heads all the time’ (p.99). However, electronic coding of the data was a more formal and structured process of identifying recurrent themes in the research participants’ accounts and interview transcripts, and patterns in observed behaviour and interaction, as they were recorded in my fieldnotes. As Emerson et al. (2011) outline, this first stage was a process of open coding; that is, recording any and all themes within the data (p.172). Although I began with a generalised list of themes to code around, as guided by my re-visiting of the data, and by the research questions and interest of this study, this phase of coding generated a long list of codes within the data (see Appendices H.2 and H.3). At this point, I also identified and labelled descriptive passages about the community centre and the research participants, in order to build up a detailed picture of the context of the study, and to provide a ‘thick description’ (Green & Thorogood, 2009, p.202; Fetterman, 2010, p.1) of the people and place.

The next stage was to look closely at the coded data, to think about what I wanted to understand within that data, and to begin to write about it. This was a process of asking questions - about what I had set out to do and about the data that I had gathered, for example:

- What do I know about the participants in this study?
- What do I know about their lives?
- What is important to them?
- Why - and how - do they use this community centre?
- What do they talk about? What don’t they talk about?
- What kind of relationships do they have with each other?
- What kind of relationships have I had with them during my fieldwork?
- How does this affect what I know about them? And how does it affect the data/outcome of my project?
As I began to write about these things, I also drew on relevant literature and theoretical ideas to help make sense of the data and to answer these questions. This was particularly important in trying to understand the relationship between the three main elements in the study: the place, the people and their understandings of health and illness. In this sense, I used the concept of therapeutic landscapes in particular (as discussed in Chapter 2), as a concept to ‘think with’ (Charmaz, 2004, p.985; Green & Thorogood, 2009, p.225). This was also in part reflexive, in terms of thinking about my own experiences in the community centre, and what that told me about this group of people and the way they interacted with one another within this particular place. The concept of therapeutic landscapes, and the questions that it raises about the relationship between people, place and health, also helped me think critically about and make sense of my own experiences, and the role that this plays in the analysis and writing of the thesis.

I was also able to conduct further interviews at this point, and to discuss my developing ideas and interpretations of the data, with Mrs Z (as discussed earlier). This was important in terms of being able to check my understandings of the data, and in terms of not being completely removed from the field site and the research participants during the processes of analysis and writing. This reflects what O’Reilly (2009) calls a ‘spiral’ approach to analysis; that ‘though an initial idea will inform data collection, the collected data will then raise questions about theory, which in turn leads to more data collection, analysis, writing, and the ongoing development of ideas’ (p.15).

4.9.3 Writing, interpretation and representation

As well as being a methodology, ethnography is also a product; that is, ethnographic writing, in the form of written accounts of fieldwork, as books or academic papers (Sanjek, 2002, p.193). What connects these is the activity of writing, which is done both as ‘writing down’ in the field and afterwards as ‘writing up’ (O’Reilly, 2012, p.179). Writing down and writing up are not necessarily separate activities, but an ongoing process of interaction between field and desk. In this sense, as discussed above, engagement with, and analysis of the data is an ongoing process, rather than a separate and clearly defined stage of the research process (Fetterman, 2010, p. 93). In a description of fieldwork, Carrithers (2002) describes this merging of fieldwork and analysis, through the process of writing:
‘But it [fieldwork] doesn’t end there. Back home at your desk you will continue to be engaged laboriously with the people you study, through imagination, recollection and reconstruction. It is easy to forget that writing is as much a part of fieldwork as any choice passage of travel or startling encounter.’ (Carrithers, 2002, p.231).

Madden (2010) also highlights the centrality of writing in ethnography; that it is part of the whole process of making sense. He describes ethnographic writing as ‘a form of collating, reporting and interpreting at the same time’ that is ‘both systematic and artful’; and suggests that ‘it is in the writing of ethnography that we finally realise what we want to say about our ethnographic experiences’ (p.153).

Like the tension between emic and etic perspectives in ethnographic analysis, there is also a tension in ethnographic writing between ‘the duty to facts and validity and a literary voice that conveys rich, evocative and persuasive description’ (Madden, 2010, p.166). Thinking about the role of creativity in ethnographic writing also raises the issues of representation. As noted earlier in this chapter, this concerns what is written about research participants and the way in which they are represented in ethnographic writing. To this end, Green & Thorogood (2009) note that ‘responsibilities to participants continue in the writing up and dissemination of accounts’ (p.80). Being able to continue my relationship with the research participants during the processes of analysis and writing was particularly important in this respect. I attended the community centre on several occasions during my maternity leave, with my daughter, and conducted additional interviews as I was beginning to write up. The nature of my relationship with Mrs Z, as a collaborator in the study and as a cultural broker, is also important here; she is someone who was able to explain things to me, and with whom I was able to check my ideas and developing analysis of the data, and who I trusted to guide me, as necessary, in terms of the ways in which I was proposing to write about the research participants. Of course, this is not an absolute guarantee that what I present in this thesis about my research participants and my understanding of their views of the world, is immune to comment or debate. However, this is about taking due care in my representation of what I learnt about - and from - my research participants through being with them. I hope that the nature of my relationship with the research participants, and my respect towards them as people, not just research participants, is reflected in the
presentation of the thesis; in what I have chosen to write about them, and the way in which I have done so. I hope that this also conveys a sense of care with regard to the stories, opinions and life experiences that they shared with me.

4.10 Summary

This chapter has outlined the approach to ethnography as it is applied in this study. This has included discussion of the understanding of ethnography as a research methodology with its roots in anthropology and sociology; the particular activities that constituted the fieldwork in this study; and the processes of analysis and writing. This has also included discussion of the need for reflexivity in ethnographic research, as well ethical considerations, with particular regard to the issue of relationships with research participants. Issues around language in cross-cultural and cross-language research have also been discussed, with a particular focus on the use of an interpreter in cross-language interviews and the process of transcribing interviews. The following chapter sets the scene for the study with a detailed description of the community centre.
Chapter 5: Setting the Scene - The Community Centre

5.1 Introduction

Rather than simply being the location in which this study took place, the community centre at the heart of this study is explored as a central element of the study. The research participants’ understandings of health and illness are therefore explored in terms of their experiences and their views of the world, but also in terms of their participation and engagement with each other within this particular place. This approach is shaped by an understanding that:

‘Places are not abstractions or concepts, but are directly experienced phenomena of the lived-world and hence are full with meanings, with real objects, and with ongoing activities. They are important sources of individual and communal identity, and are often profound centres of human existence to which people have deep emotional and psychological ties.’ (Relph, 1976, p.41).

This is what Gesler (1991) describes as a ‘reciprocal relationship between people and place’ in which place ‘comes into being […] when it embodies meaning, when it has intentionality, and when it is an arena for interpersonal relationships’ (p.166). Andrews et al. (2014) add to this that ‘experiences of places, and the knowledge gained from being part of them or learning about them, gives rise to their intentionality (what places are about) and essences (how places feel)’ (p.210 - emphasis in the original). Reflecting these ideas, the centrality of the community centre in this study necessarily makes place part of the story; it is a study of a particular group of people within a particular place. The aim of this chapter is therefore to capture a sense of the community centre as an everyday landscape; what it is about and how it feels to be there. This will be done by situating the community centre as part of a larger organisation with a specific set of values underpinning its work, and by dealing with some of the physical and symbolic aspects of the community centre (Smyth, 2005, p.490); that is, the location and physicality of the centre, and the day-to-day activities that take place there.
5.2 The community centre in context

The community centre is part of an organisation that was set up by a group of Chinese women in the north west of England in the late 1980s in order to offer support to Chinese women who had suffered domestic violence and the breakdown of family life\(^{11}\). The organisation recognised that at that time, Chinese women faced discrimination from within both Chinese and British society. In particular, it recognised that many Chinese women were deprived of opportunities for education because of their traditional role within the family and raising children\(^*\). Among the women that I conducted formal interviews with at the community centre, this traditional role was reflected; many of them had left school at a young age and had had very little education, and they told me that for women of their generation the first priority is children and family. A number of them also spoke about the breakdown of their marriages and other family troubles, which were clearly sources of personal distress.

In 2016, the organisation is still predominantly led by Chinese women; the Director, all the committee members, and many of the staff are women. However, since it was established, it has undergone many changes and significant expansion, and now offers its services to men as well as women, and to other ethnic minority groups, as well as the Chinese community. It has also developed links with a range of other organisations in the region, including local councils, social services, the NHS, police and fire services, housing associations, and specific health support organisations. It is proud of these associations, which it says are built on ‘friendship and partnership’ and reflect the core values of the organisation\(^*\).

The organisation is a registered charity and is funded by a mixture of local council funding, various kinds of grants (including the National Lottery, Comic Relief and Oxfam) and other sources of project-based funding. It states that its values and ethics are based on Confucian thought as it is relevant to today’s society; these values include assertiveness, etiquette, loyalty and courtesy, wisdom, flexibility (in the face of change), and humanism\(^*\). The aim of the organisation is to provide ‘quality services to socially excluded and

\(^{11}\) * This indicates a reference to information available on the organisation’s website. As noted in Chapter 4, I am aware that it is possible to identify the organisation with a simple internet search. I am however, choosing not to use the name of the organisation, or of the community centre, or to list the website address here.
disadvantaged Chinese women and their families and other communities in need in the North West of England’ and to ‘enhance the well-being of [its] service-users in terms of social, cultural, educational, health and career development’*. Its stated objectives are focussed around wellbeing in terms of building a positive identity and strengthening community support, as well as in terms of facilitating access to resources and information, and building connections with other similar organisations*. It offers a wide range of services to its members, including (but not limited to): English and Chinese language classes, citizenship classes, youth work and family support projects, various services to support elderly people, Macmillan Cancer support, and mental health support.

5.3 The Centre: purpose and services

The community centre falls under the health and social care section of the organisation and is specifically aimed at providing support to older and elderly Chinese people, with membership open to anyone over the age of 55. The centre states that its underlying philosophy is that ‘being active and socially engaged will help people to remain physically and mentally active’*. It also states that ‘valuing the experience and wisdom of older people is integral to Chinese culture’ and that through the centre ‘elderly people are able to meet, to enjoy Chinese food together, and access a range of support services’*. In its annual report for the year 2012/2013 it states that its aim is to provide ‘holistic care for the elderly Chinese’ and to ‘ensure that clients have a reason to get up in the morning and a welcoming place to come and remain active, and consequently healthy’*.

When I began my fieldwork, the centre was open five days a week; however, it has since had to close on Fridays due to funding cuts. It is used on Mondays by a Somali women’s support group, and by the Chinese community on Tuesday, Wednesday and Thursday. It hosts a lunch club and various activity groups throughout the week, including Tai Chi, line dancing, table tennis and calligraphy, and is always set up with tables for playing mahjong. Members can get help with filling in forms, reading and replying to letters, making phone calls, and translation and interpreting services. The centre provides a transport service to collect members who are unable to come to the centre on their own and to take them home after lunch, as well as home visits and delivery of meals to those who are unable to attend
the centre. There is a podiatry service once a month and eye tests every six months and I also saw people having their hair cut in one of the little side offices on several occasions.

There are a number of members of staff based at the centre, including a community development worker, a mental health support worker, a care worker, several office staff, kitchen staff, cleaners and two drivers. They are all of Chinese origin; either first generation migrants or British born from within Chinese families. As noted in Chapter 4, the main language used at the centre is Cantonese, but some members also, or in some cases only, speak Mandarin. English is also spoken by most of the staff and some of the centre members.

The majority of the centre members are retired and range in age from late 50s through to 70s and 80s. Although the organisation is committed to extending its services to other minority communities, and although membership of the centre is not restricted to Chinese people, during my fieldwork period the members of the centre were all of Chinese origin. They were predominantly first generation Chinese migrants from Hong Kong, China and Vietnam. There were also some members who are Chinese, but who are not first generation migrants, e.g. husbands/wives/partners of centre members who are from Chinese families, but were born in the UK, and some of the regular members brought friends or other family members with them on several occasions.

5.4 Location and physical building

The centre sits unobtrusively on a corner in the centre of the city, set back from the road, in between a car sales yard and showroom on the main road and a Salvation Army building on the side road. There are flags on the wire fence around the garden and a big banner with the name of the centre on the fence at the front. It is a one storey building, consisting of one large, open main hall, an open office area that also functions as a reception, a kitchen with a hatch that opens onto the main hall, and two small offices. These offices are used as meeting rooms; Mrs Z and I often sat and talked in one of them and formal interviews conducted at the centre also took place in there too. The smaller office is often used for
playing games of mahjong in the break between lunch and the afternoon activities, and is also used for the podiatry, eye testing and hairdressing services.

There is a garden area on two sides of the building. At the front there is a small area of grass to one side bordering the centre car park. The Tai Chi class took place in this part of the garden, under the trees, on several occasions. To the other side of the building there is a larger garden where vegetables are grown to be used for the lunch that is served each day. Mrs S was often in the garden, weeding and pruning, or watering the plants, and we had several conversations as she pottered about with her secateurs and watering can. To the back of the building is a basketball court separated off from the building and the garden by a tall wire fence. The Tai Chi class often took place on the basketball court on fine days, when the group was too big for the garden at the front of the building.

Just inside the main entrance, there is an information board opposite the reception desk which has information about the organisation and a picture of each member of staff at the centre. There were various health information notices up on the board, and there was a free standing bookshelf below it with leaflets and pamphlets about a range of health issues and services available at the centre. The main hall is split into two areas: the main, larger, part where the Tai Chi and other activities take place and a smaller area off to one side with a TV in the corner, a couple of computers on a desk against one wall, a large round table, and some comfortable chairs against the back wall. There were often books and newspapers out here for centre members to read, and there were displays of photographs of trips that the centre has provided for members as well as a formal photograph of the Tai Chi group. In the larger part of the main hall, there are other information boards and notices up in Chinese, some Chinese decorations on the walls, and a Chinese dragon puppet suspended from the ceiling.

The kitchen is to one side of the larger area with a hatch that lifts up to open the kitchen onto the hall (for serving lunch) and a door that opens onto the car park out the back of the kitchen. The kitchen is usually open and in service for most of the day; preparing lunch in the mornings and then for tea/coffee etc in the afternoons. There is a kettle just inside the door on the workbench, and people pop in and out to fill up the teapots, and there is a hot water urn left outside the hatch in the afternoon. On the days that the Tai Chi class took
place in the main hall, this was with the accompaniment of cooking smells and the clacking of utensils against pans and chopping boards wafting from the kitchen.

5.5 Day-to-day goings on

Gastaldo et al. (2004) draw attention to the role of sounds, smells and sights, as part of the sensory experience of places (p.173). These sensory elements played a part in shaping the nature of day-to-day life at the centre; the language and intonation of conversations in Chinese, the music and voices from the television playing Chinese channels, the smells and sounds of cooking coming from the kitchen. These created a kind of living - or in-motion - backdrop to life as it buzzed along at the centre with people coming and going, taking part in the activities, and undertaking their various roles.

On Tuesdays and Thursdays the main activities at the centre are Tai Chi in the morning, line dancing in the afternoon, and usually a full house of tables for lunch in between. On Wednesday and Friday afternoons the tables are set up for ping pong. A calligraphy group also began on Wednesday mornings towards the end of my fieldwork period. There was always other noise and activity going on around these activities; the chatter of
conversation, people sitting in the corner on the comfy chairs either chatting or reading, the pouring and drinking of tea, games of mahjong in progress, people coming and going, and the staff milling around and bobbing in and out of the office chatting to people. There were also the sounds and smells of cooking in the morning, the Tai Chi music from the little transistor radio, the sound of the TV on a Chinese channel, and the line dancing music blaring out from the stereo in the afternoon.

At one of the health consultation sessions that I observed I wrote the following in my notes:

There is the noise of mahjong games and the TV (Chinese) on in the background; everything else going on as usual around the session…the bell is pinged for bowls of noodles to be taken from the kitchen to the tables for breakfast and I can hear the tumbling/mixing up of the mahjong blocks above the conversation of the group.

[FN25-20.02.14]

And the first time that I took part in the Tai Chi class, outside in the garden, I was very aware of all the sounds and activity going on around us:

The garden was one side of the centre, with the centre car park immediately in front, the entrance to the centre to one side, and council houses/flats on the other two sides. There was a wire mesh fence between the garden and a path between the centre and the houses. There was a small portable radio with a USB stick plugged into one side, playing traditional Chinese music. The radio was hanging on a wooden latticed fence, along with a selection of handbags on hooks that the ladies had brought with them. People came and went around us whilst the class went on; staff arriving at the centre, a van delivering food, a young man walking his dog. Against the sound of the music, I could hear a siren, someone throwing those little paper twists, and the noise of a motorbike and van going by.

[FN1-27.08.13]

These sensory aspects of the centre - the sounds and smells and background activity - make it an active and inclusive place, full of life and movement, conversation and interaction. Some days it was quieter than others, but for most of the time that I was there, there was a
backdrop of noise and activity, that filled the main space of the centre. This meant that even though there were usually one or two people sitting in the TV corner reading or chatting quietly, and others engaged in Tai Chi or dancing, there was a sense of communal activity, rather than a segregation of the more and less able bodied members into separate spaces within the centre.

5.6 Regular activities

Although there were other activities going on at the centre, such as ping pong and mahjong, the following are the activities that I took part in throughout the fieldwork period. These will be explored in more detail in Chapter 9, in terms of the particular activities and the ways in which the members participated in them, in order to consider how they contribute to the therapeutic nature of the centre.

5.6.1 Tai Chi

The Tai Chi class took place twice a week at the centre on Tuesday and Thursday mornings. On fine days the class was held outside on the basketball court at the back of the building and on several occasions in the garden at the front of the building. Otherwise, it was held inside in the main hall, with all the usual other activities and noise going on; people coming and going and chatting to one another, the staff milling around, games of mahjong being played, and the sounds and smells of lunch being prepared in the kitchen. The group always arrived slowly, gathering around one of the big lunch tables to drink tea and chat before the class began. The Tai Chi Master seemed to have things stored in the filing cabinet in the corner of the hall and always went to get whatever it was she needed from there before the class began; shoes, extra fans and swords, the silk pyjamas that the group wore on more formal occasions, and so on. If it was a large group, the lunch tables and chairs were moved back to make space for the class. Usually it was Mrs F who went to get the little transistor radio and the flash drive from the office and sorted out the music for the class.
The group were all women, of varying ages, and although some of them reported having health problems, they were all physically able to stand and do two hours of Tai Chi. In this respect, they represent the more physically able and fitter section of the centre members. Many of them had been attending the class and practicing Tai Chi for many years; there were also a number of women who joined the class during the fieldwork period. Most of them stayed on for lunch after the class and some of the group also stayed for the other activities as well. The group were very welcoming to me; I gradually got to know them over the course of the fieldwork period and eventually had a regular seat at their lunch table.

5.6.2 Line Dancing

The line dancing group takes place on Tuesday and Thursday afternoons in the main hall of the centre. After lunch, the tables are put away, the chairs are dispersed around the edge of the room and the floor is mopped. Some of the women from the Tai Chi group who also stayed on for dancing often played mahjong in the little office after lunch and before the dancing started. Others arrived after lunch and gathered in groups on the chairs around the edge of the room to chat and change their shoes before the class began. The group was mostly women but there were usually a few men in the group too.

The teacher usually came for lunch on Tuesdays before the class and I often chatted to him while he was getting the stereo set up and his CDs organised. His brought his CD collection with him in a hessian shopping bag and always tested out a few tracks and lined them up before the class began. The dancing class was more informal than the Tai Chi class. There was usually some sort of food laid out on the table, or brought out in the middle of the session, and a hot water urn and cups for tea and coffee at the kitchen hatch. People stopped to eat and drink and then went back to the dancing or sat on the chairs around the room to rest or chat so that not everyone was dancing all the time. The teacher told me that he is not really a dance teacher, but that he started doing the sessions because he knew a member of staff who asked him if he would do it.
5.6.3 Calligraphy

The calligraphy group began on Wednesday mornings towards the end of my fieldwork period. I attended and took part in the group on a number of occasions. A few of the women from the Tai Chi class came to this group, along with a few people who also came to the centre to play ping pong, both of the drivers, and a number of other centre members who I had not met previously. There was a mixture of men and women, and one or two of the more elderly members also came to this group. One table was set up for everyone to sit around together, with pots of ink and a box of paintbrushes, and a teapot and cups, in the middle of the table. Each week the group had a theme (such as fate and destiny, or holidays and leisure time) which they discussed and practised writing about in traditional Chinese characters, using the ink and brushes. Each person did their own piece of writing but this was punctuated with conversations amongst the group. A few people in the group had Chinese-English dictionaries or used their mobile phones to translate particular words. The conversations that I was part of during these classes were often very reminiscent about the past, and the way of life in the home country as it had been prior to the centre members migrating to the UK.

5.6.4 Lunch

A communal lunch was served every day at large round tables in the main hall of the centre. The tables were already set up in the morning when I arrived for Tai Chi; they were laid with a small soup bowl, a paper napkin and a flat deep-edged spoon in the bowl, a small tea cup without handles and a set of chopsticks for each person. Lunch was very much a communal occasion; plates of food to share were brought to each table and everybody helped themselves, and each other, to food from each of the plates. The meal always began with soup, which was brought to the table in a large bowl, and someone at the table stood up to ladle it out for everyone. We were then brought a tray with small bowls of rice for each person, which were distributed around the table, followed by several different dishes; usually a whole steamed fish, some kind of meat and a plate of vegetables. Some members came just for lunch, others came for the activities and stayed on for lunch as well. I ate with the members most of the days that I attended the centre and had many conversations and exchanges over lunch. These were often about what was good for me
and the baby to eat, sometimes about ‘the Chinese way’ with food, but most often, general conversation about the members’ day-to-day lives.

5.7 Summary

The aim of this chapter was to capture the sense of the centre as an everyday landscape, and as the place where this study unfolds. By describing some of the physical aspects of the centre - what it looks, sounds and feels like, and some of the regular activities that take place there - I have tried to convey something of what Gesler (1991) calls the spirit or personality of (a particular) place (p.164). By situating the centre as part of a larger organisation with specific aims and objectives centred around promoting wellbeing through building identity and community support, I have also tried to show some of the underlying values that shape what Andrews et al. (2014) refer to as the intentionality and essence of the centre; what it is about and what it feels like to be there.

The following chapters turn to the migration stories of the participants in this study (Chapter 6), their understandings of health and illness (Chapter 7), and their choices around the use of TCM and biomedicine (Chapter 8). These discussions help to further contextualise the ways in which the research participants engage with one another in this particular place. This is explored in more detail in Chapter 9, which considers some of activities that take place at the centre (as described above), and the ways in which the members participate in those activities. Collectively, the aim of the following chapters is to explore some of the social and symbolic aspects of place, and to show how these shape the centre as a therapeutic landscape.
Chapter 6: Gendered Stories of Migration

6.1 Introduction

This chapter addresses the migration stories of the participants in the study. These were collected through formal interviews and through informal conversations as I got to know the members of the centre. As discussed in Chapter 2, these are stories that are shaped by gender; the men and women in this study experienced migration differently, and told their stories in different ways. The women’s stories in particular highlight the traditional gender roles within Chinese families as they are relevant to this particular generation of Chinese migrant women. This reflects Yuen’s (2008) assertion that the internalisation of traditional gender roles plays an important part in shaping the migration experiences of Chinese women migrants in the UK (p.304).

Of the 18 women who were formally interviewed, ten came to the UK for marriage, three came as teenagers with their families (following their fathers), two came to earn money/find a job, and three came as refugees from Vietnam. The two men who were also formally interviewed both came to the UK to get married. These stories (and others whose stories I learnt through informal conversations), will be addressed in this chapter, in three sections. Firstly, the stories of the women who came to the UK to get married and those who came with their families as teenagers are explored. These stories highlight traditional gender roles within the family and experiences of loneliness and isolation, particularly in the early years of living in the UK. The men’s stories are explored next, as stories of migration for marriage, but in different circumstances, and expressed in a different way. This is followed by the stories of the three women who came to the UK as refugees. These stories help to illustrate the diversity of the Chinese population in the UK as comprised of people from different countries of origin and with different migration experiences (as noted in Chapter 3). Despite these differences however, these women

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12 This excludes the Tai Chi Master and Mrs Z, as these were different kinds of interview, in that I did not use the same interview schedule that I used with the other research participants (as noted in Chapter 4). I spoke with Master specifically about her experiences and knowledge of Tai Chi, and with Mrs Z about the centre and my analytical approach to the data that I had collected about the community centre and the centre members.

13 Appendix G lists the main reasons for migration and the country of origin for each of the participants who were formally interviewed in the study.
expressed the same underlying understanding of health and illness and attitude towards coping with difficulties, as the other research participants.

Following these stories, the idea of homesickness, which the women expressed in their experiences of loneliness and isolation in their early years in the UK, is discussed. This is explored as a form biographical displacement, through the loss of place. The aim of this is to show that the women’s experiences of migration play an important part in the identity of this group of people, in their engagement in the community centre, and their sense of belonging in this particular place. These are issues that will be taken up again in more detail in the following chapters.

6.2 Women’s stories

6.2.1 Home alone

As noted above, most of the women who were formally interviewed came to the UK either to get married, or with their husbands having got married in their home country. They all spoke about experiencing loneliness and isolation in their early years in the UK. This was in relation to being separated from their family and friends and from the lives that they had been leading in their home country, but also in terms of being isolated in the UK. This reflects the ‘double isolation’, from both the Chinese and mainstream society in the UK, that Chau & Yu (2001) highlight (as noted in Chapter 3). Many of them did not speak English when they arrived and many had stayed at home to look after their children (although some did work later on), meaning that the opportunities for them to be with other people were very limited in the early years. Many of them spoke about this experience of loneliness and isolation as a difficult and distressing time in their lives.

Mrs Q was born in China but her family moved to Hong Kong when she was very young. She moved to the UK in 1973 at the age of 25, after getting married in Hong Kong. Her husband’s family were already living in the UK, and Mrs Q and her husband came to join them. I asked if she had been happy to come to the UK:
Well before I come I’m a bit worried. When I first there oh, you know, I can't speak English at all, I don’t understand, I’m not quite happy. My family’s not here...quite difficult, at the night time when I finish work go home on me own, oh I feel cry to be honest with you, yeah...I want to go home, I’m home sick...yeah, very home sick to be honest.

[Mrs Q, 66, China]

Mrs F is in her 60s and originally from Hong Kong. She came to the UK in the 1970s when she was in her 20s, shortly after getting married. Her husband was already living in the UK at the time, and after getting married in Hong Kong, they came back to the UK together. I asked her the same question - whether she had been happy to come to the UK:

Mrs F: Er, yeah, yeah. Okay. Before is not happy but now, okay.

NW: So, at the beginning, you weren’t very happy?

Mrs F: No, not, not happy...because my family is all in Hong Kong...is just me here. No friend, no family and no...I can't speak English...really lonely...my life was lonely but now it's okay.

[Mrs F, 60, Hong Kong]

Mrs E is 72 and originally from Hong Kong. She came to the UK in 1965 at the age of 22. She came to join her husband who had already been living in the UK for a year. She said that she found the first two years in the UK very difficult. She did not speak English when she first came here and did not have any family or friends in the UK apart from her husband and daughter. She was not able to work because she could not find childcare for her daughter (although she did work later on in a restaurant that she and her husband owned) and so she spent a lot of time on her own at home.

I'm only me and my daughter...got no job...so I'm stay home, look after children. In that one year, I'm every night crying...no friend, can't speak English, got to be having a baby, only stay one room...no society, nothing, nothing...No Chinese that time...Chinese all go to work, nobody got time to look after you.

[Mrs E, 72, Hong Kong]

Mrs E’s statement that ‘No Chinese at that time...Chinese all go to work, nobody got time
to look after you’ reflects the dispersal of the Chinese community in the UK, associated with the catering industry in the 1960s and 1970s (as noted in Chapter 3), and shows the difficulties of this in terms of loneliness and isolation.

Mrs M is originally from Hong Kong and came to the UK in 1979 at the age of 29. Her husband was already working here in a fish and chip shop and she came over to join him after they got married. She said that the first few years here were very difficult. Like Mrs E, Mrs M also spoke about being isolated in her home; her husband worked long hours in the fish and chip shop and she spent a lot of time at home by herself (they lived in a flat above the fish and chip shop for five years).

Mrs M: First few years to be honest is not happy because I didn't have any friends in here. My husband is working day and night...he go down to the shop, we live upstairs...so I just...no television you can't...you don't know my feeling no television, no entertainment, I just sit there.

NW: So you stayed in the flat while your husband went to work in the chip shop?

Mrs M: Yeah, the shop is downstairs, the flat is upstairs...I just stay in the bedroom, no television. How can the people be happy like that to be honest?

[Mrs M, 64, Hong Kong]

These women clearly expressed a real sense of distress and loss in the face of their migration experiences, and their early years of living in the UK. They were separated from their homes, from their friends and family, and from any sort of social contact with other people, and they felt this isolation acutely. Although they told me their individual stories, there was a collective sense of these experiences, defined by being alone, and feeling painfully disconnected from the people and places that were important to them. These experiences will be explored later in this chapter, in a discussion of homesickness, conceptualised as a loss of place.

6.2.2 So she follows her husband wherever he goes

Many of the women spoke about coming to the UK with their husband in terms of gendered - and generational - expectations; that they followed their husbands and that this
was what was expected once they were married. The experiences of these women, as ‘trailing wives’ (Cooke, 2007), reflect the traditional understanding of the position of women in the family, as being subservient to their fathers, husbands and sons (Tang et al., 2002, p.976).

Mrs R came to the UK from Hong Kong after getting married; her husband was born in the UK but had been living in Hong Kong. After getting married they came to the UK for a few months, with the intention of settling here. However, Mrs R was homesick and did not get on very well with her mother-in-law, so they went back to live in Hong Kong for a few years, before returning to the UK again. At that time, Mrs R’s son was four and a half years old and her husband felt that it was better for their son to be educated in the UK. Mrs R was not entirely happy with this decision, but said that she knew before they got married, that if they had children, Mr R would want them to be educated in the UK. She could not disagree with his decision, even though she did not want to live in the UK. She laughed in a sort of resigned way as she said this.

Mrs E spoke about having had an arranged marriage and about it being expected in Hong Kong at that time (the 1960s) to marry young and follow your husband. She said that for Chinese women (of her generation) the priority is husband, children, elders, then yourself, but that this is not the English way. She also said that once you get married you have to follow your husband so she had to come to the UK because her husband was here; there was no choice about this, it was what women did.

Mrs E: So my husband coming 1964. I'm one year later coming.
NW: So you followed him one year later?
Mrs E: Follow him. And when I coming, I don't know anything. I just follow my husband. And I have my baby one year's old.

[Mrs E, 72, Hong Kong]

Mrs D and Mrs S also expressed this expectation very clearly; that choosing to marry meant following their husbands, even when this entailed considerable difficulties and significant changes in their day-to-day lives.

NW: Was it difficult to be away from your family?
INT: Yeah, at the beginning very difficult, yeah. Yeah.
NW: But you were still happy to be here?
INT: Yeah…If you’re married you, you have to follow your husband. You won’t, you know, stay in Hong Kong anyway.
NW: So in choosing to marry your husband you were also making a choice to come and live here.
INT: Yeah.

[Mrs D, 64, Hong Kong, interpreter (INT) speaking]

INT: Er, at that time, very proud, you know, to be working in a place like that. In Hong Kong, she work [in a factory], but when she move to England she work in a kitchen.
NW: So you went from a factory to a kitchen?
INT: Yeah, there’s no choice because you need to follow your husband, yeah. So she follow her husband wherever he goes.

[Mrs S, 58, Hong Kong, interpreter speaking]

Other participants expressed an understanding of the role of women based around family life and children, that correlate with this expectation of ‘following’ the husband. Both Mrs R and Mrs T said that family is the most important thing for them and that if their family is ok then they are happy. They said that this is true for women like them (Chinese women of their generation). Mrs R said maybe this was ‘small-minded’, but that they are not career women and that family, i.e. children and husband, are the most important thing for them.

Others suggested this, less directly, in the way that they spoke about their role within the family and their relationship with their husbands and children. For example, Mrs H spoke about the traditional expectations for boys and girls, in terms of education:

NW: So your brothers and sisters, did they go to school here?
Mrs H: Er, yes, my elder brother did go to school here, because he’s a boy, so he’s got more [laughs] he’s like a bread earner, so boys have more chances than a girl, because girl…Chinese girls marry off.
NW: And they would leave their family?
Mrs H: Well, that’s the traditional thinking…nowadays not like that, but for old people’s minds always, boy is the family, girls is going away.

[Mrs H, 57, Hong Kong]

Many had had arranged marriages (of a sort), and several said very clearly that traditionally, girls would leave their families once they were married and boys would stay with their own families.

Mrs G said a boy first is best, then a girl, because (at the time she had children) when a girl gets married, she goes to her husband’s family and maybe only sees her family one or two times a year. A boy stays with the family and works for the family, so it is better to have a boy first.

[FN19-21.01.14]

The traditional expectations of the role of women within the family are also reflected in the stories of the women who came to the UK with their families as teenagers. In these cases, the father/husband came to the UK first, and the mother/wife followed later with the children.

Mrs N is originally from Hong Kong and came to the UK in 1972 with her family at the age of 15. Her father had been living in the UK since 1960, where he owned and worked in a takeaway shop, and Mrs N and her mother came to join him in the UK in 1972. Mrs N spoke about first ‘following’ her family and then ‘following’ her husband.

NW: Can you tell me how you came to live in [city]?

Mrs N: I, since I follow my parent, we live in [city], and when I, after marry, I follow my husband, moved to [city].

[Mrs N, 61, HK]

Mrs H is originally from Hong Kong. She came to the UK in 1971 with her family when she was 14. Her father was already living and working in the UK and she and her brothers and sisters and mother came to join him there. For Mrs H, this pattern is repeated later in her life; following her own marriage, her husband left the UK and she followed later with their children. When we spoke about this in the interview, Mrs H talked about the move as
her husband’s decision and as something that was good for him, and about returning to the UK as something that was good for her children, for their education.

*Mrs H:* I got married in 1979...and then I have children the following year...Well my youngest one, just about...before he’s two, we went to [country]...because my husband going to [country] to open the restaurant...have some partners...local partners. Because one of our customer, they say come to [country], it’s good. So, so we... he went to [country] and it seemed to be quite good...it seemed that it’s a, a potential, for him...So he went before us to open the restaurant and set up everything, that was 1987. He went to [country] in 1986, set up everything, and summer 1987 I move with my family to live there [laughs].

*NW:* Was it your husband’s choice to go to [country] or was it yours?

*Mrs H:* Yes, it was his choice. Yes.

[Mrs H, 57, Hong Kong]

Both of these women worked in their family take away businesses when they came to the UK. Mrs N had been going to school in Hong Kong but did not continue with school in the UK; instead she worked in the family takeaway business, first of all in the kitchen and then as a waitress. After completing primary school Mrs H worked in a factory for two years in Hong Kong. However, because of the school leaving age being 16 in the UK she had to go to school in the UK for one and a half years. After that she worked in the family business; first a restaurant and then a fish and chip shop. Mrs T also had a similar story. She had come to the UK from Hong Kong with her family when she was 13. She went to school for a few months when they first came to the UK but she said it was too hard for her to catch up so she left school and went to work in the family restaurant as a waitress.

6.2.3 Working in the family business

These stories of teenage girls helping out in the family business (rather than continuing in education) reflect themes within the literature on Chinese migrant family businesses in the UK that highlight the exploitation and oppression of women (and children) in these circumstances. Song (1997a; 1997b) explores the ‘norm’ of Chinese children in the UK
‘helping out’ in their family businesses and suggests that there is a tension within this in terms of maintaining Chinese (family) identity in the UK. Lee et al. (2002) and Baxter & Raw (1988) highlight issues of isolation and social exclusion associated with women’s roles in family business, and suggest that although takeaway businesses require hard physical work and long working hours for both men and women, the social isolation associated with this is greater for women. Although the representation of the involvement of Chinese migrant women in family businesses as necessarily exploitative and oppressive is challenged (Song, 1995), the experiences of the women in this study, reflect the social exclusion and isolation that is highlighted with regard to women’s involvement in these family businesses. As above, this is reflected in the experiences of the women who began their lives in the UK as teenagers working in the family business instead of continuing in education. It is also reflected in the experiences of the women who worked alongside their husbands in businesses that they owned together.

Mrs C told me that she had worked in the takeaway that she and her husband owned, but that she had worked in the back of the shop, and therefore had not had any contact with customers. This reflects the pattern of labour division in Chinese migrant family takeaway and restaurant businesses that Song (1995) writes about; that the women often undertook roles that kept them isolated in the ‘back’ rather than the ‘front’ of the shop. For Mrs C, this meant that although she had worked, she was still isolated within her immediate family context; she did not have contact with anyone outside of her family and did not learn English until after she retired.

Similarly, Mrs Q described her early years in the UK as being limited to working with her husband and looking after her children:

We just working together, look after the children, both a lot at the shop like that yeah...we just go to the Chinese supermarket get some stuff to cook with, that’s it. Yeah, that’s how we make a living in the first ten years, we don’t go out, we got nothing, just go to work, come back home, go to work come back home, yeah, until the kids little bit grow up, yeah. [Mrs Q, 66, China]

14 As noted in Chapter 3, in contrast to this isolation of women within family businesses, in terms of the roles that they undertook, Song adds that for some of the women in her study, involvement in the family business was also a way in which women could ‘assert their skills and initiative’ (1995, p.292).
Several of the women said that they had lived above the family business, and that they had had to take their children to work with them when they were very young.

*Mrs U talked about having to take her children to work with her when they were little. They owned a fish and chip shop and they didn’t have any family in [city] so they had to take the children to work with them in the evenings. She said that it meant that they couldn’t take the children to go out with their friends or do other things - they had to take them to work, and as it was late by the time they finished they put them straight to bed when they got home, and that was the way it was.*

[FN33-25.03.14]

For the women who did work in the family businesses, this did not necessarily ease the isolation that they felt in their early years in the UK, as although they worked, this was still within the confines of their family (and more specifically, their marital relationships). This resonates with other writing about the role of women in Chinese migrant family businesses, suggesting that the isolation for women was particularly acute (Baxter & Raw, 1998, p.69).

### 6.3 Men’s stories

#### 6.3.1 So I decided to come over and start my new life

Both of the men who were interviewed also came to the UK to get married, however it was notable that they spoke about their experiences in a different way to the women. The women spoke about ‘following’ their husbands, and the men spoke about ‘deciding’ to get married and come to the UK.

Mr I is 80 and has been in the UK for 52 years. He was born in China but moved to Hong Kong at the age of 18. He spent ten years in Hong Kong before moving to the UK to get married. His wife is Chinese but was born the UK and they met while she was on holiday visiting relatives in Hong Kong. Prior to coming to the UK, Mr I worked on a building site and in an accountants’ office in Hong Kong. When he moved to the UK, he initially
worked in his father-in-law’s laundry, but later he and his wife bought their own laundry business which they ran together for a number of years. After that they bought a fish and chip shop. When I asked Mr I about his decision to come to the UK, he spoke about this as if it was a positive decision that he had made for himself.

NW:  When you got married...at that time, had you already decided that you wanted to come to England?

Mr I:  Well, actually, you know, just because I get on with [wife] very well, so I decided to come over...and then...start my new life...that’s it. [laughs]

NW:  And you were happy to come to England?

Mr I:  Yeah, yeah, yeah, yeah.

[Mr I, 80, China]

Mr I did not talk about any particular difficulties when he came to live in the UK, either in relation to language, or to feeling isolated and lonely, in the way that most of the women had. He was always positive and light hearted about problems or difficulties, or whatever was going on in his (or my) life. He often spoke about keeping busy and enjoying life; he was very busy and was always going out, doing things and going away on holiday with his wife, and we always laughed together when we talked.

Mr J spoke in a similar way about his choice to come to the UK to get married. Mr J is 70 and originally from Hong Kong. He came to England in 1976, after the sudden death of his father. At that time Mr J had a brother who was living in Canada and who was keen for the family to also emigrate to Canada. The whole family did move to Canada and Mr J spent a short time there with his family en route to England. By this time Mr J had been corresponding with his wife, who he had been introduced to by his uncle and aunt, for several months, and had decided to come to England to get married.

In contrast to the women, neither Mr I nor Mr J talked about missing their family in their home country or not having any friends and they both spoke some English when they arrived in the UK. Both of them worked in their father-in-law’s businesses when they first arrived, before owning their own business. Their recollection of working as soon as they arrived in the UK tells a different story than the women’s accounts of their early years in the UK.
Mr J said that it had been a positive experience for him coming to England. He had been learning English in Hong Kong before coming to the UK so did not find it too difficult to adjust to the language. He said that he was financially better off and that the neighbourhood he lived in was very nice and that he had good neighbours.

*NW:* Can you remember anything that was very different for you when you came to England?

*Mr J:* Um...[laughs] I think it’s no difference. A job is a job. I did a job in Hong Kong, and got a regular salary. In England when I first started the business was good, very good, so I can save up a bit, during the first ten years.

[Mr J, 70, Hong Kong]

Even though Mr I said that his English was not very good when he first came to the UK, he did not dwell on this, or talk about it as though it had been a big problem for him. Working, particularly in his own business, allowed him to overcome this hurdle and to have some integration with English people, which he spoke positively about.

*NW:* So you said that you were learning English in Hong Kong?

*Mr I:* Yeah, yeah.

*NW:* How good was your English when you first arrived?

*Mr I:* Not very...no, the thing is, I learning, but not got any people to talk to...no practice you see. But I came over, you know, and then I run a business, talk to the English people so it improve a lot.

[Mr I, 80, China]

Mr I also spoke about work when I asked him what he had found different when he first came to the UK:

*NW:* Can you remember when you first came over what was different for you?

*Mr I:* Oh...well, just, I expect good, ‘cause I expect to earn a living, you know...’cause, I read in the newspaper and things like that...like over here, or like in America you could make a bit more money if you work hard...Actually, at first I work for my father-in-law, helping them in the
laundry business, the Chinese laundry business. And then after a few years, one of his friend, that also run the Chinese laundry business, they retire, so my father in law say, oh you get your own business. So we start, you know, our own, you know.

NW: So you and your wife bought that business together?

Mr I: Yeah.

[Mr I, 80, China]

Unlike most of the women that were interviewed, both of these men had the advantage of being able to speak (at least some) English, as well as being able to work as soon as they arrived in the UK. They did not appear to have experienced the same hardships, or difficulties, as the women had; they did not speak about the loneliness and isolation that the women described, and they focussed on work in their recollections of their early lives in the UK. The loneliness and isolation that the women described, as a kind of limbo, of being suspended between what they had left behind and what they had come to, was not reflected in the men’s stories. They left their home country to come to the UK under different circumstances and were free to work rather than having to stay at home on their own as many of the women had while their husbands went out to work.

6.4 Refugee stories

6.4.1 When things come in the vines

Among the centre members who were formally interviewed, there were three women who had come to the UK as refugees from Vietnam. Their stories were different to the other research participants who had come to the UK through marriage (both the men and the women). Rather than expressing the sense of loneliness and isolation that the other women had felt in their early years in the UK, these women spoke about language difficulties and finding jobs, and reflected on coming to the UK in terms of freedom and safety.

Mrs G is 76. Her family are Chinese but she was born in Vietnam; her father moved from China to Vietnam before Mrs G was born. She left Vietnam in 1979 as a refugee with her
husband and two daughters, and spent one year in Hong Kong before coming to the UK in 1980, where she initially lived in a refugee camp. In Vietnam she was a translator (Chinese-Vietnamese) and her husband was an architect. In the UK however, her husband was only able to get work as an architect’s assistant and she did sewing to earn a living. Mrs G said that they had been upset about this; that they had both had good jobs in Vietnam and that it was difficult for them to have different (lower level) jobs in the UK.

_Very, very difficult...for a long time, because Vietnam is the life seem quite difficult, poor, must have a good job. I got a good job, so quite happy...but come to England, my husband...I can’t get a job...so after that...we are upset but okay with living here._

[Mrs G, 76, China]

Mrs G also said that the language difference had been difficult for them in the beginning. Despite these difficulties though, Mrs G said that life is better for her and her family in the UK and that she and her husband are both happy to be here.

Mrs K is 75. She was born in Vietnam but her family are Chinese. In 1978, at the age of 38, she left Vietnam as a refugee and came to England alone (all of her family remained in Vietnam). She came to the UK via Thailand (where she stayed in a refugee camp), and then spent nine months living in a refugee camp and learning English, before she got a job working in a fish and chip shop. Shortly after she came to England her husband and his four children also came over to England to join her (his first wife had died in 1975 and the children were from his first marriage). Mrs K said that she did not know anything about England before she came here but that she was happy to come here, that life was better for her here than in Vietnam and she felt safe.

_NW:_ Can you remember what it was like to first arrive here in England?

_INT:_ Oh happier, very happy. It was like new born, yeah. Like re-birth, yeah. It, it was life was so hard in Vietnam, and...when she came here, everything was...she feel safe. She got a house, no need to worry about living. And when she was waiting, you know, to be picked up...life wasn’t as certain as now. It was a hard time. So when she came here, she felt, er, freedom, and, er, life was good, yeah.

[Mrs K, 75, China, interpreter speaking]
She said that the language difference was difficult in the beginning, but that she studied English in the refugee camp and that she tried hard to learn. She said that she had been lucky to get a job, even though it was different to what she had been doing in Vietnam, that England was ‘very kind to accept her to come’, and that she had had very good neighbours where she lived. In terms of facing difficulties and adapting to life in the UK, Mrs K expressed an attitude of stoicism and positivity:

*NW:* So was it difficult to adapt to this kind of change?

*INT:* When things come in the vines, you just feel, go along smoothly...Whatever you encounter...just, just follow, follow your dreams...as they come.

[Mrs K, 75, China, interpreter speaking]

Mrs O came to the UK from Vietnam by boat as a refugee in 1978, in her early 20s. She already had a brother living in the UK at that point but she left the rest of her family behind in Vietnam (although they later left Vietnam too). She said that she was happy to come to England because she thought she would have a better life here, and that she would have freedom. She said that it used to be better in Vietnam, you could work hard and earn money, but after the war, it was very hard. When she first came to England she worked as a sewing machinist in a factory, which she said was very boring (she had worked as a tailor previously in Vietnam), and later as a waitress in a restaurant.

Although the circumstances of their migration were different to those who had come to the UK through marriage, these are women who have also been uprooted from their home countries, and have gone through the experiences of re-building their lives in the UK away from family and friends and in a significantly changed social and cultural context. These differences serve to illustrate the diversity of the Chinese population in the UK; that it is made up of people from different countries of origin, speaking different languages, and who have experienced different circumstances of migration (as discussed in Chapter 3). However, although they have had different experiences and have come from different places and under different circumstances, they share some foundational values, particularly around the traditional roles of women in the family, and in terms of an understating of health and illness that also shapes their approach to coping with difficulties. This will be explored in more detail in the following chapters, through a discussion of the research
participants’ understandings of health and wellbeing as bound up with social and family relationships (in Chapter 7), and in terms of the choices that they make about health care in that context (in Chapter 8).

### 6.5 Homesickness: loss of place

Gesler (1992) notes that the term ‘homesick’ is often used to describe the ‘absence from or loss of a favourite place’ (p.738). Many of the women spoke about experiencing homesickness; either directly, using the word homesick, or indirectly in the way that they talked about being separated from their family and friends, and being alone in their homes. In this, they expressed a sense of the tension (between person and place) that Relph (1976) describes in terms of ‘home’:

> ‘Our experience of place, and especially of home, is a dialectical one - balancing a need to stay with a desire to escape. When one of these needs is too readily satisfied we suffer either from nostalgia and a sense of being uprooted, or from the melancholia that accompanies a feeling of oppression and imprisonment in a place.’
>  
> (Relph, 1976, p.42).

Although writing specifically about the onset and experience of chronic illness, Bury’s (1982) concept of biographical disruption helps to think about the women’s experiences of homesickness; that is, ‘the absence from or loss of place’ as a kind of biographical disruption. Bury suggested that chronic illness is ‘[the] kind of experience where the structures of everyday life and the forms of knowledge which underpin them are disrupted’ (1982, p.169). He outlined three key elements of biographical disruption in the face of chronic illness; disruption to ‘taken-for-granted assumptions and behaviours’, to personal biography and self-concept, and to resources, particularly in terms of (altered) social and familial relationships (1982, p.169-170). Although in a different context, these elements of disruption are also reflected in the experience of migration, as a major change to social and cultural context. The changes brought about by migration present challenges to everyday knowledge and ways of being and to social and family relationships; collectively, this is a challenge to both identity and belonging in a new, and different, social and cultural
context. This is reflected in the stories of the women in this study; their stories of loneliness and isolation in their early years in the UK are stories about disruptions to everyday life, to the taken-for-granted assumptions and behaviours, and particularly to their social and family relationships.

However, although the elements of Bury’s notion of disruption are present in these stories, the essence of the stories is about displacement rather than disruption. As discussed above, for the women who came to the UK through marriage, following their husbands was expressed in terms of the expectations for women of their generation at that time. This is not a biographical disruption in the sense that Bury suggests, as an unexpected event or time of crisis. Rather it is a disruption in terms of where the unfolding of life and the fulfilment of expected roles takes place. The change in social and cultural context challenges the taken-for-granted expectations and assumptions of everyday life, particularly with regard to social and family relationship, because it changes the context in which this takes place. This is about a sense of identity and belonging that is fundamentally linked to place, in the way that Relph (1976) suggests; about attachment to, and rootedness within, particular places through a ‘familiarity that is part of knowing and being known here, in this particular place’ (p.37 - emphasis in the original).

Other approaches to the idea of biographical disruption reverse this concept, exploring biographical disruption as a cause, rather than an outcome, of (chronic) illness (Williams, 2000, p.51-52). This also helps to think about how the women’s experiences of homesickness might be understood. Although they do not express this as a kind of illness, it resonates with the notions of balance and harmony that are a key part of the understanding of health and illness within TCM. As Jovchelovitch & Gervais (1999) state, this concerns not just ‘bodily conditions’, but the whole person, situated within social and family relationships, and within nature, and the maintenance of the ‘self in balance with society’ (p.251). In this sense, the notions of balance and harmony are a representation of bodies as situated - or as in place - in the world. The sense of displacement, and of distress, in the women’s stories, appears in stark contrast to this. The separation from family and friends, and the isolation within the UK, represent a displacement, or a dislocation, that resonates with the fundamental sense of place implied with being ‘in balance with society’. Relph (1976) describes having roots (in a particular place) as having ‘a secure point from which to look out on the world, a firm grasp of one’s own position in the order of things’
(p.38). This is what is challenged, and temporarily lost, in the stories of the women; in their experiences of homesickness, understood as a loss of place.

6.6 Summary

The exploration of the migration stories of the research participants in this chapter show that the experience of migration is gendered; that is, that the men and women in this study experienced, and spoke about their experiences of migration, differently. The women’s experiences in particular are shaped by a traditional (and generational) understanding of the position of women within the family. However, the way that the men told their stories also express this; the women followed their husbands, but the men decided to start their new lives here. The refugee stories help to show the diversity of the Chinese population in the UK. Instead of expressing a sense of loneliness and isolation, as the other women did, these women spoke about a sense of freedom and safety associated with re-building their lives in the UK. Although their stories are different however, these women expressed the same understanding of the traditional role for Chinese women of their generation within the family. In addition, they also share an underlying understanding of health and wellbeing with the other participants in the study (which will be discussed in the following chapters). The discussion of homesickness, as a loss of place, returns to some of the ideas about place, relating in particular to issues of belonging and identity. These are issues that will also be addressed further in the following chapters.
Chapter 7: Health and Wellbeing

7.1 Introduction

This chapter addresses the understanding of health and wellbeing shared among the members of the community centre; as a collective understanding of health and wellbeing, expressed in terms of being together with other people, and being engaged with the world through relationships with others, rather than being alone. Among the participants who were formally interviewed, and among others that I spoke with at the centre, there was a range of health problems. These included diabetes, arthritis, high blood pressure, high cholesterol, heart trouble, depression and anxiety (see Appendix G). Some had one of these conditions, some had a combination, and several said that they had no health problems at the time of the interview. As this began as a study of long-term illness (as noted in Chapters 1 and 2), one of the aims of the study was to explore the long-term conditions prevalent among the centre members; to explore the ways in which having a long-term condition affected their everyday lives and what they did to manage those conditions. However, in response to this line of questioning, the participants generally chose to speak about health and wellbeing, rather than about their experiences of specific illnesses. This was articulated in terms of the connection between health and happiness, family and social relationships, being active and keeping busy, and thinking positively; all of which are addressed in this chapter. The experiences of the three participants with mental health problems reflect work around somatisation in Chinese cultures; that is, the tendency for psychological symptoms to be reported in terms of physical complaints (Kleinman, 1977, p.5). Although these are discussed separately in this chapter, these three women also expressed the same underlying understanding of health and wellbeing, as noted above.

7.2 Attitudes to illness: ‘you behave yourself, no trouble’

Most of those who reported having one (or more) health problems said that they did not see them as big problems and that it does not stop them from doing the things they enjoy or getting on with their lives. It was difficult to draw them to talk in detail about how they
managed their condition, or about who (if anyone) helped them to do so. Despite direct questioning (for example, ‘What do you do to take care of your diabetes?’ or ‘Does anyone help you with your diabetes care?’), in general people did not talk at length about this. They spoke about what they do to manage their health problems in a matter-of-fact sort of way; that they take the necessary medication, they take care with what they eat and they take some sort of exercise.

*Mr W said that he has diabetes but that he doesn’t see it as a problem. He said that he takes medication for it and does exercise, playing badminton and/or table tennis every day, and that if you keep moving and keep active, diabetes is not a problem.*

[FN37-02.04.14]

*Mrs X had the same little silver package of pills which she tipped out onto a napkin and took with some hot water. There was some discussion - and laughter - with the Tai Chi Master and Mrs G about the pills. Mrs X picked them up one by one and said what they are for - vitamins, blood pressure, diabetes. Even though she had all those pills, Mrs G said that Mrs X (who is in her 70s) is very healthy.*

[FN19-21.01.14]

Mrs E, who has had diabetes and heart problems for 20 years, talked about being able to control these conditions so that they do not affect her day-to-day life:

*NW: How does having diabetes affect your daily life?*

*Mrs E: Er, no, I control quite good.*

*NW: How do you control it?*

*Mrs E: Medicine, and I'm quite good for myself...I know what...I can enough my exercise...not overdone lot of things, so quite good.*

*NW: And that's the same for your heart problem? That you have medication and you look after yourself as well?*

*Mrs E: Yeah. Because each time when you do the diabetes checkup, they mostly check your heart too, so they say I'm quite good control myself. My weight is not up and down, not up and down, always the same thing. So that's it.*

[Mrs E, 72, Hong Kong]
Mrs F, who has had diabetes, high blood pressure and high cholesterol for 10 years, expressed a similar attitude; that it is possible to control these conditions, and that it does not affect her life very much. In the following excerpt, Mrs E and Mrs F are discussing this together (Mrs E, who is a friend of Mrs F, was also present in Mrs F’s interview):

NW: *In what way does it affect your life having diabetes, high blood pressure and high cholesterol?*

Mrs E:  *[pause] No...*

Mrs F:  *I don’t think so will affect anything, if you control yourself properly, will carry on just normal.*

Mrs E:  *Just, just eat the tablets.*

Mrs F:  *Yeah, just normal. Cut down yourself with the...the fatty things. I think, I think we control it quite well...quite well.*

NW:  *So it doesn’t stop you from going out or doing the things that you enjoy doing?*

Mrs E:  *No, no, no.*

Mrs F:  *No, no, no. Normal...I think most thing...this question is most thing you’ve got to behave yourself, that’s alright. If you’ve got something wrong, you know what you wrong, you behave yourself, no trouble. Carry on.*

NW:  *Do you agree with that? Is that the same for you?*

Mrs E:  *Yeah, yeah.*

NW:  *So, really it's down to you, to control it, and do the right thing?*

Mrs F:  *Yeah, down to you, that’s it.*

Mrs E:  *Er I think...is not very different in my life, that, that...little bit.*

Mrs F:  *Yeah, if you can control, that’s okay.*

Mrs E:  *Okay control yourself, yeah.*

[Mrs E, 72, Hong Kong and Mrs F, 60, Hong Kong]

Although both Mrs E and Mrs F use the word control, this is more a sense of discipline; as Mrs F says above, this is not about controlling the illness, but about controlling ‘yourself’. She suggests that if you have a (health) problem and you know what you can do about it, then that is what you should do; ‘you behave yourself, no trouble’. There is a

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15 This idea of discipline is discussed again in Chapter 9, in relation to the practice of Tai Chi.
sense of both responsibility and morality implied in this; about what you _should_ do and about what is the _right_ thing to do. For Mrs E and Mrs F, this is not problematic; they do what they need to do, they behave themselves and they carry on as normal.

Mr I also spoke in a similar way about ‘behaving yourself’. He recounted being told by his doctor that his blood sugar was a little high and said that he had cut down on the amount of sugar because of this:

_Mr I:_ Last time I went to...I mean blood test, the doctor said to me, I think your blood level slightly bit high, so...and then just gave me a warning, you know, so, and then I stopped eating sweets and cakes.

_NW:_ That was the sugar in your blood?

_Mr I:_ Yeah, yeah. The level, sugar level bit high, you know. Like, might be turning into diabetes or something...but he just tell me not, cut down little bit sweets...so now, just have a cup of tea, don’t put sugar in it...no problem, you know. That’s the only thing, you know. Yeah, otherwise I’m okay, everything.

[Mr I, 80, China]

Mr I did not express concern about this; he spoke about it in a matter-of-fact way, suggesting that he saw this as straightforward, as simply a case of changing his behaviour, and that this was ‘no problem’.

### 7.3 Health and happiness: ‘anything not happy, take it away…’

Many of the participants said that worrying, or dwelling on problems, is not good for you. Mrs L, who has diabetes and a heart condition, expressed this idea of not worrying about things, in relation to her health problems, as well as other aspects of her life:

_NW:_ Is your heart condition and your diabetes, is that a big problem for you or are they small problems?

_Mrs L:_ No, no, small problem.
Mrs L: Small problems?
NW: Yeah, I don't care.
Mrs L: You don't care?
NW: Yeah, because you've got to...always in your body. If you care you're not happy, yeah. If you care anything you're not happy. So you must open...not care anything, yeah.
NW: So you accept what's happening and you're happy anyway?
Mrs L: Yeah. So I'm not upset anything. Yeah, you know, included to my husband argue, yeah, nothing. I not talk with you this way, I go another way, yeah. I go to see the television, I listen to music to make me happy, yeah.

[Mrs L, 54, Hong Kong]

Others also said that worrying is not good for health:

Mrs R said that her husband had lost his sight and that she has to do a lot to help him. She said that this and her son’s divorce are her biggest worries. But she also said that she tries not to worry too much - that she is an open person and that she tries not to think too much about the things that worry her. Mrs T agreed with this as a good thing to do - not to worry too much as it isn’t good for you.

[Interview notes: Mrs R, Hong Kong and Mrs T, Hong Kong, interviewed together]

Mr Y said that health and happiness are important for each other and that you can’t have one without the other; if you’re healthy, you’re happy and if you’re happy, it helps you to be healthy. But also that if you are ill or have health problems that you shouldn’t worry about them and try to be happy anyway and do the things you enjoy.

[FN37-02.04.14]

Mrs L said that being unhappy is not good for your body and that even medication (for illness) cannot help if you are not happy:

NW: Is it good for your health to come here [to the centre] and be with your friends?
Mrs L: Yeah, oh my goodness, yeah.
NW: It is?
Mrs L: Because you’re happy and I think when you’re happy is healthy, is better than anything. If you’re not happy you take anything it can’t help you, you take a tablet it not help you because you’re not happy. I think happy is the first phase.

NW: The first phase?

Mrs L: Yeah. I think it’s...if you’re not...every time you cry you’re not happy, sad, fed up, it make your body no good, you feeling is no good, you take anything and do anything is no good for you. If I say I don’t want to come here I don’t see any people. It’s not good for me, too closed to you, you need to open, yeah, open to do anything, to do this...try this way. Yeah, if you like it go on if you don’t like it stop it. Don’t let anything control you, you control everything, yeah.

[Mrs L, 54, Hong Kong]

Mrs K, who is 75, and came to the UK as a refugee from Vietnam in 1978, expressed this more explicitly; she spoke about the harmful effect of holding negative emotions in the body. She said that health is the most important thing, more important than money, and that if you have your health you can do anything. She talked about not keeping negative or upsetting things inside the heart and not holding on to painful memories of the past; she said that if you keep hold of all these things it can make you ill.

She said don’t be grumpy all the time. It’s, got to talk to people. That even the people, you know, the...that you, not comfortable to talk to, but you need to try to be eased, and happy to talk to otherwise [...] Because your heart only that big. You can’t get all the negative feeling and emotion all into that little heart. So you need to let them all out. So anything good, anything good to remember, you keep that...always be there in your mind. Anything not happy, take it away... everything negative that, is keep inside, you’re not well.

[Mrs K, 75, China, interpreter speaking]

As discussed in the Chapter 3, within TCM, health is represented in terms of the balance of Yin and Yang and the flow of Qi through the body (Chan et al., 2006); and illness in term of imbalance or disharmony (Hwu et al., 2001, p.631; Kaptchuk, 2000; Tang et al., 2008, p.1939). The understanding of health and happiness expressed by the participants reflects
these concepts. This is particularly in terms of emotions; of not worrying too much about problems and of letting go of negative emotions. In terms of causing illness, Wong & Richman (2003) state that ‘excess emotions [can] have a deleterious effect on the body’ (p.14); this is what Mrs K describes when she says that keeping negative emotions in the heart can make you ill. The idea of ‘holding’ or ‘keeping’ negative emotions, instead of letting them go resonates with the idea of flow. Mrs L says that ‘you must [be] open…not care anything’; this is about letting negative things go and maintaining a balance in order to be healthy - and happy.

Mrs E described this idea about health and happiness as a ‘Chinese’ way of thought. This was in the context of a conversation between Mrs E and Mrs F about coming to the centre, in relation to keeping healthy:

Mrs F:  The good thing, you just only…in, in home, just you…
Mrs E:  …you stay by yourself is lonely…
Mrs F:  …by yourself home…
Mrs E:  …you coming down here mostly social you will be more happy…
Mrs F:  …you will be social more…make you happy…
Mrs E:  …in Chinese we say, if you happy and cheerful, you will be more…exercise yourself…will healthy more. That is what Chinese say.

[Mrs E, 72, Hong Kong and Mrs F, 60, Hong Kong]

Mrs E says that this is a ‘Chinese’ way of thinking about health and illness; this is what she - and others, in the way that they express the same ideas about health and happiness - understand as a ‘Chinese’ rather than an English understanding of health and illness.

7.4 Being together: ‘meeting people make you happy’

The idea of health and happiness was also expressed in terms of a collective understanding of health and wellbeing. Participants talked about their own health in relation to being together with other people and in terms of family and social relationships. What is expressed here about being together with other people being good for health, is also a
reflection of the women’s experiences of loneliness and isolation in their early years in the UK (as discussed in Chapter 6); they spoke of being alone in their homes isolated from friends and family and they expressed the distress and unhappiness they felt in that situation.

Mrs H articulated the relationship between health and happiness in terms of meeting friends and being with other people. She explained that being active and meeting with friends makes you happy and that people who are not happy are at risk of developing depression.

*Mrs H:* Meeting people make you happy. People with, er...not happy is, easy to create a...what they call a depression, is it?

*NW:* Depression?

*Mrs H:* Depression. Depression, yeah. You have to...more active. If you come here, have a laugh, you go home, you’re happy [laughs]. If you stay home doing nothing [laughs]...you’re just not, not happy. I think getting out is er...is very good, you know...meeting friends. You have a good laugh. Yes.

[Mrs H, 57, Hong Kong]

The emphasis here is that it is important to be with other people, to go out every day, and not stay at home alone all the time. Others also expressed this clearly:

*Mrs E* started singing at the top of her voice. She had a piece of paper in her notebook with the words of the song she was singing, and explained that it was about how to be old - not staying at home alone all the time and being miserable, but that you should go out and do activities and meet people.

[FN41-22.04.14]

There were many occasions when the women were singing songs like this; about friendship and being together. Singing these songs together was a way of expressing this shared understanding - of being together and being happy in order to be healthy - and of strengthening the friendship and support between them.
7.5 Health and Family: ‘how you going to look after your parents if you are not well’

Mr W, who has diabetes, spoke about his own health and happiness in terms of the health of his family:

*Mr W said that family is important for health and happiness - that having a family, and taking care of your family and children, makes you happy. He said if your wife is healthy, and your children are healthy, you are happy [...] He spoke again about having family and doing things to be happy and that he had lots of friends and a good social life, and that this was important for both his health and happiness.*

[FN37-02.04.14]

Mr J also spoke about his family as an important part of keeping healthy:

*NW:* What’s the most important thing that keeps you happy and healthy?

*Mr J:* Oh I think, er, my sisters and brothers, my family. My son’s children.

*NW:* Your family.

*Mr J:* Yeah, I always think of them as my next best thing. Because...somehow I, when I went to Canada I got really connected with my sister and brothers, although they are far away, but every time I spend time with them I feel very, very warm, very warm and welcoming. Not a moment of...of bad things, every moment is precious with them. So I...I...I even this time my mother pass away...only at that moment I was very upset but afterwards we’re together and then we do things altogether my sister and brothers. So we’re very, very closely related.

[Mr J, 70, Hong Kong]

The closeness of his relationship with his brothers and sisters is very important; he speaks about being connected and feeling welcome and says that being together with his brothers and sisters helped him to cope with the death of his mother. Later in the interview, he said that he has also tried to maintain this closeness in his relationship with his children and grandchildren.

Mrs Z spoke about keeping healthy in terms of family relationships and responsibilities:
The reason why...how you going to look after your parents, if you are not well... this is the responsibility you keep yourself well. It is your job. If you are not, you are a bad person. So, this is the way we’re brought up with [...] the family...they give you all the good ingredient, to support your positive growth. So, your job is, when you’re getting older, is support them back. And, supporting the young.

[Interview with Mrs Z]

This is not just about being with other people, and maintaining good social and family relationships. There is also a sense of morality here; that keeping healthy is a way of fulfilling responsibilities to others, in particular to parents and children. In this way, keeping healthy is not about individual health, but about family relationships and responsibilities. Most of the participants expressed a sense of responsibility towards their families; to look after both their parents and children and that it was expected that they would do this. In this respect, Mrs E spoke about the Chinese - as opposed to the English - way of looking after the family:

*Chinese culture, always singing, look after the baby, look after the top. But in English culture, look after myself, look after small one, never my gran...grannies out. I don't like it. That is very wrong.*

[Mrs E, 72, Hong Kong]

Mrs E said this in the context of talking about going to live with her son. She had lived alone for a long time following the death of her husband, and although she feels that she is still able to manage on her own, she said that she is getting old and she does not know how long she will be able to manage on her own. I asked her how her children view this:

*Mrs E:  My children is...same English way.*

*NW: They think the English way?*

*Mrs E: Yeah, but...they still care, but not like proper Chinese care. They care...this is my mother. I’m okay, I got my mother okay. But in proper way, Chinese, mother by myself, I got to be all together, you know, all together.*

*NW: So you wouldn’t live on your own?*
Mrs E:  Won’t living on your own. But in Chinese way, you got to be living with the family. You know, those kind of thing. But I’m half English, I don’t want living with them. But now, I thinking I got to be ready myself, get in their group.

[Mrs E, 72, Hong Kong]

Others also expressed a reluctance to rely on their children for help, and said that they did not want to trouble their children with their problems or worries, or to be a burden to them. Mrs S, who has diabetes and ongoing problems with her nose and throat, lives alone but sees her children regularly. She talked about family responsibility and the importance of taking care of her family. Her parents live in another town (several hours away) and she regularly goes there to look after them. She also regularly travels to Hong Kong to look after her mother-in-law. She said that having children makes you ‘so happy, happy beyond words’ and described her children as a blessing. I asked if she talks to her children about her health problems, but she said that she does not want to trouble them and that they have their own lives to lead:

INT:  She doesn’t want to trouble them. They have their work and their own time.
       She try to, you now, find time herself, don’t to, don’t trouble them.
NW:   Not to trouble them.
INT:  Yeah, she... she not going to stay with her children because they have their own life. You need to know er, you know, don’t, not to trouble other people.
NW:   You need to be independent, that’s important?
INT:  You need to look after, know how to look after yourself. Not to let children worry about you.

[Mrs, 58, Hong Kong - interpreter speaking]

Mrs D, who suffers with anxiety and stomach problems (to be discussed in more detail later in the chapter) also said that she does not talk to her children about her health problems for the same reason:

NW:   Do you talk to any of your children about your health?
Mrs D: Children I don’t talk.
NW:   Why is that?
Mrs P also said that she does not discuss her health with her son. Although she said that she did not want to trouble him with her problems, she also emphasised the generational difference between them, which she said made it hard for him to understand her problems:

NW: Do you talk to [your son] about your health?
Mrs P: Er...no, I don’t. Because they young...they are not...in your shoes...they don’t feel...when I was young I will not expect, oh I am near there. I still have more things...to do...I will, I will try to achieve some more things.
NW: So it’s hard for him to understand?
Mrs P: Yeah.
NW: Where you are in your life because he’s...
Mrs P: ...still in the peak of his life.
NW: Yeah

Mrs P suggests a separation from her son in terms of life experiences and circumstances. However, this also seems to be reflected in relation to generational change within the family. As Mrs E suggests, the younger generation - her children - view their family responsibilities differently. She attributes this to being influenced by ‘English’ ways. This suggests that the traditional values concerning care within family relationships are played out in a context of change. In this respect, Mrs Z spoke about the differences for people of her generation (and older) living in Hong Kong and the UK. She spoke about this in terms of financial independence; that in the UK, older Chinese people (at least those who are associated with the community centre and the wider Chinese community in the area) have greater financial independence:
Mrs Z: Even though they all have the same concept that the sons should look after them when they’re getting old…that traditional concept still remains…but they are more free than in Hong Kong, because the people in Hong Kong, they still need to rely on their son to look after them, they need to say, can I have some money. But, in here, I don’t really care, you know. But, I expect you coming, you know, get me something, but I…but I’m fine, you know. So…it is completely different…you know, the dependence on the children. Here they are totally independent and in charge…in control over their lives, but there is different.

NW: So it changes the family relationships?

Mrs Z: It does, yeah.

NW: So, even though the expectations are the same, it changes the reality of it?

Mrs Z: Yeah. And, I think, you know, gradually they do realise the realities that children can’t stay with them. And, they accept that.

[Interview with Mrs Z]

7.6 Being active: ‘you’ve got to find summat to do keep yourself busy’

Like the understanding of not worrying about problems or holding negative emotions in the body, the idea of ‘being active’ - of going out, doing activities and meeting people - also reflects some of the underlying concepts of health and illness within TCM. This idea of being active is not specifically about physical exercise (although many of the participants said that they take exercise regularly), but about movement and flow, and engagement with the world. This was reflected in the ways that participants spoke about keeping busy, doing things, and being with other people, rather than staying at home alone doing nothing.

Mrs Q spoke about this in terms of keeping busy and said that she does not want to stay at home all the time on her own feeling sad:

Mrs Q: I think the people keep moving, keep happy, should be healthy. That’s why I won’t stay home all the time, no, no. Later after dancing we go to play
muhjong...yeah...keep busy, should be keep busy [...] Keeping busy I’m happy, yeah.

NW: If you’re unhappy do you think that that causes illness?

Mrs Q: Yes.

NW: Can you explain that?

Mrs Q: Er, sometime I’m not happy I’m still...oh I feel quiet all the time. No, no, just like that, I feel cry. Like during the week day we go out here or dancing like Friday, Saturday I’m okay to stay home. Yeah, I’m very happy to stay home two days or go to work it doesn’t matter, yeah. Monday to Thursday I’m staying home and Friday, Saturday oh no I don’t know what to do.

[Mrs Q, 66, China]

Mr I, who is 80, and who has high blood pressure and high cholesterol, also spoke about being busy and doing something - as opposed to doing nothing - as important for health.

NW: How do you keep yourself healthy?

Mr I: Er...being busy, you know. Being busy, yeah, busy, because, once you stop it’s no good, you know. Yeah, that’s it...being busy, part of it, really...you know, doing nothing, I don’t think is doing any good, you know...you’ve got to find...summat to do to keep yourself busy. And then, you know...well, with some of them, not able to do a lot, but at least...do something...better than doing nothing.

[Mr I, 80, China]

He spoke about people retiring and having nothing to do and again said that finding something to do is important for health. He used his father-in-law as an example to show that even when people have health problems they should still try to be active and find something to do:

Lot of them people retire, just sit at home...doing nothing. You know, for example, my, my father-in-law, he had got diabetes, you know, they don’t do nothing...my mother-in-law spoil him, you know, don’t let him do anything, that’s no good...don’t do the garden, don’t do nothing. Sit down watching the telly, and then smoke. That’s all what he does, you know. Even go to the barber, only about...not that far...he can
walk, and then he ask, ask me for the lift, down the road, you know. That’s a good idea, ten, fifteen minute walk, come back. So he just…and then die of a heart attack. You know, they, it’s no good do that...just waiting to die innit...yeah. That’s the only thing, yeah, people retire, don’t just completely stop, you know. Find something to do. Yeah. So that’s...[laughs]. Yeah, it’s very important, I think. You know.

[Mr I, 80, China]

There is a sense of stagnation in what these participants say about staying at home alone and doing nothing; Mrs Q says that you need to keep moving, Mr I says that ‘once you stop it’s no good’, and that doing nothing is ‘just waiting to die’. Mr J adds to this an understanding of wellbeing that also relates to an awareness of the environment around him:

NW: You used the word wellbeing before.
Mr J: Wellbeing, yeah.
NW: What does that mean to you? What does the word wellbeing mean?
Mr J: Wellbeing means, er, you are just, er, being happy and healthy I think. To be like conscious of what...what the environment doing to you and you...what you are feeling, happy and healthy about what you doing. And, yeah, that’s what I thought of the word wellbeing.

[Mr J, 70, Hong Kong]

The importance of being active, expressed by these participants, reflects a sense of being engaged with the world; through doing things and through relationships with other people. This resonates with the holistic understanding of health and illness within TCM; that health and illness concern not just the physical body, but the whole person, as it is situated in social and family relationships, and in relation to the environment (Jovchelovitch & Gervais, 1999, p.251).
7.7 Thinking positively: ‘we are not talking about the negative things’

I spoke to Mrs Z about the fact that many of the centre members who have health conditions said that these are not problems, and that it had been difficult to get them to talk in detail about what they do to manage those problems. We also spoke about the idea of health and happiness as it had been expressed by the participants. Mrs Z explained this in terms of their upbringing, as a generational trait; that they were taught to be positive rather than dwell on problems.

*This is the way we’re brought up with...we need to think positively [...] it’s all talk about positive...it’s not talking about, well, you’re ill, what you going to do. We don’t think about that...we think about we’re all responsibility, and a positive outcome...if you done well. So, this is the concept we have. We are not talking about the negative things. So, you will never think, how you going to keep... if you ask them, if you’re ill, what you going to do, they still talking about, I will do this, do this to get better....So, I think this is straight away the perception, and it’s all come out from our upbringing. And, all is...is our, you know, belief system.*

[Interview with Mrs Z]

This was expressed by the centre members not just in terms of health and illness but in terms of a general attitude to life and a way of coping with difficulties. Mrs P expressed this in terms of the importance of seeing other people with worse problems than her own; that it is important to accept what we are given and to find a balance, or a sense of peace, with this:

*God give us some bad things and good things, so we have to accept it. You know, like some people are more beautiful than the others, but some people beautiful they may not be the happy ones because they have some unlucky things in their life. As my son put it, I say why some people are lucky, good looking, some ugly, some fat, some thin, some tall, some small. Say no, we all have our own identity, we...that is what he say...variety, so we are all different, we all have our own beauty [...] And also, you are not alone. Yeah, some people have some very...un...solvable problems.*

[Mrs P, 66, China]
When she spoke about getting used to her life in the UK and some of the difficulties that she had faced, Mrs M said that she never says that she cannot do something and that she will always try. She had spent much of the first few years in the UK alone in the flat she shared with her husband above the take away shop where he worked, and said that this had been an unhappy time for her.

*I always said that the English, is how do you say, never say I can't do it like that in Chinese...you never say do that, you can, you never say that I can't, you can. You try to do it, you can do it [...] My life is like that...some time I really shy lady...but now, you must do...I need to do and I can do it, everybody can do it. So it's like that. If you say I can't do this so you upset your life you're here, I can do it, get the power to do something. I just like that.*

[Mrs M, 64, Hong Kong]

Mrs Z explained that this attitude of letting bad things, or problems, come and go, is the way that Chinese people approach problems; by thinking positively and trying not to focus on negative things. This attitude was clearly shared among the participants, and was particularly evident in the way that they spoke about not worrying about problems and not keeping negative emotions in the body (as discussed above).

7.8 Mental health

There was a notable difference in the way that the three participants who had problems with anxiety and depression spoke about their health. In contrast to the other participants who said that their illnesses were not problems and they did not stop them from getting out and doing things, Mrs C, Mrs P, and Mrs D all expressed a sense of distress about their health problems. When I discussed this difference with Mrs Z, she explained that in TCM a distinct separation is not made between physical and mental health. She said that the idea of ‘health’ is more holistic; that there is just one word for it, and that it incorporates both mental and physical health.
In the Chinese medicine textbook it talks about Jingshen, you know Jingshen is a Chinese term for mental health. It is not hundred per cent equivalent to mental health in English term. So, jing is your essence, shen is your spirits. So the body essence plus the spirit is your mental health in the western terms. So, it’s not right translation...but this is what Chinese call Jingshen, if they say, oh, how are you, yeah, and you look well, that mean your Jingshen well, that means you’re physically and mentally, you know, well.

[Interview with Mrs Z]

Mrs Z is clear that it is not that Chinese people do not experience mental health problems, but that it is conceptualised and understood in a different way. It is not separated out, but rather it is bound up in a broader understanding of health, with physical and mental health bound together. As discussed in Chapter 3, this represents a cultural patterning of illness, and reflects elements of Kleinman’s work on somatisation in Chinese culture(s), in which psychological symptoms are reported as physical complaints (Kleinman, 1977, p.5; 1980; 2004). Kleinman (1980) suggests that somatisation provides a mechanism for creating distance from emotional and psychological problems by focussing concern elsewhere (p.149). He (and others) also highlight the stigma and shame associated with mental health problems in Chinese societies (Green et al., 2002; Kleinman, 1977; Li & Logan, 1999; Yang et al., 2014; Yang & Kleinman, 2008; Yang & Singla, 2011), such that ‘minor psychiatric problems frequently are given a medical sick role by the popular culture, and by other health care sectors’ (Kleinman, 1980, p.125). He adds to this that for some, the diagnosis of mental health problems is ‘morally unacceptable and experientially meaningless’ (2004, p.951). These issues hold relevance for the three women in this study who experienced problems with depression and anxiety as sources of personal distress and suffering, but for the most part spoke about this in terms of physical symptoms.

7.8.1 Mrs C

Mrs C has suffered with depression for over 20 years. She said that she does not know what the cause of it is, but that it ‘came to her’ as she went through the menopause, and that it has ‘followed’ her ever since. She takes medication which her GP changes every few months; she said that her body gets used to the medication after a while so it is less
effective. She said that when her depression is especially bad, that she cannot eat, sleep or walk.

NW:  And how does the depression affect your everyday life?

INT:  Very hard, very difficult. Can't eat, can't walk. Today is not very good because she didn't sleep well.

[Mrs C, 72, Hong Kong, interpreter speaking]

This is different to the other participants who said that their illnesses do not particularly affect their daily lives. None of the others said that their illness stopped them from doing things, whereas Mrs C says quite clearly here that when she is unwell that she cannot do things. She said that she is aware that she has some anxiety and that this also stops her from going out when she is unwell:

INT:  Yeah, she aware that she's some form of anxiety. Like, now, she talking to us, she feel is a bit nervous and then starts to sweating. She know that, yeah. Yeah, so she feel that, you know, even that when she speaks it's not so fluent, you know, it's, because it's anxiety, can't relax.

NW:  Is that a symptom of your depression?

INT:  Yes.

NW:  So when you feel really bad you don't go to [the centre], because of the anxiety?

INT:  She's not normally so tired so she couldn't make effort to go. There's not - the loss appetite, so there's no point to go.

NW:  So you stay at home when you feel really bad?

INT:  So if she feel a little bit better she will force herself to go out, walk round the block, yeah. Get some fresh air and meet friends, yeah. Outside, walk, big difference, yeah.

[Mrs C, 72, Hong Kong, interpreter speaking]

Although this excerpt is focussed on how Mrs C’s depression affects her daily life and the things she is unable to do when she is unwell, it also reflects some of the things that other participants said in relation to getting out and meeting with friends playing an important part in maintaining health. The difference here is that although Mrs C does those things -
getting out and being with others - when she is well, she also spoke about not being able to do those things when she is unwell. She was a member of the Tai Chi group and also came to the centre for lunch but she only did this when she was well. At the time of the interview she had not been to the centre for several months. However, I did see her at the centre on several occasions after the interview and she was obviously an established member of the group. She said in the interview that she was happy in the UK because she has a lot of friends here, that she had been involved in singing, Tai Chi and English classes at the organisation that the centre is part of, and that she has friends there too. She also said that when she is unwell, her neighbours look after her:

\[ NW: \] You said that your [Chinese] friends in this building are important?
\[ INT: \] Yeah, very important, yeah...Yeah, sometime she's not well and you know [name] she came to see her...Yeah, [name] came to see her as well, yeah.

\[ NW: \] So where do you get the most support from when you're really ill?
\[ INT: \] They, they [her neighbours] just come...you know, they know that she's not well. They just come automatically. Yeah, they just come.

[Mrs C, 72, Hong Kong, interpreter speaking]

Although Mrs C openly said that she has depression, and used the words depression and anxiety, she did not speak about this in terms of emotions. She said that it is her brain that makes her unwell, and that when she is unwell that she cannot sleep, that she feels tired, and that she has no appetite. These were the reasons that she gave for not going to the centre when she is unwell - being tired and not being able to eat. Her articulation of these physical symptoms reflects Kleinman’s suggestion that somatisation enables concern to be focussed elsewhere, away from emotional problems (Kleinman, 1980, p.149).

7.8.2 Mrs P

Mrs P suffers with anxiety, depression and problems with sleeping, all of which she said had troubled her for most of her life. Like Mrs C, she talked about these difficulties in a different way than other participants had done about their health problems, and there was a greater sense of sadness with the difficulties that she had faced in her life. She described a long struggle with stomach problems, with difficulty sleeping, and with tinnitus, and said
that she had tried many different kinds of treatment for these problems over the years. However, within this, she also expressed some of the same ideas as other participants about trying to stay positive and about being with other people, as mechanisms for maintaining, or striving for, good health.

NW: Before, you said that you make yourself come here.
Mrs P: Yeah.
NW: Is that for your health as well?
Mrs P: Yes, for two reasons. One is for my own health and one for...seeing people...
NW: A lot of people have said to me that it's important for your health to be happy.
Mrs P: Yes.
NW: Do you agree with that?
Mrs P: I am, yeah
NW: Can you explain that?
Mrs P: I, just...recently...become...to consider why I make myself so anxious, so angry, so unhappy, if I cannot change that bad things, is better to see to the positive side, anything bad I just put it aside and to see the positive side. If I am happy, my health problem will be better, you know. So, it's better when you see people, you smile, and you are happy...I believe, I believe, when you are happy your body will be more relaxed, and...the circulation better.

[Mrs P, 66, China]

Although this is the same idea of health and happiness, Mrs P expressed a sense of struggle with this; that even though it is not easy for her to go out and to be with other people, she feels it is important for her own health to try. This was particularly related to the danger of being on her own too much, even though she is shy and can find it difficult to be among people she does not know all that well.

Mrs P: I am not an active person, and I feel...you know I have try very hard to come out...to join this Tai Chi class...I am a shy person, I can’t face strangers...home is my shell...I feel comfortable...secure, safe, at home.
NW: So it’s quite hard for you to come out?
Mrs P: Come out.
NW: But you do come here twice a week, don’t you?
Mrs P: Yeah, try very hard.
NW: Does it feel important for you to do that?
Mrs P: It is important.
NW: Why is that?
Mrs P: I can, you know, I can understand that if I...have no chance to meet people I will be on my own...alone...in my own little world, and maybe I will develop some kind of...mental problem, so I need to come out to see people, how people...you know this, you know, across the world is changing, people’s behaviour also...changing. So I need to...know this...to see people, and how they...behave, and how the world is changing, how people is coping with the new society...you know, the new techniques.

[Mrs P, 66, China]

Mrs P was very open and candid in her interview; although she spoke about a long struggle with difficulty sleeping, stomach problems, and tinnitus, she also talked about feeling anxious, angry and unhappy. Unlike Mrs C, she did speak about her emotions (anger, anxiety and unhappiness), which caused her obvious distress and discomfort. She struggled greatly with her health problems, and although she was open, she did not speak with the same ease with which other participants spoke about their health problems. This last excerpt expresses a sense of change, which she also referred to in other parts of the interview. Talking about going back to Hong Kong she said: ‘I am a foreigner there...because, there...the world is changing. The whole world…it wouldn’t be the same as what I have left behind...no, is not the same’, and later added, ‘I don’t belong to anywhere’. This depicts a sense of being in between life as it was and life as it is now, and a sense of being out of place, that also resonates with the idea of a holistic view of health and illness that conceptualises bodies in place in the environment and social relationships (Jovchelovitch & Gervais, 1999, p.251).
7.8.3 Mrs D

Mrs D has had diabetes for 30 years. She said that having diabetes does not particularly affect her daily life or stop her from doing the things that she likes to do; just that she needs to take medication every day and be careful with what she eats. Like others, having diabetes did not seem to be much of a problem for her. However, Mrs D also spoke about an ongoing problem with stomach pains which she has seen her GP about on numerous occasions. Mrs D told me that her GP says this is caused by a psychological problem (anxiety) and so has stopped the medication that Mrs D had been taking for this problem.

INT: Now she [the GP] cut all the medication. Tells her don’t need to take all this medication. Cut two to three medicine.

NW: So your doctor is telling you to take less medication?

INT: Yeah...she says she have a stomach pain, but the doctor cut the stomach medicine, yeah.

NW: Do you agree with what the doctor is telling you?

INT: She’s not agreeing with the way she treat her, and...now she’s very painful, told her it very, very painful, but she says there is nothing can do about it.

NW: The doctor says there’s nothing?

INT: The doctor say so, yeah.

NW: So what does that mean for you? What do you do when you the doctor says she can’t help you?

INT: Yeah. It’s okay. The relationship’s okay. Even she don’t prescribe anything, but still okay...just bear the pain herself...it’s difficult because pain everywhere...so every time she goes to see the doctor she says it is a psychological problem. Yeah, so nothing to say about that. Yeah.

NW: And how does that make you feel?

INT: She only accept it.

NW: You accept it?

INT: Can’t do anything about it.

[Mrs D, 64, Hong Kong, interpreter speaking]

This interview excerpt followed on from Mrs D talking about having had to change her GP; Mrs D said that her previous GP had been very good, and that the new GP had been
good to start with, but Mrs D was not so sure now. This seemed to be in part because the GP had stopped some of her medication. Mrs Z told me that when Chinese people go to the doctor they expect to be given something - a prescription or some sort of medication - and that they think it is not good if they are not given anything. This (unmet) expectation is evident in the way that Mrs D judges her GP as not good because she has stopped some of her medication. Mrs D expressed a real sense of despair about this problem and said many times during the interview that no one can help her.

"No one can help. No, even the doctor can’t help her. Even the doctor said I can’t help at all. If you are doctor, you know, he can’t help my illness then how can he be a doctor?"

[Mrs D, 64, Hong Kong, interpreter speaking]

In contrast to what the other participants said about being active and being with others as an important part of keeping healthy, Mrs D said that she does not have any hobbies or interests and that she does not go out very often. She just stays at home and sometimes goes out for a walk or to do some shopping. Although she said that she knows most of the people in the apartment block and that she sometimes sees friends in the building, she did not say that they stop by to see her when she is ill or do anything to help her (as Mrs C had) and she did not mention a social group that she belongs to and where she gets support from. She did not seem to have much help from anyone (although Mrs Z said she goes to see her and I did see and speak to her at the centre on one occasion after the interview) and she seemed lonely and despairing about her health. In this respect, and in the fact that she described her own health as very bad, Mrs D characterises what the other participants said about the connection between health and happiness; about being active, getting out and being with others playing an important part in maintaining health.

Mrs D’s situation reflects Kleinman’s (2004) suggestion that the diagnosis - and labelling - of a mental health problem for Chinese people can be ‘morally unacceptable and experientially meaningless’ (p.951). Mrs D spoke about having specific stomach pain, and general pain everywhere, and said that she had reported this to her GP many times, only to be told that it is a psychological problem. This diagnosis is clearly meaningless for her; she says that she ‘can’t do anything about it’ and that ‘If you are doctor, you know, he can’t help my illness then how can he be a doctor?’.
Mrs Z spoke about the problems this creates in the context of western health care, for example in the NHS in the UK, where the different understanding of mental health in Chinese cultures becomes problematic. Where evidence of a physical problem cannot be found and a patient is diagnosed with a mental health problem, this is a source of great distress and discomfort. There are consequences of this in terms of the provision of care for Chinese people in this situation, as Mrs Z describes:

*It’s going back to the original concepts of health…if you’re talking about physical health, but the doctor give investigation where there’s no particular significant thing physically…then the doctor remove them to mental health problem. But, in Chinese medicine it’s different…if you say, well, you…you’ve got physical problem…you know, if you can’t sleep, you can’t eat properly, that is all talk about your physical health […] So, your mental health is a bit down…it’s not you’re having a mental illness. So, the perception is different…we don’t talk about mental health…we talk about physical health. […] Mental health is not existing…they don’t perceive this is a mental health problem…this is a Chinese describe when you get this type of problem…your whole body will affect it. So, it’s not particular this is mental health. So, you might not perceive this is the mental health diagnosis, that’s the western medicine. But the western doctor will make the diagnosis, if there’s nothing with it physically…then, you move the category to mental health. So, how can I accept that, because it’s…no, I’m not that. It doesn’t make sense to them, it’s not make sense.*

[Interview with Mrs Z]

I asked her what this means for people who find themselves in this situation, whether they feel helpless:

*It’s not only helpless…it’s refuse…to going to receive any treatment. Because, this is not what they…expecting, this is not the problem, no. If you say, well, take the depression drugs…I’m not depressed, I just can’t sleep, I just can’t eat properly. I just can’t concentrate…on the things I want to do…no motivation because my Jingshen not well. So, I’m not depressed. Well, you can say, yes, I’m a bit down, I’m not…I’m not happy, yes, I can say that I’m not happy, but I’m not depressed in the…in the term, you know…in the illness term.*

[Interview with Mrs Z]
Mrs D’s situation illustrates this very clearly; she keeps going to her GP with a physical problem, but the GP repeatedly tells her that she has a mental health problem that she cannot treat, and this in itself causes more distress. Mrs D did not say that she had been offered any treatment for this psychological problem, or whether she would accept any treatment for this, but her despair and distress at her circumstances were clearly evident.

7.9 Summary

The understandings of health and wellbeing expressed by the participants in this study resonates strongly with the holistic approach to health and illness within TCM; that health and illness concern not just the human body, but the whole person, in harmony with other people and with the word around them (Jovchelovitch & Gervais, 1999, p.251). The participants spoke in particular about the connection between health and happiness; about being together with other people, about being active and keeping busy, and being engaged with the world, in order to be happy and therefore healthy. The importance of family relationships in this conceptualisation of health encompasses notions of responsibility and morality associated with keeping healthy in order to support other family members, in particular parents and children. As Mrs Z put it: ‘how you going to look after your parents if you are not well’. Generational change within families was highlighted, with the younger generation being seen as more ‘English’ and the different circumstances of older people living in the UK and Hong Kong were also highlighted in terms of the circumstances in which family responsibilities are played out.

With regard to social relationships and social engagement with the world, participants spoke about getting out, being with other people and doing things together, as an important part of keeping healthy. This was expressed directly in terms of health and happiness; for example, Mrs H said that ‘meeting people makes you happy’ and Mrs E said that ‘if you’re happy and cheerful you will be more…healthy’. However, it was also expressed indirectly by the women with mental health problems. To this effect, Mrs P said: ‘I can understand that if I…have no chance to meet people I will
be on my own…alone…in my own little world, and maybe I will develop some kind of…mental problem’.

The way that the participants spoke about health and wellbeing also reflects Kleinman’s work on somatisation in Chinese cultures, in particular the idea that focussing on physical symptoms creates a distance from emotional problems (1980, p.149). Mrs C, who has suffered with depression for 20 years, said that she does not go to the community centre when she is unwell, referring specifically to her physical symptoms (tiredness and loss of appetite) to explain this. Others expressed this in terms of trying not to worry too much or to focus on difficult or troubling things. Mrs L said that ‘If you care anything you’re not happy’, Mrs R said that she tries not to think too much about the things that worry her, and Mr Y said that ‘if you are ill or have health problems that you shouldn’t worry about them and try to be happy anyway and do the things you enjoy’. As Mrs Z explained, ‘this is the way we are brought up with […] we are not talking about the negative things’. This reflects Kleinman’s assertion that learning to control emotions is an important part of maintaining family and social relationships, such that individual wellbeing is dependent on harmonious relationships (1980, p.133).

This understanding of health and wellbeing is reflected in the way in which the participants in the study engage in the community centre, with each other and through particular activities that are culturally and socially meaningful (which will be discussed further in Chapter 9). The next chapter explores the participants’ choices around health care and treatment, within the context of this underlying understanding of health and wellbeing, but also taking in to account how this is shaped and influenced by other factors, particularly around identity and belonging.
Chapter 8: Maintaining health and treating illness

8.1 Introduction

Although the participants in this study expressed a shared understanding of health and wellbeing (as discussed in the previous chapter), the choices they made in their day-to-day lives about the treatment and management of specific illnesses, or episodes of illness, varied. This is explored in this chapter in relation to the choices they made about the use of TCM and biomedicine. Their choices are made - and expressed - with reference to the way in which each type of medicine is understood to work. However, participants also drew on other contextual factors, such as their families and their upbringing outside the UK, as well as practical issues of access to and communication with doctors and other healthcare professionals.

The different ways that the participants made these choices show that choices about health care are not automatically determined by cultural affiliation, but are also influenced by other contextual factors; that is, by the particular circumstances in which they are made. To this effect, Jovchelovich & Gervais (1999) suggest that choices about health care are influenced by the ‘concrete conditions of living…the particular patterns of interaction and communication within any given community [and] the lay and cultural knowledges that guide the interpretative frameworks used to make sense of health and illness’ (p.248). The choices that the participants in this study made about their use of TCM and biomedicine clearly reflect this.

Their choices also highlight issues of identity and belonging that relate to their migration stories (as discussed in Chapter 6); so that their experiences of migration and of rebuilding their lives in the UK are also a significant part of the context in which decisions are made about the treatment and management of illness.
8.2 TCM and biomedicine

As discussed in Chapter 3, TCM is a medical practice that ‘systematically addresses ailments as life-energy (or Qi) imbalances’ (Yang et al., 2009, p.207), and includes the treatment of illness with practices such as acupuncture, herbal medicine, moxibustion, massage, foot therapy, and physical exercise (J. Tang et al., 2008, p.1938; Yang et al., 2009, p.207). It is based on a holistic approach to health and illness that views the human body as situated in harmonious relationship with others, and with the environment (Jovchelovitch & Gervais, 1999, p.251). Illness, or ill-health, is conceptualised as imbalance, disharmony, or excess and deficiency (Hwu et al., 2001, p.631; Kaptchuk, 2000; Kleinman, 1980, p.91; Kleinman & Kleinman, 1991, p.284; Tang et al., 2008, p.1939).

In contrast, biomedicine, very broadly, refers to medical practices based in biological sciences and developed through clinical and laboratory research (Kroker, 2008). As a dominant medical model in western societies (Bury, 2013, p.111) it is associated with the development of medicine and medical care in hospitals, in which diseases were ‘dissociated from the bodies that [host] them’ and treatment was ‘directed at the disease rather than the person’ (Checkland et al., 2008, p.789). Kaptchuk (2000) emphasises that whereas TCM views each part of the body in terms of ‘its relation to the whole’ and situates illness in ‘the context of a person’s life and biography’ (p.7), biomedicine is ‘primarily concerned with isolable disease categories or agents of disease, which it zeroes in on, isolates, and tries to change, control, or destroy’ (p.3). Unlike the holistic approach of TCM towards health and illness, biomedicine is therefore seen as a ‘paradigm which treats body, mind and society as separate entities’ (World Health Organisation, 2007).

Bearing these formal definitions in mind, the participants in this study expressed their understanding of TCM and biomedicine in a more simplified way. This was expressed primarily in terms of different types of medication working in different ways to treat different illnesses. This is outlined briefly here, and explored further through the data presented in this chapter.

As noted in Chapter 7, among the participants who were formally interviewed, and among others that I spoke with at the centre, there was a range of health problems. These included
diabetes, arthritis, high blood pressure, high cholesterol, heart trouble, depression and anxiety. Some had one of these conditions, some had a combination, and several said that they had no health problems at the time of the interview. Many of those who were formally interviewed expressed a preference for western, rather than Chinese, medicine. None of the respondents said that they use only Chinese medicine; some said that they use both; some said that it should be one or the other not both together (biomedicine only in the case of these participants); and one participant said that she prefers not to take any kind of medicine at all.

Most of the participants who have long-term conditions said that they take medication prescribed by their GP. This included medication for diabetes (tablets and injections), medication for high blood pressure and high cholesterol, anti-depressants, sleeping tablets and painkillers. A number of the participants also said that they have regular check-ups, which included blood tests, blood pressure and blood sugar readings, heart monitoring, being weighed and having their feet checked (for those with diabetes). These types of medication and health care interactions in formal settings were described by the participants as being western or English; that is, healthcare provided by non-Chinese speaking and non-Chinese trained doctors or health care professionals, and the use of chemical medicine (i.e. derived from synthetic/chemical rather than natural sources). This included GPs who were of Chinese origin and spoke Chinese languages, but who were doctors of western/English, rather than Chinese, medicine. The use of the term biomedicine in this chapter refers to this articulation.

In terms of TCM, participants spoke about using herbs, herbal tea and soup, which could be purchased in a Chinese supermarket or a Chinese pharmacy, and which they would prepare and consume in their own homes. However, the use of TCM, other than herbal preparations and soup, was limited. Three of the women mentioned acupuncture as a specific example of TCM; one had had acupuncture for back pain, one for a problem with her wrist, and one as a treatment for depression. Another woman spoke about using a traditional remedy that her mother had given her as a child (a cream applied to the skin) for pain in her knee. These were the only specific instances of TCM that were mentioned in the interviews. With this in mind, in this chapter, the term TCM refers to natural (as opposed to chemical) herbal preparations (such as soup and tea), and herbal medicines or
treatments such as acupuncture administered by health professionals trained in a Chinese country.

As in other studies of medical pluralism among the Chinese in the UK, there was a shared understanding among the participants that TCM and biomedicine work in different ways to treat different types of illness (Gervais & Jovchelovitch, 1998; Green et al., 2006; Jovchelovitch & Gervais, 1999; Liu et al., 2015; Prior et al., 2000; Rochelle & Marks, 2010; 2011). Specifically, participants expressed an understanding that; TCM uses natural, and therefore softer medicines, and takes longer to work; that biomedicine is stronger, and works more quickly, but also has more harmful effects; and that TCM treats the root cause of illness and biomedicine treats the symptoms. In general, participants also expressed an understanding that TCM is used to maintain health and biomedicine to treat illness. This is reflected in the way they spoke about their use of both kinds of medicine; in general biomedicine was used to formally treat specific types (and episodes) of illness (such as diabetes, high blood pressure, high cholesterol), and TCM was used less formally, in their own homes, not usually prescribed by a doctor, but as a regular part of maintaining good health.

8.3 Maintaining health and treating illness

Most participants said that it depends on the type of illness whether TCM or biomedicine is more appropriate. Some explained this in terms of the ways in which the two types of medicine work; others expressed this in terms of the difference between maintaining health and treating illness.

Although Mrs P said that she does not use TCM, she explained that Chinese (herbal) medicine and chemical medicine work in different ways; that the former works more slowly and is less harmful for the body, and that the latter is quicker:

Mrs P:  *In Hong Kong we use both the...natural medicine...the herb medicine, and the chemical medicine. It’s...some illness is better to use the chemical medicine. It’s quicker. The...herbal medicine is slower, but the harmful is*
less. You know like these, our body has so many, the circulation have so many points...the acupuncture...that stimulate the circulation, it helps for some kind of illness

NW: So in some cases you would do that rather than take a tablet or some kind of medicine?

Mrs P: Yeah, yeah. So it two ways to work together [...] the natural, the herb medicine, and the chemical medicine, it depends on the nature of the illness. If for a pain, have a terrible headache, paracetamol, it helps in a minute, but with herbal, it takes...a few hours.

[Mrs P, 66, China]

Mrs C spoke more specifically about this, saying that for depression (which she has had for 20 years), TCM, in the form of herbs and soup, does not work:

Chinese medicine you need to boil the herbs...so it's, it's different. You can't take Chinese medicine for a dose or a couple of dose, you can recover. Her illness take a long time to recover...so that’s different. The Chinese medicine, we believe in one, a couple of dose, then you don’t need to take any. For her for problem you just can't take one or two dose so it's a long-term, using medicine, it doesn’t work.

[Mrs C, 72, Hong Kong, interpreter speaking]

Mrs C takes antidepressants and sleeping tablets and she had also tried acupuncture for depression which she said she had found painful and had caused her more distress.

Mrs B, who has high blood pressure, high cholesterol and diabetes, also clearly expressed that TCM and biomedicine are two different kinds of medicine and that the particular illness determines which one should be used:

NW: Do you think that there are some illnesses Chinese medicine is better for?

INT: Depends...Yeah, it’s a different reaction of Chinese medicine and western medicine. Chinese medicine is only...is secure the foundation and make a recover...and western medicine is treat straight away, for example fever, you can, you know straight away you can stop fever, but Chinese medicine can’t do that.
NW: It takes longer?
INT: It takes longer, yeah.
NW: How do you choose when to use western medicine and when to use Chinese medicine?
INT: Like the long-term condition, only western medicine. For her own health, to maintain good health, she will have some boiling soup with er, Chinese herb.

[Mrs B, 70, Hong Kong, interpreter speaking]

Mrs B suggests above that TCM deals with the cause of illness (‘secure the foundation’) whereas biomedicine treats the symptoms (‘western medicine is treat straight away’). In this respect, she uses TCM - in the form of herbs and soup - for maintaining health, rather than treating illness. Mrs G also expressed this idea, saying that soup is ‘not really medicine’, but rather a part of maintaining good health:

NW: Do you use any Chinese medicine?
Mrs G: No. No, no, no, no. No, no.
NW: Why is that?
Mrs G: Because...only some medicine, eating...something like the soup, but they not really medicine. I don’t want no Chinese medicine.
NW: Do you think that Chinese medicine is good for some types of illness?
Mrs G: I think both, I think...compare, I always talk to my friend compare to keep, keep the health long-term some Chinese good, eating...like the make the soup...but if you got an illness, I think the English [medicine]...good. So I always...got a headache or something, I take English medicine...I don’t...I don’t want Chinese medicine.

[Mrs G, 76, China]

Mrs Z spoke about the use of herbal preparations and soups; that she had found (through her own research) that a lot of Chinese people who had lived here for a long time still used this kind of TCM. However, like Mrs G, she explained that this is not really medicine, but a part of daily life:
Lots of Chinese people, you know, even they live here a very long time they still using Chinese medicine. But, this is not as a medicine, it's a daily life, you know, ingredient in the food.

[Interview with Mrs Z]

She went on to talk about this in the context of family life:

It's not only the soup, it's the family around...it's meaningless when you boil, you know, three or four hours soup only for yourself. So, it's do it for particular for the family member to maintain...their good health.

[Interview with Mrs Z]

8.4 Doing things the ‘English’ way

As noted in Chapter 3, although different, TCM and biomedicine are generally viewed as complementary systems of medicine that can be used together (see for example, Kaptchuk, 2000; Jovchelovitch & Gervais, 1999). Although many of the participants in this study used both TCM and biomedicine, according to what they felt was appropriate for different types of illness, not all of the participants shared this view. Two of the women said very clearly that TCM and biomedicine should not be used together; that it is bad for the body to use both at the same time. Mrs E, who has diabetes and a heart condition, said explicitly that using both TCM and biomedicine together is very bad; ‘both medicine, altogether, make people sick’. She told me this in the context of a story about someone she knew who had used both kinds of medicine at the same time and who had died shortly after doing so. She said what had happened to her friend had made her scared about using TCM and biomedicine together. She went on to say that:

I tell everybody if you...want English medicine, you use English medicine, you never touch Chinese. If you don't want English medicine, you touch Chinese. You don't do it both...you can't do it two way. One is inside, one is inside, both fight. Your body no good is it.

[Mrs E, 72, Hong Kong]
Like others, she also expressed the same understanding that the two kinds of medicine work in different ways:

*Mrs E:*  
*I don't say Chinese medicine no good. Chinese medicine take a...quite slow motion...in your body, quite slow motion. English medicine take you quite fast.*

*NW:*  
*So they work differently?*

*Mrs E:*  
*Work differently. Maybe they both is a work same time...but that same time is no good, is it? I just thinking you got to take one. But I believe it...English medicine is the best.*

[Mrs E, 72, Hong Kong]  

Mrs F, who has high blood pressure, high cholesterol and diabetes, also expressed the same idea that using both kinds of medicine together is not good for the body; that it should be one or the other, not both together. Mrs E and Mrs F talked about this together during Mrs F’s interview:

*Mrs F:*  
*The English doctor told me eat that, when I go eat more Chinese medicine it's too much.*

*NW:*  
*It's too much?*

*Mrs F:*  
*Yeah.*

*NW:*  
*Do you think that English medicine is better?*

*Mrs F:*  
*Because the doctor told me eat that, is better, but no Chinese doctor tell me eat that...*

*Mrs E:*  
*We don’t see the Chinese doctor.*

*Mrs F:*  
*No see the Chinese doctor.*

*Mrs E:*  
*But we are mind just thinking, we got diabetes, we got blood pressure. They can give you tablet, control and behave yourself, they will do job, why go to see Chinese doctor? Already control it. That's the point, that is the point.*

*NW:*  
*So the English medicine that the doctor gives you, it helps you and it works?*

*Mrs E:*  
*Yes.*

*NW:*  
*So you don’t feel you need anything else?*

*Mrs E:*  
*No, no, no. We don’t need...*
Mrs E: If I er...anything else, it’s double, too much, yeah.

NW: It's double.

Mrs F: Yeah, yeah...it's not...not very good for your body...

Mrs E: ...mix the body, you know...because they don’t know the direction. Where you go to English, where you go to Chinese...[indicates two types of medicine in her body with her hands]...the medicine don’t know the direction so, so we don’t agree that.

Mrs F: Just one, one side, not both side. Yeah, if you eat that one, then don’t eat that one. If you eat that one, then don’t eat that one.

[Mrs E, 72, Hong Kong and Mrs F, 60, Hong Kong]

Both women also expressed this choice in relation to their identity; that choosing to use biomedicine rather than TCM is one of the ways in which they think in an English rather than a Chinese way. Mrs E said that she is ‘English person’ in this way:

In my mind English [medicine] is best. I think it is. That is why they say I'm English person. I'm not Chinese person because I think the English thing [medicine] is better than Chinese thing.

[Mrs E, 72, Hong Kong]

With this choice, both women also expressed something about their adaptation to life in the UK; that they are here and that it makes life easier for them living here to do some things the ‘English’ way:

Mrs E: Because we are mind is...we stay England...take the English...

Mrs F: That’s easy for the, the...

NW: ...because it’s easy for your own self?

Mrs F: ...yeah, yeah, yeah.

Mrs E: If I need Chinese medicine, something wrong, how can I go to see the doctor?

Mrs F: There’s no doctor, no doctor.

Mrs E: The doctor won't want, won’t want know you. They won't understand. That’s why, if you trouble, you go to your GP...you don’t go to Chinese medicine.
Others also expressed this in terms of being used to the English way of doing things. Mrs O, who came to the UK in 1978, said that she does not use TCM and that if she was unwell she would go to her GP. She said that when she first came to the UK, as a refugee from Vietnam, there were very few Chinese people living here so it was hard to get hold of TCM; now she is used to going to her GP and would not consider using TCM. Although expressed slightly differently, this is also a choice about making life easier and adapting to her life in the UK.

Mrs N, who has diabetes, said that she does not use TCM because it would cause problems with her GP. Again, this is a choice about making her day-to-day life easier:

\[
\begin{align*}
NW: & \quad \text{Do you ever use any Chinese medicine?} \\
Mrs N: & \quad \text{Not really, no.} \\
NW: & \quad Why not? \\
Mrs N: & \quad Because I go to check up, yeah the doctor, he...you trust me...you just be no use that, you not allow use something else to control your diabetes. So that's why I know, I like England here, so I just listen the doctor, what I do, what I do not take. I don't take the Chinese medicine, so, yeah. Because if I take Chinese medicine, they don't look after me.
\end{align*}
\]

[Mrs N, 61, Hong Kong]

8.5 The influence of family

For others, family and social contexts influenced the choices they made about using TCM or biomedicine. Mrs K, who has pain in one of her knees, which she said she thinks is caused by the type of work she has done in the past (in Chinese restaurants and takeaways), talked about using a cream that her mother used to give her as a child:

\[
\begin{align*}
INT: & \quad \text{Before bed yeah. Ointment.} \\
Mrs K: & \quad Yeah. Every night.
\end{align*}
\]
NW: Is that from your doctor?
Mrs K: No, no. [Chinese Spoken]
INT: The Chinese, the Chinese ointment.
NW: And why do you use that for your knee?
INT: It helps...it more comfortable after put the ointment.
NW: But if it’s not from a doctor, how do you know that it’s good for you?
INT: It was from her mum. So, every time there was...she stomach ache, so put it on her hand and then rub on her tummy, so yeah [...] Even the doctor saw that, did also tell her to do, use it, yeah.

[Mrs K, 75, China, interpreter speaking]

Mrs K spoke about this as a fond memory of her mother, and of her childhood; she smiled when she spoke and it was clearly a comforting memory. In this sense, her family context plays an important part in her choice to use this cream for the pain in her knee. However, Mrs K also said that she takes aspirin as a painkiller. She started to take it several years ago after having tooth ache; she had gone to a chemist and had been given aspirin for the pain and has taken it ever since because it also helps with her knee. For Mrs K, family is just one of the contexts which shapes her choices about her health; her family, or more specifically a memory of her mother from her childhood, and advice from a pharmacist in a chemist, represent two different contexts for making these choices.

Mr J also talked about using TCM in the context of a family relationship. He spoke about using a herbal remedy in the past which his sister had given to him:

NW: Do you ever use any Chinese medicine?
Mr J: Not...not now. Not now. I rarely use it now. Maybe long time ago... Chinese medicine like...I still have the tablet...It’s made from a Chinese...plant...I don't know whether I’ve still got it or not. It’s like...it’s like a plant but they...but they grind it into powder to make a capsule. It’s...it’s good to your wellbeing...like general health. So I had that occasionally. Just swallow with water.
NW: But you don't take that now?
Mr J: No, no, I used to have, yeah.
NW: Why did you stop using it?
Mr J: Um...I don't know why but...it’s, er...not all that helpful...I can do without it that’s all, yeah.

[Mr J, 70, Hong Kong]

I asked him if anyone else in his family, or among his friends, uses TCM and his response to this suggests that he sees the use of TCM as linked to location; that people living in Hong Kong (his sister for example) may still use it, but that people here (such as himself) do not. This also resonates with others who expressed their choice to use biomedicine rather than TCM in terms of their adaptation to life in the UK.

Um...not really, now. Er...my sister in Hong Kong maybe use it, the Chinese...but I don't know anybody that uses Chinese medicine [here]...don't seem all that popular now.

[Mr J, 70, Hong Kong]

Mrs H came to the UK with her family as a teenager. She said that even in Hong Kong as a child her family used biomedicine, rather than TCM. Like others, she emphasised that it is the type of illness that determines what sort of treatment is appropriate:

NW: When you were a child were you given Chinese medicine?
Mrs H: Not quite, not quite.
NW: So it's not something that you’ve learnt from your parents?
Mrs H: It, it really depend what sort of illness that you get.
NW: So are there some illnesses that Chinese medicine is good for and some that English medicine is good for?
Mrs H: That is hard decision. You see, we were, we were brought up in the western style. Hong Kong, we got hospital, because we all were born in hospital...not like the olden day, you, you deliver it at home. So I think, er, it depend what sort of illness that you get.

[Mrs H, 57, Hong Kong]

For her, using TCM is a case of trying different things to see what works:
Mrs H: If I got a cold or something...I just get one of those herbal tea from Chinatown and put hot water and cover for...ten minutes to drink it.

NW: Would you just go to a shop and buy that or would you go to a Chinese doctor?

Mrs H: Yeah, you go to a shop. Yes. That is really simple. Just like the herbal tea...you could buy in most of the, the Chinese supermarket.

NW: And how do you know that that helps you? If you have a cold, how do you know what to choose?

Mrs H: It, it just, you know...when you begin if you've got a cold you buy some of the tea, drink it, and you seem to feel better.

NW: So it's just by trying something and seeing if it works?

Mrs H: Yeah, by trying, yes.

[Mrs H, 57, Hong Kong]

Mrs H said that she had also tried acupuncture for back pain; she had been to a western doctor, and had tried various treatments that had not worked, and then tried acupuncture on the suggestion of a friend. She notes that it was ‘people from China’ who administered the acupuncture that she tried:

Mrs H: Acupuncture, that is good.

NW: What's that good for?

Mrs H: Er, good for quite a lot of things. I remember once I got a backache, I did a whole session, it’s gone [...] I twist my back. Because I was carry my youngest boy. He was sleeping, I had carry him...he was quite big. I carry him because I won’t dare to wake him. I was in Hong Kong, holiday...because we had to carry him for quite a while. But at night when I get back I, I can feel the pain in my back...that last me for a few months. So when I went [home] they told me that there is a Chinese acupuncture, the people from China, so I went a whole session. That cure...that cure, yes.

NW: Do you remember why you chose to do that rather than going to a different kind of doctor?

Mrs H: I did see a western doctor, do X, Y and thing, but...took the medicine, it doesn’t work...it didn’t help, so people say try acupuncture, so I did try. So it was okay, yeah.
[Mrs H, 57, Hong Kong]

For Mrs H, the main criterion is the particular illness; she seems to be comfortable using different kinds of treatment for different problems and trying different things to see what works best.

Like Mrs H, Mrs Q grew up in Hong Kong using biomedicine rather than TCM. In contrast to Mrs H though, she says that because of this she does not trust TCM, and that she would never use it:

NW: Do you ever use any Chinese medicine?
Mrs Q: No.
NW: Why is that?
Mrs Q: Um, I don't know, er, to my mind I think I don't trust it.
NW: Why don't you trust it?
Mrs Q: I don't really...when a little girl started I'm always with the English doctor. In Hong Kong they had not English people, Chinese people that gave the English medicine you know what I mean? I don't...I don't go to Chinese...Chinese medicine oh no, no.
NW: So even as a child you didn't?
Mrs Q: Oh yeah, I never have that, no. Don't trust it.
NW: So you would have no reason to use it here?
Mrs Q: No, no, no.

[Mrs Q, 66, China]

When I asked her if she thought that there are some illnesses that TCM is better for and some that biomedicine is better for, she said again that she does not trust TCM:

I don't know....I never have the Chinese...I don't know...I’m always have the English since I’m baby my mum tell me. My mum tell me, yeah [...] Like...like I say I’m just like an English people, I look Chinese but I’m like English people, everything.

[Mrs Q, 66, China]
By saying that she uses biomedicine because it is what her mother told her as a child, she is placing her trust in biomedicine, through her relationship with her mother. In this way, Mrs Q’s family context and her upbringing, play an important part in shaping her choices about the use of biomedicine rather than TCM.

8.6 The importance of location

Other participants also spoke about trust in relation to what types of medicine they choose to use. Some, like Mrs Q above, said that they do not trust TCM at all and some said that they do not trust TCM in the UK but that they would use it in Hong Kong or China (whichever was their country of origin). This view that TCM is different in the UK and in Hong Kong or China is reflected in other studies; for example, Rochelle & Marks (2010) report that the participants in their study suggested that they thought it was possible for people to open TCM shops in the UK with little experience or formal training, and that the TCM practised in the UK was tailored for non-Chinese people (p.722).

Mrs L said that she does not believe in TCM in the UK, but that she might consider using it in Hong Kong. Like others, she expressed an understanding that TCM works more slowly than biomedicine, and she would therefore have to be in Hong Kong for a long time if she were to use it.

NW: Do you use any Chinese medicine?
Mrs L: No.
NW: Why is that?
Mrs L: In England not too many Chinese doctor, yeah, I not believe in it. When I go back to Hong Kong I use, if I stay a long time in Hong Kong I will see the Chinese doctor when we take the Chinese medicine. Because the Chinese medicine you need to get quite a long...a long trip...
NW: You take it for a long time?
Mrs L: Yeah, yeah. Because they softer than English tablet.
NW: Softer?
Mrs L: Very soft, to make you a little bit different, grow up to better and better and better. Not like English you take...when you’ve got a temperature you take one or two tablets and it’s gone but in Chinese maybe two day the...the temperature’s gone. It’s very slow to go not quick to go. So it’s a bit different that one. But you not always stay in Hong Kong you can’t take the Chinese medicine. But in England I not believe that, yeah.

[Mrs L, 54, Hong Kong]

Although she talks about the different ways in which the two types of medicine work, this is also a reflection on her adaptation to life in the UK. She expresses her choice about using biomedicine as a response to her circumstances; that she lives in the UK and that there are not many Chinese doctors here so it is easier for her to use biomedicine here. However, she does suggest that in different circumstances, i.e. being in Hong Kong for a long period of time, that her choices might also be different, and that she would consider using TCM there. For Mrs L then, location plays a part in her choices about what medicine she uses; if she were to live in a different place, her choices might also be different.

Mrs R and Mrs T, who have both lived in the UK for over 40 years, also said that they do not trust TCM in the UK, but that they had used it in Hong Kong. Mrs T said quite clearly that the training and expertise of TCM in the UK is not as good as it is in Hong Kong:

Mrs R said she doesn’t trust the training here - that in China or Hong Kong people would be properly trained in Chinese medicine, but that she doesn’t trust the training in the UK. She wouldn’t go to a Chinese doctor here (who prescribes Chinese medicine) but she might consider it in Hong Kong. Mrs R said that she had had acupuncture in Hong Kong for a problem with her wrist. I asked her why she had that in Hong Kong rather than the UK. Mrs R said that it was cheaper, but Mrs T disagreed and said that it was because in Hong Kong they have better training and more experience.

[Interview notes: Mrs R, Hong Kong & Mrs T, Hong Kong, interviewed together]

Mrs R also added to this that her children do not believe in TCM. She said that two of her sons are doctors and one is a pharmacist, and that they all tell her that TCM is not good.
Like Mrs L, location plays a part in her choices, but this is also shaped by her family context as well.

Mrs M was more explicit about why she does not trust TCM in the UK. She spoke about the lack of regulations around the production of TCM; that it all used to be natural but that now she would not trust that what goes into TCM is natural:

**NW:** Do you ever use any Chinese medicine?

**Mrs M:** No, I don't like....if the real one, is okay, [but] sometimes it’s not real...because I talk about the public one, the Chinese doctor he got...he come from the China, he said before, the Chinese medicine is grow in the...in the mountain...natural...now it’s in, how do you say, it’s not the...the natural...

**NW:** Oh so they, er, manufacture it...?

**Mrs M:** Yeah, they manufacture they kill disease and put some [in]...there is not...it’s changing now the medicine, you can't control it, even here in here I seen him, he said he didn't know the...the medicine where it come from...he can't control it.

**NW:** So you don’t really trust it?

**Mrs M:** I don't trust it. It’s...it’s better the natural thing.

[Mrs M, 64, Hong Kong]

In contrast to this, however, she said that she does trust biomedicine, and that she would take it if her doctor told her to. She spoke about the regulations and research associated with biomedicine, suggesting that this gives more transparency about what specific medicines actually are:

**NW:** Would you have English medicine if your doctor told you to take it?

**Mrs M:** Yeah, I trust that.

**NW:** Why do you trust English medicine?

**Mrs M:** They have research, they have to...in the lab to do something is one tablet, how many...how many company...you get government to check properly.

**NW:** So it's the regulations and the research?
Mrs M: Yeah the regulation, yeah. If they increase the tablet and then...or increase then they just look after you, how many slow down, slightly slow down my...my family doctor. Er, you have, er, if you hit the age of 50 it just get rest, drink a lot of water, no need the medicine. But in Hong Kong, er, they just give you five tablet to eat, what is it? I don't know...I get injection...I don't know.

[Mrs M, 64, Hong Kong]

8.7 Interaction with doctors

Many of the participants said that they would follow the advice and take any medication that they were given by their GP. For those with a good relationship with their GP this was straightforward. Mrs Q said that she trusts her GP and that she would do whatever she was told to do. She spoke about this in a straightforward way, implying that there was no reason for her to think otherwise;

NW: Do you have an English doctor?
Mrs Q: Yeah, the GP, yeah.
NW: And how do you feel about your GP...?
Mrs Q: It’s okay, nice, because some time maybe my English not very...because they’re very nice, all very nice, yeah. I just have the injection this morning, they give me the pneumonia for, yeah, they gave me letter to have this morning. Very nice, they all very nice.
NW: So you feel they’re helpful?
Mrs Q: Yes.
NW: And you trust them?
Mrs Q: I trust them, oh of course I trust them, oh yeah.
NW: So if they gave you some advice...
Mrs Q: I would eat it, everything just put it in the mouth, I don't know.
NW: Whatever they tell you?
Mrs Q: Yeah, whatever they tell me to do I just do it, yeah.

[Mrs Q, 66, China]
Mrs M also said that she has a good relationship with her GP and that he is willing to help if she does not understand something. She also has a friend who is a nurse, who she goes to for help if she needs to (this is the nurse mentioned in the excerpt below):

NW: Do you have an English doctor?
Mrs M: Yeah.
NW: So an English speaking doctor?
Mrs M: Yeah.
NW: And do you...how do you find that?
Mrs M: Yeah....If I didn't understand I just ask them, they very kind [...] [the clinic] have a website...so I go back home read it properly, I have the nurse to answer me, mention to me clearly... how to do. So they print it for me on a few paper to go home. So some say, oh no my doctor is never like that. I say yeah my doctor is like that, he’s so good. He's keep me for...he’s look after me very long, long time.
NW: So you’ve had the same doctor for a long time? Yeah.
Mrs M: Yeah. He’s so good why do you change the doctor? I never change.
[Mrs M, 64, Hong Kong]

Like Mrs M, Mrs E said that she has had the same GP for a long time, with whom she has a good relationship. She said that she would do what she is told and that if she does not understand what she has been told, that she will keep asking until she does:

Mrs E: Because I’m stay in that area is such a long time, all the nurse, all the doctor know me.
NW: So you've had the same nurse and doctor?
Mrs E: Er same...they got the record for me, it's such a long time. So it's okay.
NW: So you have a good relationship with the doctor...your doctor and the nurses then?
Mrs E: Yeah, I do, I do...But I'm very open, I got to ask because I'm not very good English, I always ask clearly. Sorry, doctor, I not understand, what's that mean. I should do that, I should do that, I should do that? Yes, you got to do that, do that, do that. So doctor very good [laughs].
NW: And do you always do what the doctor tells you?

Mrs E: Yeah, I do. I won't say no. If doctor tell you do, don’t do that, don't do that, I don't do that [...] I think doctor always is thinking it's right, tell you do what you got to do.

[Mrs E, 72, Hong Kong]

These participants expressed their interactions with their GPs as generally unproblematic. All of them said that they have an English (or English-speaking) GP, and that although there are times when they might need to ask for help in understanding what they have been told, they viewed the relationship as a good one and said they trust their doctors. However, this was not the case for all of the participants. As reported in studies of barriers to healthcare services among the Chinese in the UK, for some participants, issues of language and communication made interaction with their GP problematic (Chau, 2008; Chau et al., 2011; Li & Logan, 1999; Li et al., 1999; Liu et al., 2015; Long et al., 2015; Rochelle & Marks, 2010; Sprotson et al., 1999; 2001; Yu, 2000; Yu, 2009;).

Mrs K spoke about having to take her son to the GP with her to help with translation, and said that without someone to interpret for her, the doctor will not see her:

Every time her son went with her [to the doctor]. If she don’t understand her son will help...interpreting. She says the doctor is very, kind of arrogant, or straight, you know, if she’s not speaking properly, and she might not listen. But that’s why she asks her son to do interpreting. And she won’t talk to the doctor if she can’t speak properly [...] If she doesn’t speak good English, the doctor won’t see her. So if no-one go to interpreting, he won’t see her [...] He is doctor, not going to shopping. Because it’s a serious matter to see a doctor, so it’s not like shopping [...] Same as the hospital...yeah, they won’t, they won’t...you can’t see the doctor without interpreter.

[Mrs K, 75, China, interpreter speaking]

For Mrs K, language is a barrier in terms of both access to a doctor and in terms of communicating with a doctor when she does see one.
Mrs D, who currently has an English-speaking GP, spoke about having had a Chinese-speaking GP in the past. She said that the Chinese-speaking GP was better because it was easier to communicate her symptoms and that the doctor cared about her more:

*INT:* Yeah. The first doctor diagnose her have diabetes was a Chinese doctor. Chinese-speaking doctor…that was her GP, a western medicine GP. And she been diagnosed by him. But then he left and then she, she transferred to [another doctor].

*NW:* So it was the second doctor who wasn’t very good?

*IT:* Er, wasn’t very good.

*I:* But, but the Chinese doctor was better?

*IT:* It’s much more easier to communicate, you know, her illness to the Chinese doctor, and also he’s more concerned, you know, about her. Yeah.

[Mrs D, 64, Hong Kong]

Mrs D says that the Chinese-speaking doctor was more concerned for her and that it was easier to communicate her symptoms. This is particularly important for Mrs D who spoke about difficulties with her GP in relation to ongoing stomach problems which the GP suggested were a symptom of anxiety (as discussed in Chapter 7). Mrs D describes this difference in approaches to the interpretation and labelling of symptoms as a problem of both communication and care.

8.8 Summary

The participants expressed a common understanding that TCM and biomedicine work in different ways to treat different types of illness. In this respect, the use of TCM was more strongly associated with maintaining health and biomedicine with treating illness. However, alongside this, there are varying contexts within which the participants make choices about their use of TCM and/or biomedicine, and which shape their choices in different ways. For some, this choice is shaped by their upbringing and their family relationships. Even though all of the participants grew up in China, Hong Kong or Vietnam, not all of them grew up using TCM within their families. Mrs H and Mrs Q both
spoke about using biomedicine in Hong Kong as children, so that biomedicine is not something that is strange and unfamiliar, or associated only with their lives in the UK. For Mrs Q, this meant that she had never used TCM and she said that she never would. However, Mrs H was comfortable using both TCM and biomedicine for different things. Others spoke about their choices in terms of identity and their adaptation to life in the UK, so that they were making decisions that made their day-to-day life easier. Both Mrs E and Mrs F stated a clear preference for biomedicine rather than TCM, and said that they are ‘English’ in this way. For others, the use of TCM was linked to place; several participants said that they would not use TCM in the UK but that they would use it in Hong Kong. Many had English-speaking GPs. Of those, some said that they had a good relationship with their GP and although language sometimes made communication difficult, this was not expressed as particularly problematic. For others, language presented a bigger problem in terms of both access to and communication with their GP, making the use of biomedicine problematic.

These varied contexts, and the ways in which they shape the choices that the participants make about their use of TCM and/or biomedicine show that choices about the treatment and management of illness are shaped within multiple contexts. This is important in terms of the ways in which culture might be understood and applied in healthcare settings and in terms of the provision of culturally sensitive health care. As discussed in Chapter 3, the Chinese population in the UK is diverse, with different waves of migration characterised in different ways, and with significant differences between first and later generations of migrants. With this in mind, Yu (2009) cautions against the assumption that ‘all members of the same ethnic minority group organise their health and social care according to their cultural principles, and that these cultural principles are monolithic’ (p.58).

In the case of this study, the fact that the participants are Chinese, does not automatically mean that they all use TCM, or that they all share the same views about the use of TCM and biomedicine. As noted above, although all of the participants grew up outside the UK in Hong Kong, China or Vietnam, not all of them grew up using TCM. Some used biomedicine even as children; others articulated their preference for biomedicine in terms of their adaptation to life in the UK. It is important to reiterate here that, as migrants, the participants in this study have had to rebuild their lives in the UK and to recreate an identity that is meaningful in relation to the circumstances that they are living in. Their
choices about the management and treatment of illness should be considered with this in mind; that the choices they make are also choices about responding and adapting to change and negotiating daily life in ways that are meaningful.

This is explored further in the following chapter, which addresses some of the regular activities that take place at the centre and the ways in which the participants interact with one another through those activities. These are addressed as everyday practices that contribute to the maintenance of health and wellbeing (i.e. about maintaining health rather than treating illness).
Chapter 9: Practices of Wellbeing

9.1 Introduction

The previous two chapters explored the understandings of, and approaches to, health and wellbeing among the research participants; firstly in Chapter 7, in terms of the underlying orientation to health and wellbeing; and then in Chapter 8, in the context of choices around the use of TCM and biomedicine. The focus of this chapter is to consider health and wellbeing in a different way; in terms of everyday practices that contribute to the health and wellbeing of the participants in this study. This is explored through some of the regular activities that take place at the centre and the ways in which the participants interact with one another through those activities.

With regard to their reasons for coming to the community centre, many of the participants said that it is important to get out of the house, to meet with other people, to be active, and to do something (as opposed to doing nothing). This was most commonly expressed in terms of being together at the centre instead of being at home alone.

_Mrs H spoke about not staying at home and being alone and unhappy, but getting out of the house, doing something with others to feel happy. I commented that this seems to be why people come to the centre, and Mrs H agreed. Now that she isn’t busy in the morning while her husband is away she prefers to come here rather than stay at home on her own._

[FN9-11.12.13]

_Mrs E and Mrs F were singing from a photocopied song sheet. Mrs H gave me an explanation of the song; that it was about friendship and bringing people together and not being alone, coming here (to the centre) to be together with each other. I asked if this was a particularly Chinese way of thinking and she said yes; that in the past, children would stay in the home or nearby but now they grow up and move away so people (of her generation) are left alone. The song was about coming_
together instead of being at home alone and unhappy; that it’s better to be together and be happy.

[FN24-13.02.14]

This articulation of being ‘together here’ in relation to ‘home alone’ resonates with a core part of the migration stories of the research participants. As discussed in Chapter 6, for the women in particular, their early years in the UK were shaped by experiences of loneliness and isolation; as illustrated above, these experiences are also contained in the way that the participants spoke about coming to the community centre in order to be together and be happy. It also reflects the particular understanding of health and wellbeing among the research participants, as discussed in Chapter 7. As Mrs H explained (above), this is about being together with other people and about being happy, as opposed to being alone and unhappy; many of the research participants expressed this idea as an important part of maintaining (good) health.

With this in mind, the focus of this chapter is the way that this understanding of health and wellbeing is reflected in the particular activities that take place at the centre and the ways in which the members interact with one another through these activities. These are presented as everyday practices of wellbeing, and it is argued that participation in these activities is a way of re-connecting with the past and of re-creating and maintaining a sense of identity within this particular place; and that this in turn is significant for the health and wellbeing of the centre members.

9.2 Tai Chi: practising together

As already noted in Chapter 5, one of the regular activities at the centre was a Tai Chi class that took place twice a week on Tuesdays and Thursdays. The class was often held outside on fine days; otherwise, it took place in the main hall. The group were all women, including the Tai Chi Master. What follows is an exploration of the activity of this group, in terms of maintaining a connection with a previous time and place in their lives, engaging in familiar ways of doing and being, and the enactment of both an approach to life, and an understanding of health and wellbeing, through being together in this group.
When I asked Master how she began learning Tai Chi she located this very clearly in a particular time and place in her early life in China. She told me that she began learning Tai Chi in 1974 in Canton in Southern China. She had watched her father practicing with a group every morning in the park; he was in his 60s and never had any kind of illness, and he encouraged her to join the group. After practicing with the group for a while, Master felt very relaxed and although she had a stressful job, she began to find this easier to cope with, and that she had much more energy. She practised with her father’s group until 1979, when she moved away from the area, and said that she did not have any sort of illness during this time. Over the following years she learnt from many different Tai Chi Masters, and even now when she goes back to China, she visits her Tai Chi Masters to practice with them and continue learning. It was clear that the time and place of this beginning are important to her; she told me this story without any hesitation and with obvious pride. It was also clear that it is important for her own sense of identity; Tai Chi is something that she learnt in China, but it also shapes her life in the UK. She said that Tai Chi is the most important part of her life and that she wants to use her skills and knowledge to help other people to be...
well. In this way, teaching and practicing Tai Chi at the centre is an everyday practice that creates a continuity between her present life in the UK and her previous life in China. In sharing her knowledge and skills, which she brings from her life in China, Master is also creating an important connection with a previous time and place for the women in the group. Through engagement with a culturally familiar practice, their participation in this group is also participation in this connection with their early lives outside the UK.

Master was very clear that practising Tai Chi has significant benefits for maintaining good health. As well as speaking about her father’s health, she said that since she retired in 1993, that she has not had any kind of illness, not even a cold. She also spoke about using her knowledge of Tai Chi to help other people at the Centre. In particular, she spoke about one of the centre members who had been very ill; she described how she had helped this woman by teaching her Tai Chi, and said that even the woman’s GP had noticed a great improvement in her health and had advised her to continue doing Tai Chi.

Master said that the form of Tai Chi that they practice at the centre is mainly for maintaining good health, and she emphasised Qi and strength in relation to this. She described Qi as ‘the essence…the vital energy’ and she talked about the practice of Tai Chi as opening the channels between the acupuncture points in the body so that the Qi flows through those points and smoothly round the body. She emphasised that there should be strength in all the movements, saying that ‘if you’re not sweating, [it’s] because you don’t use the strength’.

I asked Master if there is a difference between doing Tai Chi alone, or doing it in a group, and she told me that it is better to do Tai Chi in a group. She said that this is because with a group the energy (Qi) is greater than it is for one person alone and that each person in the group can benefit from this. But she also talked about this in terms of building a group in which they take care of and look after one another.

*It’s a group of people and you need to interact with each other, so it’s all the communication with the others…and getting close….through doing Tai Chi. So, before, she doesn’t know you, and then you come to learn Tai Chi and now she knows you…so this is a kind of closeness…that you get from doing this as a group.*

[Interview with Master, interpreter speaking]
Although the women in the group did refer to the Tai Chi as exercise, and said that exercise is important for maintaining good health, they placed greater emphasis on the social nature of the group, as the reason why they come to the class and as what makes it enjoyable. When I asked Mrs L why she comes to the class, she clearly expressed this:

Mrs L: You need plenty friends to talk with you, you need to talking, yeah, you need to smiling. And I come in the morning I need this exercise, yeah.

NW: So the Tai Chi, that’s exercise for you?

Mrs L: Yeah, because at home you alone, you not do any exercise, I never do it, but when you come here and you altogether, you will do it…every Thursday I’m very happy.

[Mrs L, 54, Hong Kong]

Mrs E expressed this in a similar way:

NW: What is it that you like about the Tai Chi class here?

Mrs E: I like social.

NW: It's a social thing?

Mrs E: Yeah, I like social thing and happy with the people all together laughing, you know...cheerful...if you don't happy, you just sitting around...I think everybody...in our age, old person, should be happy...not miserable. You got money, no money, you've got to be happy. Happy mean you...cheerful.

[Mrs E, 72, Hong Kong]

The social structure of the group is also significant. Mrs E explained this in terms of the right way to behave within the group, including respecting the Master:

You know, when you in a group, you got to appreciate what people do, which one is best, which one is not best. You know, you got to understand who is the boss.

[Mrs E, 72, Hong Kong]

Master also talked about the nature of the Tai Chi group in this way, and in particular how the group act towards her:
The group members respect her a lot, and even though she has told them that she doesn’t expect to be repaid in any way, they take her out to restaurants and give her a high status in the centre. She feels very respected from the others...they not calling her Master now, they calling her sister, so even closer.

[Interview with Master, interpreter speaking]

During the interview with Master, Mrs Z (who was present as an interpreter) also spoke about the structure of the Tai Chi group:

The Master need to be in a higher status...You can see from them [the group], the Master decide, the Master say what they need to follow, they do it, and that is the relationship for the interaction with the Master. And you need to obey. A Master is actually another form of your parents. Because all the [movements], you know, secret [knowledge], inheriting, that is the wisdom being passed down, transferred [from the Master to the group].

[MrsZ, speaking in interview with Master]

This idea of the Master being ‘another form of your parents’ reflects Kleinman’s (1980) writing about the nature of Chinese family relationships. He states that the father-son relationship is the ‘template for relationships with teachers, supervisors, those older and socially superior as well as those younger and socially inferior’ (p.134), and that in the master-disciple relationship, ‘the beliefs of the dominant person are treated as authoritative’ (p.137) 16.

This structure was also reflected in the style of teaching and learning within the group; primarily through observing and following the Master, and usually through demonstration rather than words. It was a particular way of learning, through practice, repetition and discipline; of following the Master slowly and patiently and the learning would come. This style of learning is also reported elsewhere; that ‘knowledge transmission in Chinese cultures relies more on rituals and on gestures than on explanation; knowledge is mainly passed on through observation and without the explicit mediation of speech’

16 Although Kleinman is writing here about life in Taiwan in the 1970s and 1980s, this idea about the structure of family relationships is also reflected in this study, despite the participants being from different Chinese backgrounds to those in Kleinman’s work.
Jovchelovitch & Gervais, 1999, p.251). Many of the group commented to me that they had been doing Tai Chi for a long time, some for years, and that I should not worry about getting things wrong, but just keep watching and trying to follow Master. I never saw anyone get flustered or frustrated about not being able to do some of the movements; they all continued to watch and follow Master, to practice every week, and to enjoy doing this activity together.

I asked Master if there is a correct way to learn Tai Chi, and she explained that:

*It’s regulate your body, the person needs to be calm…natural, normal breathing…you use the breathing to go along with the [movement]. The body needs to be straight…you need to be strong…so it comes from the core of your body…slow, slowly, but from the slow you have strength…no panic, no rush. The whole style is move…smooth and follow one another.*

[Interview with Master, interpreter speaking]

This explanation of the right way to learn, through maintaining the body in a state of calm, but also harnessing strength, reflects the way that Mrs K spoke about her experiences of leaving Vietnam and building her life in the UK. She said that ‘When things come in the vines, you just feel, go along smoothly…whatever you encounter…just, follow your dreams…as they come’. Although talking about learning Tai Chi is obviously very different to talking about the experience of coming to the UK as a refugee, Master’s explanation of the attitude to learning seems to be an embodiment of this sentiment; that when difficulties come (in life, or in the pursuit of skills and knowledge) that one must remain calm and strong, and continue on. In this way, Master’s teaching is not just about the skills of manipulating the body through a precise set of movements, but is also about practising an approach to life, about developing resilience and strength, and about disciplining the self in other ways too. This is also reflected in the way that Mrs E and Mrs F spoke about illness (in Chapter 7); that living with illness is not a matter of controlling the illness, but of ‘controlling yourself’ or ‘behaving yourself’, and carrying on as normal.

See also E. Hsu (1999), who gives an account of learning the practice of Qigong in China in this way.
The above discussion shows that as well as the health benefits of practising Tai Chi, participation in the Tai Chi group is also therapeutic in other ways. Master’s knowledge and skills, which she brings from her previous life in China, create an important social and cultural continuity for the group. This continuity is also maintained through the structure of the group, particularly through the respect for Master shown by the women. Both Master and the women in the group expressed a sense of the importance of practicing together; that it creates a sense of belonging and provides a space in which they can take care of and look after one another. In this way, participation in the group entails engagement in familiar ways of doing things and of being together; through the practice of a particular approach to life and of coping with adversity.

9.3 Food: eating together

In her study of South Asian migrant women in Canada, Dyck (2006) suggests that the ‘remembering’ of place includes a material form (p.6). For the women in her study, she contends that ‘cultural’ items, such as food or traditional medicines, either brought from the home country, or locally available, help to create ‘a life with cultural continuities, as well as change’ (p.7). Sociological writing about food and eating practices also highlight the association of memory and emotion with food, as well as its role in structuring family and social relationships (see for example, Lupton, 1996; Mennell et al., 1992). These ideas are reflected in the following discussion of the communal lunch that was served every day at the centre.

As with the Tai Chi, lunch was both a social and structured occasion, in which things were done in a particular way. The food was shared and eaten together; rather than an individual plate of food being given to each person, plates of food were brought to the tables for everyone to share. There was a sense of informal ritual in the way that the food was shared out; for example, someone (often, but not always, the same person at each table) stood up to serve the soup out to everyone at the table and to hand round the bowls of rice, and the fish, which was usually served whole, was skilfully broken apart with chopsticks so that everyone could help themselves.
There was an attentiveness towards each other in the way that food was shared; as well as helping themselves to food, everyone served each other food as well. This created a sense of inclusion, in which everyone at the table was acknowledged and made to feel welcome, and through which everyone took part in the meal. This was also a way of taking care of each other; of making sure that everyone had some of everything that was brought to the table, and that everyone had enough to eat. This communal way of eating, as a particular form of social interaction, was highlighted when we went to another community centre for an exchange day. This was a non-Chinese (predominantly white working class) community centre, where there was a Tai Chi class taught by two English women. The women had established a connection with the Chinese community centre and we had been invited to take part in a day of Tai Chi, and other activities, including lunch, at their community centre. When we ate lunch there, we sat in lines at long thin tables and various people brought cutlery and paper napkins (the tables had not been set yet). Individual plates of food arrived in dribs and drabs, so that not everybody was served at the same time, and there were a number of people sitting waiting for food as others were busy eating. This was a notably different kind of meal, not just in terms of the food that was served, but in the way that it was served and eaten, alongside other people, but not as a shared meal.

There was one occasion at the centre when I sat at an extra table that had been set up because there was not enough space for everyone at the round tables. I sat with two other women, and we were each given a bowl of soup, a bowl of rice and an individual plate of food with a variety of items on it. However, even though we were brought an individual plate of food, the two women still shared their plates of food, swapping things and putting things on each other’s plates. In this way, the boundaries marked by the individual plates were broken, so that the food was shared and eaten together, rather than individually.

There was a social hierarchy reflected through the sharing of food. This was particularly evident among the women in the Tai Chi group, who usually sat together to eat, and whose respect for the Master was also demonstrated in the sharing of food during the meal. Someone at the table, usually whoever had cut up the fish, always gave the fish tail to Master, and whoever was sitting on either side of her, always put food in Master’s bowl before their own.
A sense of identity was expressed in terms of the actual food and the way it was eaten; that the food was authentically ‘Chinese’ and that there was a proper way to eat it:

*Mrs P said that the fish was steamed and that ‘you’ (English people) fry fish instead of steaming it.*

[FN5-17.09.13]

*Mrs E talked about the proper way to hold chopsticks - not to let the third finger be lazy and sit on top of the bottom chopstick, and that most of the others (at the table) don’t do it properly with the third finger in the right place. She also said that the food here is ‘family food’ and not what you get in Chinese restaurants (in the UK), which she called ‘English Chinese’.*

[FN7-10.10.13]

*At one point Mrs E commented that I was very lucky because with Chinese food there is a lot of variety and that there is always something different for lunch (at the centre). She said that English food is boring and not much variety.*

[FN27-27.02.14]

Most people said that the food that was served at the centre was also the kind of food they cook and eat at home; although some did say that they also sometimes ate ‘English’ food at home with their children. In both of the health consultation sessions that I observed at the centre (one for the Care Quality Commission and the other for a Mental Health Improvement programme), the lack of Chinese food in care homes and hospitals was raised as an important issue in relation to the provision of culturally sensitive healthcare services. For those who spoke about this, the provision of Chinese food was an important aspect of care, and something that made a difference in the way that care homes in particular were viewed. For them, Chinese food - as something socially and culturally familiar - reduced the fear and anxiety associated with care homes, particularly for the very elderly. This highlights the importance of food as a way of maintaining an important social and cultural connection.

In terms of food as a way of maintaining the body in good health, this was most evident in relation to my pregnancy. There were many occasions during lunch when I was advised to
eat a specific dish or item that was particularly good for the baby, or given more of something, specifically for the baby.

Before class Mrs E talked about making ‘bone soup’. She was talking about this - saying that I would like it - because Master said that Chinese women prefer sour things in pregnancy. [FN20-23.01.14]

Mrs G and Mrs W both gave me food, slopping stuff over the table as they did so. Mrs G gave me quite a lot of fish and said ‘more fish for baby’. Mrs X also said to me to eat more fish for the baby. [FN28-04.03.14]

One of the dishes at lunch today was a translucent seaweed-type thing that Mrs E insisted on giving me an enormous frond of. She plopped it in my soup and told me it was good for the baby and that they think it is good for protecting against cancer too. Master nodded across the table and joined in telling me that it was good for the baby. [FN30-13.03.14]

Mrs F was very diligent keeping my bowl full at lunch, and telling me that the fish she had put in my bowl was for the baby, and that the seaweed thing was good for the baby too (she also said it’s good for skin). [FN38-03.04.14]

As noted above, being given food by other people during the meal was a normal part of communal eating; everyone served themselves as well as giving food to others at the table. The above fieldnotes show that this interaction was also extended to me; I was always given food by others at the table, which acknowledged my presence, and included me in the meal. This was also a way of extending care and concern towards me, particularly with regard to what was good for my baby. In terms of the understanding of food as a way of maintaining the body in the right way, many of the participants who were interviewed spoke about the importance of eating healthily (for example, eating more fruit and vegetables and less meat and sugar) and maintaining a steady weight. When I spoke with
Mrs P about using TCM, she explained that if you eat the right food, then there is no need for medicine:

*Mrs P:* I believe we all have our own nature. If you, eat for our nature, your own nature, you eat the foods suitable to your nature, you don’t need medicine.

*NW:* So it depends what kind of person you are?

*Mrs P:* Yes. Because we have different natures. So, you have a baby, when you, you bring off the milk, you gradually introduce the baby in, with food you need to notice whether the baby is allergic to certain kind of, you have to look you know, whether the baby is agree with certain food, or not agree with certain foods. We, we don’t all eat the same food...we are all different.

*NW:* But if you eat the right food, you don’t need to use medicine?

*Mrs P:* Is suppose, yeah, in theory.

[Mrs P, 66, China]

As noted in Chapter 8, Mrs Z explained that the use of TCM is a kind of diet therapy - as a part of daily life - and that there is a particular social (family) context to this;

*Lots of Chinese people, you know, even they live here a very long time they still using Chinese medicine. But, this is not as a medicine, it’s a daily life, you know, ingredient in the food...it’s not only the soup...it’s the family around...it’s meaningless when you boil, you know, three or four hours soup only for yourself. So, it’s do it for particular for the family member to maintain...their...their good health.*

[Interview with Mrs Z]

As well as the food that was provided by the centre, the members often brought food items into the centre to share, such as sweets or fruit, either from Chinese markets or shops, or from their visits to Hong Kong or China. There were also occasions where other items were passed around and exchanged among the women; things that Dyck (2006) refers to as ‘cultural’ items, in that they came from Chinese shops or markets, or from people’s homes.

*There seemed to be a lot of exchanging of bits and pieces and money this morning before class. Mrs Y handed Mrs A a carrier bag with a pink Tai Chi pyjama suit in it which Mrs A tried on and gave £15 to Mrs Y. Mrs Y gave some money to Mrs E, and*
someone else gave a small bag of tea or some sort of herbs to Mrs Y. Mrs S arrived with a box of Tai Chi shoes with Chinese characters on the side for Mrs E, who proceeded to slice through the parcel tape on the box with the end of a spoon. And Master also gave Mrs E a bag with a pink suit in in like the one that Mrs A also had.

[FN36-01.04.14]

The above discussion, about the food served at the centre and the way it was eaten, shows that food also plays an important part in creating and maintaining social and cultural continuity. The food provided at the centre was described by the members as ‘Chinese’ food and as different to ‘English’ food. As well as being about the food itself, this was also about the way that it was eaten; as a particular form of social interaction, and as an everyday social practice constituted through a familiar - and structured - way of interacting with one another. This interaction around food, as a materiality, and the handling and sharing of cultural items, shows that remembering, through material things, plays an important part in the creation of social and cultural continuity (Dyck, 2006).

9.4 Calligraphy: remembering together

The idea of handling and exchanging material goods (as cultural items) as a way of physically engaging in a connection with other times and places was also evident in the way in which centre members participated in the calligraphy group. The group members sat together around one large table, set up with sheets of paper, pots of ink and a selection of brushes with Chinese markings on them. There was a theme for the session each week (for example fate and destiny, or holidays and leisure time) which the group discussed and wrote about in traditional Chinese characters. The conversations that I had during these classes were often very reminiscent about the past, and the way of life in the country of origin as it had been prior to the members migrating to the UK. These conversations took place while the group members were holding the brushes, dipping them into the ink pots, making deliberate and specific markings on the paper and gradually getting ink stains on their fingers.
There was much reminiscence about the ways that Chinese writing had been taught and how the content of what they were writing was about values and structures that were different now, particularly as the family identity changes with the younger generations and mixed marriages. For example, Mrs N talked about learning calligraphy in school and how the relationship between children and teachers is not the same now.

Mrs N wrote out a list of words for me to try that she said were the words that you learn to write first as a child in primary school. She said she remembers her parents teaching her to write them when she was little….And she said that in school when you were learning calligraphy the teachers (in China) would be very strict and they would rap you over the knuckles or clip you round the ears if you didn’t get it right. She said that if you didn’t get the characters right that the teacher would make you change them so that they were right. She went on to say that in the past the discipline between teachers and children, and parents and children, was very strict; that you had to do what you were told whether it was right or wrong, but that now it’s not the same and children can complain about teachers and not do what they are told.

[FN39-09.04.14]

I had a conversation with Mr K about a poem he had written and how it represented the particular relationship between a teacher and student. He then went on, in a similar way to the way that Mrs N had spoken, to talk about the traditional family structure in Chinese families.

There was a character [in the poem] that signified the relationship between mother/father (old people) and son/daughter (young people). This was made up of two characters but together they represented the relationship between the two. He talked about the hierarchy in Chinese families, that the father comes first, then the mother, then the son, and then the daughter. He said that in English families, everyone was equal. He said that in Chinese families, the father would always be called ‘father’, not by his name (e.g. Thomas), even by son/daughter-in law. He said this is what he prefers and that his daughters-in-law call him ‘father’ and that he calls his wife’s parents ‘mother’ and ‘father’.

[FN46-14.05.14]
This kind of remembering and reminiscing through doing particular activities together, was more than just recalling things about their previous lives and the way things used to be; it was a physical engagement, through the act of handling the ink and brushes, and making the markings of traditional Chinese writing that was associated with their own education and learning. They were actively engaged in this remembering, as a sort of re-situating from one place into another, and from the past into the present. This was a collective remembering that they could do together in this particular place, through this particular activity, and through the handling of these specific objects. This reflects the ideas of Gastaldo et al. (2004) about the role of memory, nostalgia and reminiscence in reconnecting people within and to different places; but it also adds a physicality to this, so that the remembering is embodied and enacted, through the handling of the ink and brushes, and through the marking of words onto paper.

9.5 Locating home: between here and there

The above discussion of the members’ participation in meaningful activities, as a way of establishing and maintaining continuity with their early lives outside the UK, is complicated by their views of their countries of origin. Many of the members who were formally interviewed expressed a sense of being settled in the UK, and at the same time a sense of disconnection with the country of origin. Many said that they were used to life in the UK now and that they no longer liked aspects of the lifestyle in their home country.

Mr I, who came to the UK in 1963, said that because he has been here for so long, he has got used to the way of life here and it feels like home now:

NW: So you’ve been here for more than 50 years, does England feel like home?
Mr I: Yeah. Now it feels like home, definitely, yeah feel like home, you know. I get used to everything now. I like the English way, you know...like working and holidays and that, you know. Yeah.
NW: Do you feel English?
Mr I: Yeah, I do feel English, yeah. I do feel English. Because you live in the same place 50 years, so everything...you know, just like one of yours, yeah... just get used to the life, you know.

[Mr I, 80, China]

Mrs N, who came to the UK as a teenager with her family in 1972, spoke about preferring the UK now because the lifestyle in Hong Kong is too busy:

Now I prefer England more than Hong Kong, because everything...Hong Kong is very modern, everything is fast, you know, so. If I live here so long, if I go back Hong Kong, it's so many people. So if I go out in the station, train station, or you know [laughs], I feel it's a headache. Really fast, everything, you know, life is very busy.

[Mrs N, 61, Hong Kong]

When Mrs Q spoke about life in Hong Kong, she expressed a sense of in-between-ness; that she realises that the life she had in Hong Kong, and the Hong Kong that she was part of, does not exist anymore.

I feel the Hong Kong people about the same, but not now, I'm talking about before come here, because under the, er, English government, isn't it, before, they all learning English...everything it could be same in here. But now they all change now, yeah, I prefer here the all...more gentleman. Everybody know they happy to queue and now they don't care they just push in, everything, yeah, I don't like Hong Kong now. I go to every year visit my family but I don't like it to stay now, no.

[Mrs Q, 66, China]

Mrs H also expressed this idea of what she left behind in Hong Kong no longer existing as it was:

Hong Kong...I don't...it's not...I don't really like Hong Kong because it's too crowded with people. The space are so small. And don't have much friend in Hong Kong because I left Hong Kong so many year...40 years....more than 40 year. Only got one or two friend, that's it. And they working, they are bit busy. It's different
lifestyle...I think... I've been here quite long, so I quite like... I'm settled with [life] here.

[Mrs H, 57, Hong Kong]

Others also expressed this sense of disconnection. Mrs G, who came to the UK as refugee in 1979, said that she feels English. She expressed this in terms of where she feels she belongs now, rather than where she came from originally.

NW: So you've been in England for 30 years...
Mrs G: Over 30 years...very long.
NW: Does England feel like your home?
Mrs G: Yeah. Like home, yeah.
NW: And would you describe yourself as English?
Mrs G: English, yeah...I'm not Vietnamese now. I'm not Chinese now...Chinese is all...my father is a China...China from Vietnam. I born in Vietnam, but we are now in...say...I am not a Vietnamese, I come from another country, so......now England is my country.

[Mrs G, 76, China]

Mrs G also commented that life in Vietnam is changing and that it is not the same now as it had been when she and her husband left. This shifted the sense of belonging from the past into the present; that life in Vietnam is different now and the life that she had known there has changed.

Mrs K, who came to the UK as a refugee in 1978, expressed a similar sense of home, in relation to the present rather than the past. I asked if she is English, or Chinese, and she said that she is a British citizen and that her life is here. She said that England is her home, this is where her present life is, and that Vietnam is in her past. Like Mrs G, this suggests a sense of belonging that is defined in terms of the present, and where her life is now, rather than looking to the past, to where she had come from and to what life had been like before coming to the UK.

NW: So you’ve been in England since 1979?
Mrs K: ‘79, yeah.
NW: Do you feel English? Or would you, do you describe yourself as Chinese? Or as something else?

INT: Because, er, she a citizen, British citizen, so she thinks she is British now. Yeah.

NW: And is England home?

INT: Yeah.

NW: Not Vietnam any more?

Mrs K: No. Mm, mm.

NW: Why is that? Why is England home?

INT: She don’t want to think about the past. The past has...has passed. So, er, just, you know, keep on with things.

NW: This is where your life is now?

Mrs K: Yeah, yeah. I think forever. [Laughs].

[Mrs K, 75, China, interpreter speaking]

This sense of defining home in the present rather than the past, and of looking forward rather than back, was also reflected by other participants. Most of the participants that were formally interviewed had been in the UK for at least 30 years, and for most of them this is the larger part of their lives. When I asked where home is for them, most of them said that it was the UK; this was expressed in relation to their families, predominantly children and grandchildren, and their friends, being in the UK. One the one hand this was a positive statement about the family relationships and other ties that root them firmly in their lives in the UK. But it was also expressed as a sense of disconnection from their previous lives, through the loss of relationships. For example, Mrs L and Mrs N both said that they no longer have friends in Hong Kong:

NW: So you’ve been in England for over 30 years. Is England your home now?

Mrs L: Yes.

NW: Why is that?

Mrs L: Because you...you...your friend anything all in England. When you younger in Hong Kong the friend is all finished, they not...when I come back to Hong Kong I can’t find them.

[Mrs L, 54, Hong Kong]
Now I prefer England. Because er, more than life in England, so, 40 years more than, 40 years now, yeah, so...I go back Hong Kong I don't know everyone, because the friend, school friend, schoolmate, all grown up now, they got family. No it's...so I like England.

[Mrs N, 61, Hong Kong]

Mrs F expressed this as feeling like a visitor when she goes to Hong Kong:

NW: Where is home for you?
Mrs F: Ah...oh it's England.
Mrs E: Second home.
Mrs F: Because I live in here for...forever.
Mrs E: Here home now. Never mind Hong Kong.
Mrs F: I go to Hong Kong just for holiday.
Mrs E: Because they are children all in born here [the UK].
Mrs F: All born here, yeah. I go to Hong Kong just for holiday about few weeks, just holiday, then come back.
NW: What does it feel like when you go to Hong Kong for a holiday?
Mrs F: Just for holiday, yeah.
Mrs E: Not like home, just like holiday.
Mrs F: Just holiday.
Mrs E: Enjoy yourself, eat all the...
Mrs F: And I go to other, other...go to the America, er...just...
NW: So the same as going to any other place?
Mrs F: The same...just for the holiday, not home, not home feel now.

[Mrs E, 72, Hong Kong and Mrs F, 60, Hong Kong]

9.6 Family as a site of change

This sense of family as locating home in the UK however, is not uncomplicated. Many of the members who were formally interviewed expressed a sense of their families as sites of change, and for some, of tension and conflict.
There was a distinct generational change between the centre members and their children and grandchildren in terms of education and employment. Whereas most of the centre members had worked in and/or owned fish and chip shops, takeaways, or restaurants, many of their children and grandchildren had been university educated and were in different professions (such as lawyers, doctors, dentist, opticians, pharmacist, etc). Mr J, who had owned a fish and chip shop with his wife, explained this pattern in relation to his own, and his friends’, children:

*Because in the New Territories [of Hong Kong] in those days, the villages, those young boys and girls they all wanted to come to England to make a living, that’s why I teach them English. And when I come to London I saw all the students became mum and dads, you know, in London working, but most of them working for restaurants and takeaways. But nowadays the later generations all got professional jobs now. Like my children, they not really want to carry on what their mum and dad used to do. Most of my friends’ children got professional job, like now they’re in their thirties or twenties if they, er, got the university degree they do like a doctor, lawyer or dentist or chemist, or whatever. They don’t want to carry on. So...so all the old generation’s professions mostly gone now.*

[Mr J, 70, Hong Kong]

This generational difference was also apparent in terms of the orientation to the cultural traditions of the household.

*We also talked a bit about traditional roles for men and women. For Mrs E, the women did (and should do) all the housework and household chores, and she still agrees with this - that it should be this (Chinese) way. She said that her daughter always complains that she sides with her son-in-law not her daughter (about housework etc) - and that her daughter thinks the English way about the man sharing the housework etc.*

[FN20-23.01.14]

Mrs E expressed a sense of tension in her relationship with her children. She often spoke of having disagreements with them, or being nagged by them for being ‘old fashioned’:
Mrs E asked if I thought she is ‘old-fashioned’ and said that her children think she is and that she argues with them about this. I asked if she thinks it is easier for her children’s generation, having been brought up here but also having Chinese culture in their families. This was because she said that the Chinese way has a lot of rules and traditions, which are more important for her generation, and why her children think she is ‘old fashioned’. She said yes, it is easier for her children’s generation.

[FN22-28.01.14]

Mrs E commented that when her children were little that babies/children were wrapped up (in blankets) so that they couldn’t move about, but that now children are so energetic and moving around all the time. She went on to say that her daughters tell her that it’s not like that anymore and that she has to be open minded. She thinks that if you don’t keep up with things (changes) you get left behind everyone else, so she tries to be open minded about everything (about things being different now than in the past).

[FN14-14.01.14]

Language is also an important way in which family is a site of change. Most of the centre members have children and grandchildren born in the UK, and many have children and grandchildren who have married non-Chinese people. For many centre members, their children and grandchildren speak predominantly English, and some do not speak Chinese at all. This reflects, in part, the blending of families through marriage (to non-Chinese partners), and the socialisation of the children and grandchildren in both English (through school and English-speaking workplaces) and Chinese (mainly family) circles.

Mr I spoke about his children as being ‘English’ rather than Chinese:

NW: Do you think that your children’s lives have been different to yours?
Mr I: Er [pause] in what way?
NW: Because you grew up in China and Hong Kong, and they’ve grown up in England, what do you think has been different for them?
Mr I: No, I think they, they, be...they be in English way now. Yeah, they all in, in, in English way, you know.
NW: So they’re not Chinese?

Mr I: They not Chinese anymore [laughs]

NW: Is that what they would say?

Mr I: Yeah, I think so, yeah...especially my two daughters, you know, hardly got any Chinese friends. So what do you expect, you know. They can’t speak Chinese, so especially, you know...you know, so, that’s their way.

[Mr I, 80, China]

Mrs Q spoke about her son and daughter-in-law speaking English rather than Chinese with each other:

NW: Do your children speak English or Chinese?

Mrs Q: Oh, yeah, they...English, er, little bit, um, Mandarin...but mostly English because he can't speak Chinese...he can, but speak English easier. He can talk to me Chinese but easier to talk English because he...he’s grown here. Just like English boy learn Chinese.

NW: And does [your daughter-in-law] speak English?

Mrs Q: Oh yeah, English, yeah. She’s study in America. They both talk together English...they talk English together, yeah.

[Mrs Q, 66, China]

When Mr J talked about his children and grandchildren speaking English, he was keen to point out that all of them had been born in the UK, as if to say that this naturally meant that they could not speak any (or very little) Chinese:

NW: Is your daughter-in-law English or is she Chinese?

Mr J: Oh she is English born Chinese, like my son.

NW: Do either of them speak Chinese?

Mr J: Er...she is better in speaking Chinese but not very good. He can't speak Chinese, so they’re both English speaking.

NW: They speak English together?

Mr J: Mm.

NW: And your granddaughters?

Mr J: They are both, er, English born...[name] speaks English, yeah.
Mr J: There’s no words from her yet, only two months.

[Mr J, 70, Hong Kong]

Both Mr I and Mr J, who came over to the UK to marry Chinese women who had been born in the UK, said that they have always spoken English with their wives. Mr J spoke about corresponding by letter in English with his wife before he came to the UK to meet (and marry) her:

Mr J: I study English in, er, in Hong Kong. She respond in English, she doesn’t know how to write Chinese...she can listen to your conversation, but she...all her brothers and sisters are born here, so they don’t know...any Chinese characters. They know, they can understand their mum and dad, talking local language, but not writing, so we wrote to each other by English correspondence.

NW: So you’ve always talked with [your wife] in English?

Mr J: Yeah, yeah, always.

[Mr J, 70, Hong Kong]

Mr I said that his wife only speaks a little Chinese and that she relies on him for communication in Chinese:

You see her mum doesn’t speak much English so we have to communicate with her in Chinese but she, she understand, you know, but not very well is she speaking, because, it is, usually...that’s why she’s sat there quiet, she don’t like to speak...don’t often like talking to people, she doesn’t speak very good Chinese...you know, but mostly she got more English friend herself than, than Chinese. It’s just er, school friends, and, er, you know when we usually go out dancing, all mostly English, you know, people mixed you see, so...that’s the way, you know. She rely on me you see, Chinese communication, you know.

[Mr I, 80, China]

Several participants used the expressions ‘BBC’ for British-born Chinese and ‘half-half’ to describe their children or grandchildren. Some of the participants also described
themselves in this way too, in relation to thinking the ‘English way’ about particular things such as a preference for biomedicine rather than TCM. This seemed to be a way of talking about social and cultural changes within the participants’ families, and about changes with the younger generations. For example, some participants spoke about their children wanting to mix with non-Chinese people when they were growing up, and about their children being integrated into ‘English’ life in a way that they were not. I spoke to Mrs Z about these generational changes and she said for her generation, being in the midst of so much change, meant that they needed two brains to survive:

We talked about the generational differences and Mrs Z said for her generation that you need to have two brains; that for her generation a lot of them are ‘frozen’ in a particular time and cultural frame and that they need to be able to split their brain into two - the ‘frozen’ part, but also another part that accepts change and that things are different to that ‘frozen’ frame of life (as it was in Hong Kong, China and Vietnam in the 1960s and 1970s). Mrs Z said that ‘everything is changing’ and that they need to accept that change and have two brains, otherwise life is very difficult.

[FN16-15.01.14]

9.7 Summary

The above discussion explores some of the activities that take place at the centre and the ways in which the members participate in those activities. These are presented, and discussed, as everyday practices that are socially and culturally meaningful, and through which a continuity with the members’ early lives outside the UK is created and maintained. The re-creation and maintenance of a sense of identity in this way is important because it allows for both continuity and change at the same time. Through being at the centre, engaging in socially and culturally familiar practices, and participating in social interaction mediated by material things, the centre members momentarily step out of the changes happening around them; in their families, in their evolving views of their countries of origin, and in their views of life in the UK. This momentary pause is a space in which they can participate in an embodied remembering of time and place that both restores and re-creates a meaningful sense of identity.
The idea of (re)connecting with a previous time and place draws on the role of memory, nostalgia and reminiscence in recreating places; what Gastaldo et al. (2004) explore through the idea of ‘therapeutic landscapes of the mind’ in their study of migration experiences. Gastaldo et al. suggest that therapeutic landscapes of the mind function as a ‘mind bridge’ that ‘gives identity and a sense of belonging, provides stability in a process of displacement and anchors back individuals when they are in a state of transition’ (2004, p.171). The role of memories and nostalgia - of both time and place - in the activities at the centre and the modes of interaction between centre members, are shown here as ways of re-connecting with social and cultural aspects of identity.

The articulation of the UK as ‘home’ and the disconnection from the country of origin, add complexity to this re-creation and re-location of identity. Many of the participants acknowledged that the countries they had left behind had changed and that life as they had known it did not exist in those places any more. This suggested a sense of ‘in-between-ness’, in both time and place; of being somehow suspended between then and now, between here and there. Although many said that the UK was ‘home’, this was often defined in terms of a dislike of the lifestyle in the country of origin, and in terms of looking forward rather than to the past. At the same time, the generational changes within the families of the centre members show that the present - that looking forward - is also not uncomplicated. Generational change within the family was expressed as a dilution of ‘Chinese’ identity, through their children departing from the occupations that defined this wave of migration into the UK, through their marriages to non-Chinese partners, and through the changing use of language, as a marker of identity, within the family. All of these things make the family a site of change. This sense of ‘in-between-ness’ - of being in a space that exists between what was then and what is now - makes the process of re-creating and maintaining a sense of identity meaningful, because it provides a moment of stability ‘in a state of transition’ (Gastaldo et al., 2004, p.171).

Writing about the experiences of Hong Kong immigrants in Singapore, Kwok-bun (2005) suggests that ‘the past is held on to in order to cope with the present and the future’ (p.84). Being at the centre and participating in these socially and culturally meaningful activities, allows the centre members a pause in which they can step out of the ‘in-between-ness’ and re-connect with their past, in order to adapt to the changes that are going on around them in
other places in their lives; in their families as they are changing through the generations, and in their connections to their countries of origin which no longer exist in the way that they had known them. Kwok-bun (2005) describes cultural change as ‘a long process of forgetting - and remembering - this or that part of oneself, of picking and choosing, of mutating and transforming’ (p.8). This frames the re-creation of identity, through engagement with culturally familiar materialities and everyday practices, and through memory and nostalgia, as a form of adaptation. It also echoes what Mrs Z said about her generation needing two brains in order to cope with change; that the ‘frozen’ part needs a counterpart which accepts change. The momentary pause, in which the members engage in reconnecting with the past, through embodied reminiscence, can then be seen as a way of mediating between those two minds.

The next chapter returns to the idea of therapeutic landscapes, in order to consider the way in which these everyday practices, shaped by the participants’ experiences of migration and by their particular understanding of health and wellbeing, can be seen as practices of care that contribute to health and wellbeing in this particular place.
Chapter 10: Discussion - Everyday Practices of Care and the Re-creation of Place

10.1 Introduction

This chapter returns to the central orientation of the thesis; the relationship between people, place and health. Each of these elements have been addressed in the preceding chapters; the migration stories of the participants are explored in Chapter 6; their understandings of health and wellbeing are explored in Chapters 7 and 8; and the physicality of the community centre, the everyday activities that take place there, and the ways in which the centre members interact with one another in the centre, are explored in Chapters 5 and 9. This has been shaped by the concept of therapeutic landscapes, which has been used to explore processes of healing and the maintenance of health and wellbeing in a wide range of places (as discussed in Chapter 2). In this study, it has been applied as a conceptual lens through which to explore, and to bring together, the three elements of the study; the people, their understandings of health and illness, and (their participation in) this particular place.

Drawing on the literature around therapeutic landscapes, the community centre in this study has been approached as an everyday landscape. Rather than being a place primarily associated with processes of healing, or formalised health care, the community centre is explored as a setting for everyday life; what Wakefield & McMullan (2005) describe as ‘ordinary places’ where ‘commonplace processes of healing’ take place (p.299). The community centre is also viewed in terms of an understanding of place as relational. In this respect, the study of place is concerned with ‘the dynamic interactions between individuals and contexts, rather than simply the effect of a particular physical environment on health’ (Plane & Klodawsky, 2013, p.3). This resonates with a conceptualisation of place as constituted through ‘social relations and practices’ (Laws & Radford, 1998, p.81). It also reflects the idea that it is the meanings and experiences that people associate with particular places that make them significant (Gelser, 1991, p.164). The way that the research participants engage in this particular place also reflects a consideration of place in terms of community; that is, an understanding of community which focusses on participation and engagement in particular places and the ways in which this promotes a sense of belonging within, and to, those places (Plane & Klodawsky, 2013, p.5).
In terms of addressing the question of culture in the relationship between people, place and health, culture is understood in this study as enacted and emergent through everyday practices. This is illustrated in the underlying understandings of health and wellbeing among the research participants (discussed in Chapter 7) and the different choices they make with regard to the treatment and management of illness (discussed in Chapter 8). The migration stories of the research participants also reflect this approach; understood as a major change in social and cultural context, the focus on migration provides a lens through which to consider culture in a context of change, so that what is meaningful must be negotiated and enacted in response to the changing circumstances of life. In this way, it is understood that rather than living in cultures, people ‘live culturally’ (Ingold, 1994, p.330).

The focus on migration also shows that place plays an important part in shaping what is socially and culturally meaningful for different people in different places; in particular, because it highlights issues of identity and belonging that are associated with place. The migration stories bring an important context to the understandings of health and wellbeing that are expressed by the research participants, the ways in which they interact in this particular place, and the ways in which these are connected.

In the context of culturally competent health care, Borovoy & Hine (2008) highlight that it is important to ask what ‘health’ actually means to those concerned (p.18). As Kleinman (1980) suggests, this is essential for understanding processes of healing in particular places and for particular people (p.91). The other side of this however, is to ask what ‘care’ might mean; that is, what can be understood in particular places, and for particular people, as care. The orientation of the concept of therapeutic landscapes around processes of healing as they are played out in particular places helps to ask this question; about what is therapeutic, or healing, in particular places, but also about how the relationship between people and place shapes this. In approaching the community centre in this study as a therapeutic landscape, it is therefore important to explore the ways in which healing can be understood. This in turn helps to think about care; about processes, or practices of care, that take place outside of formalised spaces of care, and outside of a biomedical approach to health and wellbeing.

The focus of this chapter is therefore to discuss what can be considered as healing - or therapeutic - in the context of this study, for this particular group of people, in this
particular place. This raises important issues around community, identity and belonging, as they are implicated in the relationship between people and place, and as they are reflected in the enactment of a particular understanding of health and wellbeing by the participants at the centre. This is presented as everyday practices of care that play an important part in contributing to the health and wellbeing of the participants in the study.

10.2 The community centre as a place of care

In the preceding chapters, the community centre has been addressed as an everyday landscape; as an ‘ordinary’ setting for everyday life and a place in which ‘commonplace processes of healing’ take place (Wakefield & McMullan, 2005, p.299). It has been explored primarily as a place in which its members can meet socially and engage in activities together. However, as noted in Chapter 5, the community centre is also a place in which both health and social care services are provided to its members. Some of these are provided directly, either at the centre or in people’s homes by the centre staff. This includes things such as befriending, home visits, meal delivery services, activities and outings, podiatry, and hairdressing. The centre also acts as a gateway in providing access to, or facilitating the use of, other health and social care services, particularly through helping its members with interpreting and translation. It has established links with other organisations in the region, including local councils, social services, and the NHS. These associations are an important part of the ethos of the larger organisation that the community centre is part of, and reflect its mission to provide social and welfare services to disadvantaged Chinese families in the region. The community centre specifically states that its aims are to provide a space in which ‘elderly people are able to meet, to enjoy Chinese food together, and access a range of support services’

18 As noted in Chapter 5, I acknowledge that the identity of the centre is relatively easy to find, but I have none-the-less chosen not to use the name of the community centre, or the larger organisation, in this thesis (*indicates information that it available on the organisation’s website).
It is useful to re-iterate this context for the community centre in terms of the nature of the Chinese community in the UK; in particular for the generation of migrants associated with the growth of Chinese takeaways and restaurants in the 1960s and 1970s, which the participants in this study are all part of. It is noted that due to economic competition between family run takeaways and restaurants, this generation of Chinese migrants are widely dispersed throughout the UK (Chan et al., 2007; Tran et al., 2008). Chau & Yu (2001) suggest that this creates a ‘double social exclusion’ for older Chinese people in the UK; that through their involvement in these family run business, they are geographically separated from one another, and at the same time isolated from mainstream society (p.120).

Most of the participants in this study live alone, or with their spouse, rather than in extended family groups. Mrs H, who has 4 children, spoke about the feeling of emptiness once her children had all left home. She also commented on this in terms of the changing nature of family life, in comparison with the ‘olden day’:

*Like most of British people, once their children are left home, they all feel emptiness. I sometime do feel that when they all left the house. You know, you’ve got nothing to do all day [laughs]. It’s, it’s different. We’re...at the olden day the Chinese you have...you know, family live together, you know...Nowadays, we tend to keep small family rather than a big family.*

[Mrs H, 57, Hong Kong]

Mrs H does not work and said that since her husband was away a lot (in Hong Kong) she prefers to come to the centre instead of being at home alone:

*That’s, that’s why I come to do more Tuesday and Thursday. Normally I only come Thursday afternoon to do the dancing...but now my husband, he’s away most of the time...Yeah, my husband is away most of the time, yes.*

[Mrs H, 57, Hong Kong]

Mrs Z also spoke about the members of the community centre living alone. Some of them live in apartment blocks in the city centre that are run by a Chinese housing association. The three interviews that were conducted in the participants’ homes were in apartments in these blocks. The tenants are all Chinese and these blocks form an important part of the
Chinese community for those living in them. We met several people on the street as we walked to the apartments, and several people in the corridors, who all seemed to know Mrs Z, and greeted her as we passed. She spoke about people living in these apartment blocks in relation to the changing circumstances within families around the provision of care for older relatives (by children):

*I think, you know, gradually they do realise the realities that children can’t stay with them. And, they accept that...You know, before the [housing association], you know, older people’s...space, they don’t want to be there. The first lot went in, they were very sad, very depressed, because they thought the son and children abandoned them in that social housing...but, once they found the benefit, you know...it’s near the centre, near Chinatown, everything in there, so maybe word of mouth, or whatever, so they’re just watching everybody going there. And now, they couldn’t get a place...they try everything to get in, you know...trying to register and get a room in there [...] So we can see, the change...is the need of the support...they’re so desperate, even they think this is a shame to apply for benefit, but they still, you know, because the support is there...they really knew that their son and daughter really can’t look after them...they really realise that...and they gradually accept that is the reality [...] They say...I live so far away...I’m getting old, I can’t really drive, you know, how am I coming to the centre? You know, when they getting older they start to see, you know, the future is...you know, if not near the community, it is...it’s so helpless. So...they start to worry.*

[Interview with Mrs Z]

Here, Mrs Z suggests that the changes in family circumstances mean that many older Chinese people are living alone, rather than with their children or in extended family units. In this respect, she talks about the changing attitude towards living in the apartment blocks run by the Chinese housing association. This evolving attitude is a response to change; they realise that their children cannot look after them, and they need to find support elsewhere. As Mrs Z puts is, ‘they are desperate’, and being isolated from the community makes them feel ‘helpless’. This is important in relation to the way that the Chinese population in the UK is viewed; as self-sufficient and as having a lot of family support for elders (Chan et al. 2007, p.510; Li & Logan, 1991, p.1). Chan et al. (2007) highlight that this has an impact on the provision of health and social care services to the Chinese in the
UK (p.510), and in this respect, Yu (2000) suggests that ‘the cohesiveness of the Chinese community is overstated’ (p.10).

As noted above, most of the participants in this study live alone, or with their spouse, rather than in extended family groups. Like Mrs H, many of them said that they prefer to come to the community centre and be together with each other, rather than staying at home on their own. As discussed in Chapter 7, this resonates with the underlying ideas about health and wellbeing that many of them expressed; that individual health is tied up with social and family relationships and that getting out and being active and socially engaged is important for maintaining health and wellbeing. With this, and their changing family circumstances, being together at the community centre is especially important. It is in this respect that the community centre is considered as a space of care; not because it provides access to health and social care services, but because it is an important source of community. This is a sense of community - understood in terms of identity and belonging - that is created through the particular ways in which the participants engage with one another in this place. In this way, the centre is a place in which health and wellbeing are attended to in meaningful ways. The remainder of this chapter therefore addresses the ways in which the participants engage with one another in the centre, as everyday practices of care. This will be done through a discussion of healing, fields of care, embodied memories of place, and continuity and change.

10.3 Healing and Care

Kleinman’s work on understanding processes of healing is a useful place to start in terms of thinking about conceptualisations of healing and care. He discusses healing as part of a ‘system’ of medicine, suggesting that:

‘...ideas about the cause of illness (as well as its physiology and course) are linked to ideas about practical treatment and intervention. Part of medicine’s therapeutic mandate is that sickness beliefs organize health care seeking choices and treatment interventions.’ (Kleinman, 1980, p.91).
Although Kleinman uses the term medical healing, in the context of medical systems, this idea also helps to think about healing outside of the confines of healing as ‘medicine’ - precisely by referring back to the particular understanding of health and illness in a given context. In this way, understanding what is healing - or therapeutic - begins with understanding how health and illness are conceptualised. To this effect, Kleinman states that ‘healing is not the outcome of diagnostic acts, but the healing function [of medical systems] is active from the outset in the way illness is perceived and the experience of illness organized’ (1973b, p.208). He adds to this that both illness and healing take place within specific symbolic realities; that is, within ‘[the] social and cultural world of ideas, values, sentiments, meaningful symbolic forms, social relations, and the like’ (1973a, p.160). In this respect, he emphasises that healing is a ‘social and cultural activity’ (1973a, p.162), which ‘connect[s] cultural events and forms with affective and physiological processes’ (1973b, p.210).

This approach can be applied to the question of understanding what healing means in the context of this study; that is, through the exploration of the particular understanding of health and illness articulated by the participants in the study. This has been explored in the preceding chapters; in Chapter 7 in terms of the ways in which the participants spoke about health and illness - or more precisely, about health and wellbeing; in Chapter 8 in terms of their choices about the use of TCM and biomedicine to maintain health and treat illness respectively; and in Chapter 9 in terms of the everyday activities and the interaction between participants at the centre, as everyday practices of wellbeing. As discussed in Chapter 6, many of the women in the study experienced loneliness and isolation in their early years in the UK. They spoke about this in terms of ‘homesickness’ - of being separated from family and friends and from a familiar place - and they expressed this as a time of significant personal distress. Their sense of ‘knowing and being known here’ (Relph, 1976, p.37 - emphasis in the original) and of having a ‘secure point from which to look out on the world [and] a firm grasp of one’s own position in the order of things’ (Relph, 1976, p.38) is temporarily lost. This also presents a challenge to their understanding of health and wellbeing. As discussed in Chapter 7, the participants in this study expressed a holistic understanding of health and wellbeing that is tied up with social and family relationships and with being engaged with the world; this is about being in place in the world, and this is what is disrupted in these experiences of homesickness.
Writing about the experience of disruption, Becker (1997) suggests that:

‘In all societies, the course of life is structured by expectations about each phase of life, and meaning is assigned to specific life events and the roles that accompany them. When expectations about the course of life are not met, people experience inner chaos and disruption. Such disruption represents loss of the future. Restoring order to life necessitates reworking understandings of the self and the world, redefining the disruption and life itself.’ (Becker, 1997, p.4).

This is especially important in the context of migration; the experience of migration for the women in this study was not a disruption in the sense that it was an unexpected event or crisis, but rather because it was experienced as a loss of - or a disruption to - place. The idea of ‘restoring order to life’ (as above) resonates with Kleinman’s suggestion that processes of healing are also about chaos and order. He states that ‘For many traditional medical systems illness is disorder, and healing is a socio-cultural activity by which chaos is transformed into order’ (1973a, p.162).

The migration experiences of the women reflect these ideas about chaos and order. The experience of homesickness, as a loss of place, can be understood as a disruption of this kind; as a disruption to (social) order, to the expectations about life, and to the circumstances (i.e. the place) within which life is lived. Healing in this sense is about the restoring of order and the creation - and maintenance - of continuity, which Becker (1997) suggests takes place through ordinary, everyday practices:

‘A sense of continuity is captured in ordinary routines of daily life, the mundane and comforting sameness of repetitive activities, such as drinking a cup of coffee with the morning newspaper.’ (Becker, 1997, p.4).

The point is that this - the cup of coffee with the morning newspaper - should be socially and culturally meaningful. To this effect, Becker emphasises that ‘continuity has a culture-specific shape’ (1997, p.4). The ways in which the participants engage with one another through the particular activities at the community centre are presented in this thesis in this way; as everyday practices that contribute to the re-creation and maintenance of order and continuity in the face of change. This is an enactment of social and cultural values - for
example, through the sharing of food and the practice of Tai Chi - that are important in relation to identity and belonging, and in turn to health and wellbeing. In this sense, these everyday practices can be seen as a form of healing - or care - in that they are concerned with the restoration of order and the maintenance of continuity.

10.4 Fields of care

Relph (1976) uses the term ‘field of care’ to describe the sense of attachment and belonging that people come to feel within and towards particular places. He writes that:

‘To have roots in a place is to have a secure point from which to look out on the world, a firm grasp of one’s own position in the order of things, and a significant spiritual and psychological attachment to somewhere in particular.’ (Relph, 1976, p.38).

In this way, he suggests that ‘The places to which we are most attached are literally fields of care’ (p.38). He adds to this that:

‘to care for a place involves more than having a concern for it that is based on certain past experiences and future expectations - there is also a real responsibility and respect for that place both for itself and for what it is to yourself and to others’. (Relph, 1976, p.38).

This can be applied in this study as a way to think about care in place. This can be seen in the context of the migration stories of the women (as discussed in Chapter 6 and in the previous section), in which this ‘secure point from which to look out on the world’ is challenged in their experiences of loneliness and isolation. This is also challenged by the generational and cultural changes within their families which have implications for their sense of identity and attendant sense of security. In this respect, the centre is a safe space in which a sense of identity and belonging can be re-created and maintained in the face of these experiences.
Mrs Z spoke about the centre members being comfortable and at ease at the centre in a way that they are not in other places, and that even though they may have problems and difficulties, they do not feel that they are suffering when they are at the centre. In this sense, being at the centre, and participating in it in a particular way, is a sort of ‘escape or retreat’ (Gesler, 1992, p.735-6) in which a sense of balance and order can be restored.

If you look at the people here...even they...they have a lot of suffer in the past. But now, they enjoy life. So...when they come to the centre, even they have a lot of issue out there...maybe not happy...but the time they coming here, they find comfortable...they can find the rest, they like the situation here...so, if you talk about, you know, what the situation in the past they are not happy, it’s okay, because they’ve found that yes...I got this, I got that, I got this, so at the moment, when you talking...you know, they content. So, it’s okay.

[Interview with Mrs Z]

Mrs Z adds to this that the centre members share an implicit understanding about health and wellbeing:

In the centre...we all in common...about general health. How to maintain the body in the right balance. Everybody coming here, they have all the same concept, you don’t need to say it. So, we all know.

[Interview with Mrs Z]

Writing about healing practices in Northern Senegal, Bignante (2015) draws attention to the importance of this kind of shared understanding in healing encounters. She describes this as human solidarity, and suggests that this is important in creating ‘emotional support’ and ‘a sense of reassurance’ in the healing encounter (p.708-9). This idea of human solidarity as the foundation of support and reassurance is what Mrs Z is also talking about here; that the unspoken understanding among the centre members, about health and illness, is an important part of what makes this a comfortable, safe place for them to be. Bignante also writes about the importance of cultural belonging in healing encounters, which she approaches in terms of the room where the healing encounter takes place and in terms of the material things that are part of the healing process, such as herbs, scriptures, music, and so on (2015, p.709). She suggests that these materialities create a sense of cultural
belonging - or a sense of place - in which the patient feels comfortable and safe. This can be applied to the community centre in this study, so that it can be seen as a healing, or therapeutic, environment in this way. The everyday practices - the particular activities and the material things associated with these - create a sense of cultural belonging within the community centre, in the way that Bignante describes. This is about creating a sense of belonging - and identity - that is socially and culturally meaningful, for these particular people in this particular place.

Relph (1976) suggests that:

‘In both our communal and our personal experience of places there is often a close attachment, a familiarity that is part of knowing and being known here, in this particular place. It is this attachment that constitutes our roots in places; and the familiarity that this involves is not just a detailed knowledge, but a sense of deep care and concern for that place.’ (Relph, 1976, p.37 - emphasis in the original)

With the ideas of solidarity and cultural belonging in mind, this can be understood as about care in place; that through being part of this place, through interacting with one another in particular ways and through doing particular activities together in this place, the participants enact a sense of care that is important to their wellbeing. This is a sense of care that is about belonging and identity, as it is experienced, created, and maintained in this particular place. In this way, the centre can be understood as a field of care; as a place within which its members express care and concern for each other through the ways in which they engage with one another at the centre. This is also relevant in terms of the understanding of health and wellbeing among the research participants; in particular, that individual health is understood to be tied to social relationships and engagement with the world (as noted above and discussed in Chapter 7). This is reflected in their participation in the centre, so that the importance of being in this place is about being there together, and participating in socially and culturally meaningful activities together. This is about the creation and maintenance of order through harmonious social relationships in the way that Kleinman conceptualises healing as a process in which ‘chaos is transformed into order’ (1973a, p.162) and Becker writes about the ‘restoring [of] order to life’ in the face of disruption (1997, p.4). As such, the centre can be understood as a place in which everyday practices of care are enacted.
Kleinman (2013) writes about practices of care in terms of morality, which he describes in the following way:

‘enduring moral practices of caring [such] as the laying on of hands, the expression of kindness, the enactment of decency, and the commitment to presence - being there for those who need them’ (Kleinman, 2013, p.1377).

Although this is in the context of formal caregiving (in medical practice) this helps to extend the conceptualisation of care; from the idea of care as practical tasks (e.g. feeding, dressing, washing) to something that can be understood - and practised - in a different way. As Kleinman suggests, this approach to understanding care is about actions and practices that concern morality and a sensitive engagement with personal experience. He offers an anthropological perspective of practices of care to emphasise this:

‘The anthropological perspective suggests that care resembles gift exchange between individuals whose relationship to each other really matters. Stories and meanings are exchanged, but also the raw experience of responsibility and emotional sensibility.’ (Kleinman, 2013, p.1377).

This highlights a social aspect of care that resonates with this study; with the way in which the participants express concern for one another through the everyday practices that constitute the day-to-day life at the centre. Importantly, this is about ‘individuals whose relationship to each other really matters’ (as above). This is particularly relevant in the context of an understanding of health and wellbeing in which individual health is bound up with social relationships and family responsibilities. In this way, the expression of care for one another through these everyday practices, is about attending to relationships that really matter. As Kleinman suggests there is a sense of both responsibility and sensibility in this; it is about attending to each other implicitly, through shared understandings and human solidarity. This is an expression of care through the enactment of social and cultural values. The way in which the participants engage with one another in the centre can therefore be understood as ‘practices and engagement over what really matters’ (Kleinman, 2011, p.804); and this in turn, can be understood as everyday practices of care.
10.5 Embodied memories of place

Casey (2001) proposes the idea that the body ‘bears traces of the places it has known’ and that through being in and experiencing a place ‘we are forever marked by that place, which lingers in us indefinitely and in a thousand ways’ (p.688). Like Gesler’s notion of places having a spirit or personality (1991, p.164), Casey suggests that this marking of place on the body is about the ‘presence of place’, about ‘how it felt to be in this presence’ (2001, p.688). He contends that through this ‘holding’ of place within the body, and in memory, that ‘place and self actively collude’ (2001, p.687).

What Casey is suggesting is an embodied memory of place (and time) through which the feel or spirit of one place is brought to another. This is reflected in the engagement of the participants in the centre; in the evocation - through memory and reminiscence - of other times and places that are significant in their lives, and which are brought to the centre through embodied remembering, in the form of everyday practices. As discussed in Chapter 9, this includes the practices and associated materialities that constitute the day-to-day life at the centre; the activities, the noises, smells and physicality of the building, the food, and the way of expressing care and concern for one another through these, as embodied practices. This resonates with the suggestion that places are records of the values of the people within them, that: ‘knowing places through sociality in community, places are records and expressions of the cultural values and experiences of those who create and live in them.’ (Relph, 1976, p.61).

Gastaldo et al. (2004) approach this in a different way, using the idea of ‘therapeutic landscapes of the mind’. With this, they consider ‘imagined or recreated places’, suggesting that therapeutic landscapes of the mind are ‘non-traditional landscapes, the ones constructed and experienced in one place but that refer to another location’ (p.171). They write about this specifically in relation to the experience of migration, so that these imagined or recreated places play an important part in the experience of moving from one place to another; as ‘a therapeutic coping mechanism for ‘missing’ the places of home’ (2004, p.160). Like Casey’s embodied memory of place, this is the idea that the essence of one place can be brought to another. In this respect, Gastaldo et al. suggest the idea of a ‘mind bridge’ that creates ‘identity and a sense of belonging, provides stability in a process
of displacement and anchors back individuals when they are in a state of transition’ (2004, p.171).

This re-creation of place - or bringing of one place to another - through memory and reminiscence and through everyday practices, plays an important part in creating a sense of identity and belonging within the centre for the participants in this study. This is about identity in place, in the way that Casey and Gastaldo et al. suggest; in the ‘active collusion of self and place’ (Casey, 2001, p.687), and in the ‘reconstruction of the individual’s self in relation to a new place’ (Gastaldo et al., 2004, p.172). This in turn, is important in relation to health and wellbeing for the participants in this study; particularly in terms of being in place in the world, through social relationships and engagement with the world.

Kleinman & Kleinman’s (1991) use of the term ‘local moral worlds’ also helps to explain this. They use this to refer to:

‘the local context that organizes experience through the moral resounding and reinforcing of popular cultural categories about what life means and what is at stake in living.’ (Kleinman & Kleinman, 1991, p.293).

This is what is re-created at the centre; a local moral world that shapes ‘what life means’ and ‘what is at stake in living’ - ‘what really matters’ in this particular context, for the people and place in this study. The activities and the associated materialities that form part of the day-to-day pattern of life at the centre help to create a sense of cultural belonging for the centre members. However, the way in which the participants engage with one another through those activities and material things, also plays a part in creating a local moral world. This is about the shared understandings and solidarity amongst the centre members; about the implicit understanding of what is important for them in this place. As has already been suggested above, as practices of care, the day-to-today activities at the centre are an enactment of social and cultural values; of an understanding of health and wellbeing linked to family and social relationships and engagement with the world. In this respect, the centre can be seen as a local moral world in which these enacted values are socially and culturally meaningful. In terms of the relationship between people and place, this is about identity in place, as it is implicated in the health and wellbeing of the participants in this study.
10.6 Continuity and Change

Although emphasis has been given to the importance of creating a sense of cultural belonging through memory and reminiscence and through socially and culturally meaningful (i.e. ‘Chinese’) activities and materialities, it is important to re-iterate that it is not only Chinese things that take place at the centre. There are also other things that take place there which are not specifically Chinese; such as line dancing, hairdressing, eye testing, podiatry, and so on. In this respect, the centre is a place in which these things sit comfortably together.

As discussed above, the centre is a place in which ‘what really matters’ is attended to; in part through socially and culturally meaningful activities and materialities, and in part in the way that the participants engage with one another through these. The shared understandings and solidarity between the centre members make it a safe place; that is, a place in which they ‘know and are known’ (Relph, 1976, p.37), in which they do not feel that they are suffering, and in which they are in a ‘secure place to look out on the world’ (Relph, 1976, p.38). This is about the essence or the feel of place - about what it felt like to be living in another time and another place - which is re-created and maintained at the centre, in the way that the participants engage with one another. However, the blending of ‘Chinese’ and ‘non-Chinese’ things in the centre reflects the way that Kwok-bun (2005) describes cultural change; as a ‘process of forgetting - and remembering - this or that part of oneself, of picking and choosing, of mutating and transforming’ (p.8). In this sense, whilst the ‘essence’ of place is maintained and ‘what really matters’ is protected, the co-existence of Chinese and non-Chinese things in the centre is also about responding to change. In this way, the centre can be seen as a place in which identity is negotiated and in which some of the tensions and conflicts in other parts of the participants’ lives are mitigated - through the existence of continuity and change together, at the same time, in this particular place.

In relation to negotiating continuity and change, Becker (1997) suggests that ‘people maintain continuity with the past amid the facts of change by interpreting current events so that they are understood as part of tradition’ (p.4). She adds to this that in the face of disruption ‘restoring order to life necessitates re-working understandings of the self and the world, redefining the disruption and life itself’ (p.4). This is about re-working a sense of
identity in order to find something that is meaningful - socially, culturally and personally. This is also what Kwok-bun (2005) is suggesting; that in the process of (cultural) change, some things are remembered and protected and others are transformed and changed. What is maintained at the centre is ‘what really matters’; through the social and cultural values, enacted in the everyday practices that constitute the day-to-day life of the centre. This is a way of creating a sense of continuity, in a safe place, around which others things change.

This is also reflected in the varying contexts within which the participants in this study make choices about their use of TCM and/or biomedicine, such as their families and their upbringing outside the UK, as well as practical issues of access to and communication with doctors and other healthcare professionals. Although the participants in this study expressed a shared underlying understanding of health and wellbeing, this was manifest in different choices about health care, for different reasons, and also in different illness experiences. The choices they make are about responding and adapting to change and negotiating daily life in ways that are meaningful.

Gervais & Jovchelovitch (1998) write about the choices around health care among Chinese people in the UK in terms of identity. They suggest that representations of health and illness are ‘not just about health’, but are about ‘being Chinese or not, about being able to have an identity and have it recognized […] and about deciding how to cope with the differences between “the Chinese way” and that of the host society’ (p.725). In a similar vein, writing about the way in which South Asian women attend to health and illness in Canada, Dyck (2006) suggests that meanings are ‘remembered, re-crafted and reconstituted in the context of […] local, lived experiences’ (p.14). This connection between representations of health and illness and issues of identity helps to understand the ways in which the participants in this study engage with one another in the community centre; as both an enactment of their particular understanding of health and illness, but also as a process of maintaining a sense of identity - in this particular place.

**10.7 Limitations of this study**

Methodological issues within this study are discussed in Chapter 4, with a particular emphasis on ethical considerations and the need for reflexivity in ethnographic research,
and issues around language in cross-cultural research, both in terms of conducting fieldwork, and in terms of the data generated. The discussion of these issues addresses questions about the reliability and validity of the data gathered in this study and the analysis drawn from it. It also addresses the conduct of the researcher, in particular with respect to the relationships built up with research participants in the field. This has important implications for both the trustworthiness and the credibility of the study. It is important to note here however, that despite the care and consideration taken to conduct the study as ethically and robustly as possible, there are none-the-less some limitations to the study.

As discussed in Chapter 4, language is an important methodological issue in this study. Although it was not an insurmountable obstacle, it still remains that language does present a limitation for this study. Firstly, the fact that I do not speak any Chinese means that I was not able to speak to, or get to know, all of the members of the centre. However, as discussed in Chapter 4, I was able to build good relationships with many of the centre members who did speak English, and to make connections in other ways with some of those who did not speak English. The latter are included in the data generated in this study, through fieldnotes, observations, and accounts of my interactions with them over the period of the fieldwork. In this way, they also play an important part in the study, despite the fact that my ability to converse with them through language was limited. Not all of the centre members were interviewed; some who were approached declined an interview because they said their English was not good enough (although I suspect that for some this may have been a polite way to refuse to participate). Others were interviewed with the help of Mrs Z, acting as an interpreter. Even without the issue of language, it is unlikely that I would have had a strong rapport with all of the centre members; in any research setting it can reasonably be expected that not all of the people approached will be willing or interested in taking part in research. The personality of the researcher and of the research participants, as well as social and cultural differences, including language, also impact on this.

The participants in this study represent a section of the members of the centre; those with whom I was able to make some kind of meaningful connection, those who were willing to talk to me because of their relationship with Mrs Z (as a gate keeper and interpreter), and
those who were interested in what I was doing and were willing to take part. Others’ views may not be represented here, and this could be seen as a limitation to the study.

With more time at the centre, I may have been able to conduct additional interviews with some of the older members of the community centre who spoke little, if any, English. However, this would of course have been dependent on their willingness to take part, and on Mrs Z’s willingness and availability to organise interviews on my behalf, and to interpret during them. With greater financial resources, more formal processes of translation and interpreting could have been undertaken to allow for cross-checking and back translation. In this respect, I was reliant on Mrs Z’s knowledge of the Chinese community, and her ability to translate this into terms that I could understand, that were also faithful to the meaning of what was being explained. I acknowledge that reliance on a key informant in this way can mean that the findings are influenced by that person’s perspective and agenda; however, I had confidence in Mrs Z’s abilities in this respect - and in her understanding of the aims of the study - and there was consistency across the interviews that were conducted with her as an interpreter and the ones that I conducted on my own. There is also resonance with other literature about Chinese communities in the UK (as discussed in Chapters 2 and 3) - about their experiences of migration, and about their understandings of health and illness - that help to strengthen the validity of the data in this study.

Although ideas for the development of the thesis were discussed with supervisors and with Mrs Z (as a key informant and collaborator) the analysis of the data was conducted by myself alone; the interview transcripts, fieldnotes, and any other data collected during fieldwork, were only coded by myself. Had coding been done collaboratively, the analysis of the data may have taken a different shape; however, this thesis is based on my analysis and interpretation of the data, undertaken with guidance from supervisors as the analysis was developed and the thesis written.

With the focus on health and place, informed through the concept of therapeutic landscapes, the observation of the research participants’ lives was limited in this study to their participation in the community centre. In this respect, other areas of their lives were not explicitly included in the study. Expanding the scope of the study in this way, may have been useful in terms of learning more about the blending of Chinese and non-Chinese
aspects of the participants’ lives outside of the centre; in their homes, within their families, in their places of work (for those who do still work), and in the other places that are part of their lives. In this respect, it may also have been useful to speak with the younger generations of the participants’ families, especially with regard to generational and cultural changes. However, despite these limitations, and ways in which the scope of the study could have been extended, the data collected is sufficient for the analysis presented in this thesis to be appropriate and justifiable within the scope of this study, with respect to both the time and resources available for this study, and the scope of the research interests.

10.8 Implications

Despite these limitations, this study none-the-less makes a number of important empirical, theoretical and methodological contributions to this field of research.

10.8.1 Empirical contribution

The community centre in this study is presented as a space of care because it is a place in which the centre members care for each other, and through this, for themselves. The day-to-day activities and the ways in which the centre members engage with one another through those activities are conceptualised as everyday practices of care. These practices are also understood as the enactment of a particular understanding of health and wellbeing, in which individual health is implicated in social relationships and engagement with the world.

Whilst these findings are clearly specific to the particular people and place in this study, they also help to ask questions more broadly about what can be considered as care and where - and how - this might take place. This has potentially important implications for the design and provision of health care and social support services for marginalised communities (such as migrants and refugees). Care in this study is shown to be emergent through the relationships and everyday activities that take place at the community centre. It is enacted and experienced communally rather than being provided to individuals by other people, or from outside the centre. Understanding care in this way, as everyday practices,
enables a different approach to be taken to the provision and design of care services. Rather than starting with thinking about what services may be required or about what potential users may want from particular services, it may be more meaningful to ask what it is that ‘really matters’ (Kleinman, 2011, p.804); what might make peoples’ lives easier and what might help them to be well, in the broadest sense of the word. How this is attended to may not require the provision of formal healthcare services, as shown in this study. The participants in this study used the community centre as a place to care for each other, and through this for themselves. This is a form of care that is not dependent on formal services or structures of health and social care. Rather, what is needed is the support and resources for them to provide care for themselves and each other - through meaningful activities - and a place in which to do this together. This suggests that rather than providing external and formalised healthcare services, the provision of resources - such as a community centre - may be more important in enabling groups like this to care for themselves in ways that are appropriate and meaningful to them. The point is that beginning with a different understanding of care, and asking different kinds of questions, creates space for different answers, and in turn, for different forms of care to be developed.

10.8.2 Theoretical contribution

The conceptualisation of care presented in this thesis also contributes to the literature around the materialities and practicalities of practices of care. The approach to care in this study moves away from an understanding of care in formalised spaces of healthcare and in terms of the practical tasks of care; rather it considers the practice of care in everyday settings. In this study, the day-to-day activities of the community centre and the way that the members engage in those together constitute practices of care; in part because they are activities that are meaningful to them, but also because they are able to do them together. This is about more implicit, everyday forms of care, that are part of day-to-day life; they are not acts - or practices - of care that are formalised or specialised, nor are they provided by healthcare (or other) professionals. Rather, these are activities that take place in day-to-day life that the members of the centre choose to participate in together, in this particular place. Each of the activities involves material things - such as food, music, ink and brushes - that are also significant because they help to recreate important connections with other times and places in the centre members’ lives.
Whilst the potential for the recognition and provision of support for everyday practices of care - for other groups of people in other settings - is noted above, this also makes a contribution to thinking conceptually about practices of care. The activities and the material things that are part of the day-to-day life at the community centre play a central role in shaping the centre as a place of care, and the engagement with those things, and with each other, as practices of care. An important part of this is the sense of continuity with the members’ early lives outside the UK that is also created and maintained through participation in the centre. This is important because it allows for both continuity and change at the same time. In this respect, the centre is a space in which its members can participate in an embodied remembering of time and place that both restores and re-creates a meaningful sense of identity. Importantly, this brings the role of (embodied) memory, reminiscence and nostalgia - as an implicit part of the day-to-day activities at the centre - into the understanding of care. In this study, this is a collective and embodied remembering, mediated through material things.

This study also makes a contribution to the body of work around therapeutic landscapes. Although the concept has been applied to studies of health and illness in many and varied places, at the time of submission, there are no other studies that use the concept of therapeutic landscapes in the context of Chinese communities in the UK. Although it has been used to explore experiences of migration (e.g. Gastaldo et al. 2004), the focus in this study on first generation Chinese migrants and refugees in particular provides a novel contribution to this literature. At the same time, the approach to landscape taken in this study also contributes to anthropological literature around the conceptualisation of landscapes. In this study, landscape is not approached in a traditional sense - as physical places - but reflects the emphasis within the concept of therapeutic landscapes on the relational aspects of people and place; that places are experienced, lived and acted. In particular, this study brings together the ideas of wellbeing, family and memory as embodied places that are (re)created through participation at the community centre. This actively engages with an understanding of landscape as embodied, emotional and experiential, and shaped through both space and time.

The focus on migration in relation to health and wellbeing in this study also makes a contribution to both the literature around health and place and health and migration. In this
study migration is conceptualised as a major change in social and cultural context; in essence a change of place. The migration stories of the participants in this study, and their experiences of living in two (or in some cases more) very different places are explored in order to contextualise their understandings of health and illness. This is discussed in the thesis in terms of the choices the participants made around the use of Chinese and biomedicine, as well as more generally in terms of their broader understanding of health and wellbeing.

Bringing the migration stories to the forefront of the exploration of health and wellbeing also makes an important contribution to literature on migration and health. As noted in Chapter 2, much of the literature around migration and health is focussed on health inequalities and experiences as a result of the event of migration. Rather than focussing on health outcomes or inequalities, this study offers novel insight into the ways in which the experience of migration shapes understandings of and approaches to health and illness in everyday life. Despite having had similar migration experiences, the participants in this study made different decisions about health care, drawing on varying contexts in order to do so. These included their upbringing and family, issues around identity and getting used to everyday life in the UK, and issues of place and trust in terms of what kind of medicine was considered to be reliable and safe. These were drawn on to different extents by different participants, according to what was important to them. As migrants, the participants have all had to rebuild their lives in the UK and to recreate an identity that is meaningful in relation to the circumstances that they are living in. Their choices about the management and treatment of illness are considered with this in mind; that the choices they make are also choices about responding and adapting to change and negotiating daily life in ways that are meaningful. This adds important contextual understanding to the study of migration and health.

10.8.3 Methodological contribution

As discussed in Chapter 4, the participatory approach used in this study enabled strong relationships to be built with the research participants over the course of the study, and through this a deeper understanding of their lives, their experiences and their understandings of health and wellbeing. Attending the centre regularly and participating in
the day-to-day activities also enabled the development of an understanding of the centre, as a key element in the study alongside the participants, which was essential for the conceptual development of the study. The idea of a ‘step in step out’ ethnography (Maddon 2010) - as a theoretically engaged and focussed participatory approach - has been applied successfully in this study. In particular, this allowed for a gradual focussing in on the theoretical and conceptual ideas within the study during the processes of data collection and analysis. This enabled the shift in the focus of the study from a being a study of illness to a study of health and wellbeing; a critical shift in the analysis and write up of the data.

This study clearly demonstrates the value of this kind of approach in relation to research in healthcare settings; in particular, that the investment of time in understanding peoples’ everyday lives within a given context, has the potential to push the boundaries of what is understood about practices of care. Taking time to get to know the centre members and the nature of day-to-day life at the centre allowed for a deeper understanding of what took place at the community centre; what it means to the research participants, what they do there, and the way that they use it together. This was particularly important as the form of care presented in this thesis - everyday practices of care enacted through the day-to-day activities of the centre - is an implicit and informal form of care. The insight gained from this particular approach - of a ‘step in step out’, focussed, and theoretically driven, participatory approach - has the potential therefore to yield valuable insights if employed in the study of everyday practices of care in other settings, in particular outside of formal healthcare settings, e.g. in the home, or in other community spaces. This approach offers the potential for seeing and understanding practices of care that take place in everyday settings that might otherwise be unseen or overlooked.

10.9 Areas for future research

The community centre in this study is clearly identified as a ‘Chinese’ place, in a way that is meaningful to its members. The research participants in the study expressed a shared identity (albeit not an uncomplicated one) and sense of belonging. They spoke about similar experiences of migration (as discussed in Chapter 6), expressed similar core understandings of health and wellbeing (as discussed in Chapter 7) and shared generational
and gendered expectations about family life. Although these manifest in different choices about health care (as discussed in Chapter 8), this shared identity is at the core of the way that they participate at the community centre and interact with one another in this particular place. In terms of taking this forward into future research, there are interesting questions about how (or indeed if) this is replicated in other places with other groups of people. In this respect, building on a focus on health and identity in place and everyday practices of health and wellbeing, questions that could be addressed are:

(How) do other community spaces work as therapeutic landscapes / spaces of care? Specifically:

- (How) does this unfold in places that provide services for multi-cultural/ethnic groups where there may not be a clear core identity in the same way?
- (How) does this unfold in multi-generational settings, in which ideas and expectations about life course and aging are negotiated?
- How do men and women engage in everyday practices of care - and use these sorts of spaces to do so - in different ways?

There are also connections with work around both the sociology of ageing and the sociology of emotions. Whilst these areas were not an explicit focus of the current study, there are important resonances with these areas of work that would be relevant and productive ways to extend the current study.

In terms of work around the sociology of ageing, it would be interesting to further explore the ways in which the experience of migration in early life has implications for ideas about successful or positive ageing. There is already some work on successful ageing within Chinese communities, both within Chinese countries (for example Hsu (2007) on ageing in taiwan, or Ng et al. (2002) in Hong Kong) and among Chinese communities elsewhere (for example Tan et al. (2010) and Tsang et al. (2004) in Australia, and Ng et al. (2000) in New Zealand). However, there is scope within this study to further this area of research given that many of the participants, who have spent the majority of their lives in the UK, spoke about the generational changes within their families, particularly with respect to the ways in which family roles and responsibilities are played out. This would be an
interesting and fruitful way to further develop this study, especially in the context of self-management, and the spaces in which this takes place.

Future research could also be undertaken in connection with work around the sociology of emotions, in particular with relation to work around ‘emotional modes of being’ (Freund, 1990). The participants spoke a lot about the importance of happiness in the maintenance of health, and this was reflected in the ways in which they engaged with one another in the centre; as the enactment, or embodied practice, of this idea. Taking a sociological approach to this, and focussing more specifically on embodiment would also be an interesting way to further extend this study. This would also make interesting connections with work around the materialities of care, which has been discussed in this thesis in terms of the conceptualisation of everyday practices of care, constituted through the day-to-day activities and associated materialities at the centre.

10.10 Conclusions

The aim of this study was to undertake an exploration of long-term illness (management) among first generation migrants, with migration conceptualised as a major change in social and cultural context. As discussed in Chapters 1 and 2, although this began as a study of long-term illness management, through the processes of fieldwork, analysis and writing, and in response to the field site and research participants, the project evolved to become a study of health and wellbeing (as opposed to a study of illness) in the context of belonging, identity and community, within a particular place. This is approached through the concept of therapeutic landscapes, which is used in this study as a conceptual lens through which to explore the relationship between people, place and health. The relationship between health and place is also addressed through the focus on migration in this study. The migration stories provide an important context for the understandings of health and wellbeing expressed by the participants, and their choices about health care, for example through the use of TCM and biomedicine. This contextualisation raises important issues around identity and belonging that also have implications for the relationship between health and place; this is about health in place.
The ways in which the participants interact with one another in this place, through the particular activities and the associated material things, are presented in this thesis as everyday practices of care. This is understood as the enactment of a particular understanding of health and wellbeing, as it is tied up with social relationships and engagement with the world. The enactment of this, through these everyday practices, helps to create a sense of identity and belonging at the centre; through re-connecting with the past and maintaining a sense of continuity with previous times and places in the participants’ lives. This is important because it allows for both continuity and change at the same time; and in turn, this is important in terms of maintaining health and wellbeing for the participants in this study. In this way, the community centre is understood as a place of care, in that it provides a space in which its members can participate in an embodied - and collective - remembering of time and place that both restores and re-creates a meaningful sense of identity, and that this contributes to their health and wellbeing. In this sense, participation in the day-to-day life of the centre is presented as everyday practices of care.


Appendices

Appendix A: Ethical Approval of the study

A.1 Ethical Approval Letter

Secretary to Research Ethics Committees
Room 2.004 John Owens Building
Tel: 0161 275 2206/2046
Fax: 0161 275 5697
Email: timothy.gibbs@manchester.ac.uk

Ref: ethics/13039

Dr Carolina Sanders,
Centre for Primary Care,
Institute of Population Health,
Williamson Building.

21st May 2013

Dear Dr Sanders,

Research Ethics Committee 4

[Wood, Sanders, Vassilev, Rogers: The impact of migration on managing a long-term condition: a qualitative study of diabetes management amongst people who have migrated to the UK (ref 13039)]

I write to thank you and Mrs Wood for coming to meet the Committee on 15th May 2013 and to confirm that it gave the above research project a favourable ethical opinion.

This approval is effective for a period of five years and if the project continues beyond that period it must be submitted for review. It is the Committee’s practice to warn investigators that they should not depart from the agreed protocol without seeking the approval of the Committee, as any significant deviation could invalidate the insurance arrangements and constitute research misconduct. We also ask that any information sheet should carry a University logo or other indication of where it came from, and that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a university computer or kept as a hard copy in a location which is accessible only to those involved with the research.

Finally, I would be grateful if you could complete and return the attached form at the end of the project or by the end of April 2014.

We hope the research goes well.

Yours sincerely,

[Signature]

Dr Deborah Bentley
Secretary to University Research Ethics Committee 4
### A.2 Amendment Approval (participant observation)

**Naomi Wood**

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<th>Deborah Bentley</th>
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<td>To:</td>
<td>Naomi Wood</td>
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<tr>
<td>Cc:</td>
<td>Caroline Sanders; Timothy Stibbs; Clancy Tara (RW3) CMFT Manchester (<a href="mailto:Tara.Clancy@cmft.nhs.uk">Tara.Clancy@cmft.nhs.uk</a>); Julia Segar</td>
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<tr>
<td>Subject:</td>
<td>RE: Ethical approval of project: Wood, Sanders et al.: The impact of migration on managing a long-term condition: a qualitative study of diabetes management amongst people who have migrated to the UK (ref 13039) - AMENDMENT REQUEST APPROVED</td>
</tr>
</tbody>
</table>

Dear Naomi,

Thank you for sending your responses and supporting documents, which I am pleased to say meets with the Chair’s approval.

Please take this email as approval of the requested amendment.

I hope your project goes well.

Best wishes,
Deborah

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**Secretary to University Research Ethics Committee 4**

Dr Deborah Bentley | Research Support Manager | Faculty of Life Sciences | University of Manchester
1.21 Simon Building | Brunswick Street | Manchester M13 9PL
Tel: +44 161 275 5465 | e-mail: deborah.bentley@manchester.ac.uk

<table>
<thead>
<tr>
<th>From:</th>
<th>Naomi Wood</th>
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<tbody>
<tr>
<td>Sent:</td>
<td>11 October 2013 13:26</td>
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<tr>
<td>To:</td>
<td>Deborah Bentley</td>
</tr>
<tr>
<td>Cc:</td>
<td>Caroline Sanders; Timothy Stibbs; Clancy Tara (RW3) CMFT Manchester (<a href="mailto:Tara.Clancy@cmft.nhs.uk">Tara.Clancy@cmft.nhs.uk</a>); Julia Segar</td>
</tr>
<tr>
<td>Subject:</td>
<td>RE: Ethical approval of project: Wood, Sanders et al.: The impact of migration on managing a long-term condition: a qualitative study of diabetes management amongst people who have migrated to the UK (ref 13039)</td>
</tr>
</tbody>
</table>

Dear Deborah,

Please find attached a response and supporting documents to the questions from the Chair, as per your email below.

Please let me know if any further information is required.

I look forward to hearing from you.

Best wishes,
Naomi

---

**From: Deborah Bentley**

**Sent: 24 September 2013 11:55**

**To: Naomi Wood**

**Cc: Caroline Sanders; Timothy Stibbs; Clancy Tara (RW3) CMFT Manchester (Tara.Clancy@cmft.nhs.uk)**

**Subject: RE: Ethical approval of project: Wood, Sanders et al.: The impact of migration on managing a long-term condition: a qualitative study of diabetes management amongst people who have migrated to the UK (ref 13039)**
Dear Naomi,

Apologies for the delay in getting back to you about this.

Thank you for sending your amendment request. Whilst we have no objection in principle to narrowing down the focus of your project to this group of elderly Chinese migrants and the introduction of participant observation as well as interviews, there are a few points the Chair would like clarifying before approval is given:

1. Will the ‘participant observation’ include video or audio recording? If so, explicit consent will be needed for this.
2. What are your arrangements for ensuring participants consent to being observed and that this is still valid over the time that the observation will take place?
3. Presumably the PIS will need to change to include the participant observation. Please send the revised PIS for the Chair’s approval.
4. How will you record your observations? E.g. notes/diary? Have you informed the staff at the community centre about this?
5. Please could you send us the English version of the ‘announcement’ that is presumably going to be made about you at the centre?

Thank you also for informing us of the change in supervision.

Best wishes,
Deborah

Dr Deborah Bentley | Research Support Manager | Faculty of Life Sciences | University of Manchester
121 Simon Building | Brunswick Street | Manchester M13 9PL.
Tel: +44 161 275 5465 | e-mail: deborah.bentley@manchester.ac.uk

From: Naomi Wood
Sent: 16 September 2013 16:12
To: Deborah Bentley; Timothy Stibbs
Cc: Caroline Sanders
Subject: RE: Ethical approval of project: Wood, Sanders et al.: The impact of migration on managing a long-term condition: a qualitative study of diabetes management amongst people who have migrated to the UK (ref 13059)

Dear Deborah,

I am not sure if you are the right person to send this to (apologies if you are not) but I have attached a request for an amendment to the ethical approval for my PhD study. This is an addition to the methodology for my study, in light of contacts made through recruitment of research participants. I would be grateful if you could let me know if this is sufficient for requesting an amendment, of if there are other procedures that need to be followed.

I would also like to inform you of a change to the supervision for this project. Dr Caroline Sanders remains the primary supervisor for this study, but Dr Iyavlo Vassilev and Prof. Anne Rogers have now been replaced by Dr Julia Segar as the second supervisor.

I look forward to hearing from you.

Best wishes,

Naomi
A.3 Amendment Approval (focus groups)

**Naomi Wood**

**From:** Deborah Bentley  
**Sent:** 05 March 2014 10:05  
**To:** Naomi Wood  
**Cc:** Clancy Tara (RW3) CMFT Manchester (Tara.Clancy@cmft.nhs.uk); Tara Clancy; Timothy Stibbs  
**Subject:** RE: Request for amendment for ethical approval for PhD study (ref 13039) - APPROVED

Dear Naomi,

I am pleased to tell you that the Committee Chair has approved your amendment request to add focus groups to the methodology for your study: Wood, Sanders, Vassiley, Rogers: The impact of migration on managing a long-term condition: a qualitative study of diabetes management amongst people who have migrated to the UK (ref 13039). Thank you for sending the amended paperwork.

Best wishes,
Deborah

Dr Deborah Bentley | Research Support Manager | Faculty of Life Sciences | University of Manchester  
1.21 Simon Building | Brunswick Street | Manchester M13 9PL  
Tel: +44 161 275 5465 | e-mail: deborah.bentley@manchester.ac.uk

---

**From:** Naomi Wood  
**Sent:** 27 February 2014 15:00  
**To:** Deborah Bentley  
**Subject:** Request for amendment for ethical approval for PhD study (ref 13039)

Dear Deborah,

Please find attached a request and supporting documents for a further amendment to the ethical approval for my PhD study. This request is for the addition of focus groups to the methodology for the study; all other aspects of the study remain the same.

I would be very grateful if the Committee could consider this request.

I look forward to hearing from you.

Best wishes,

Naomi

Naomi Wood  
PhD Student  
Institute of Population Health  
University of Manchester  
5th Floor Suite B Williamson Building  
Oxford Road, Manchester, M13 9PL
A.4 Approval for change of project title

Our ref: DIP/8370295
18 December 2015

Mrs Naomi Wood
By email: naomi.wood@postgrad.manchester.ac.uk  neomilewood@yahoo.com

Dear Mrs Wood

I am writing to inform you that the Chair of the Research Degrees Panel of the Faculty of Medical and Human Sciences has agreed to grant you permission to change the title of your research project on the PhD programme from "The role of social networks, community resources and health policy in chronic illness management" to "A place to be well: an ethnographic study of health and wellbeing at a Chinese community centre in the north of England". All other conditions remain the same.

Yours sincerely

Sally Brown
Faculty Graduate Education Manager

cc: Dr Caroline Sanders, Dr Harm Van marwijk, Dr James Hodgson
Appendix B: Participant Information Sheets

B.1 Participant Information Sheet (English)

THE IMPACT OF MIGRATION ON MANAGING A LONG-TERM CONDITION:
AN ETHNOGRAPHIC STUDY OF DIABETES MANAGEMENT AMONGST PEOPLE WHO HAVE MIGRATED TO THE UK

You are being invited to take part in a research study. Before you decide if you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Taking part in this research study is voluntary and you are under no obligation to participate.

Who will conduct the research?
This research is being carried out as part of a PhD project at the University of Manchester. Naomi Wood is the PhD student and the project supervisors are Dr Caroline Sanders and Dr Julia Segar. These people make up the research team and their contact details are listed at the end of this information sheet. The research is funded by the Centre for Primary Care, Institute of Population Health, at the University of Manchester.

What is the purpose of this study?
The purpose of this research is to understand more about the ways in which the experience of migration affects the management of long-term conditions. To do this we will be interviewing people who have migrated to the UK from another country. Addressing this question will add to previous research on migration and health. It will also add to research on health care and treatment for people from different backgrounds.
Why was I asked to take part?
We would like to understand the views and experiences of people who have migrated to the UK from another country. You are therefore being invited to participate in this study as a person who has migrated to the UK.

Do I have to take part?
Your participation in this study is entirely voluntary. It is up to you to decide whether or not you want to take part. You should read this information sheet carefully to see what is involved in the study. You may also want to discuss it with family and friends. We will invite you to sign a consent form before participating in the study to show that you have agreed to take part. If you decide to take part, you can withdraw from the study at any time without giving a reason.

What happens if I decide to take part?
If you decide to participate in this study, you will be invited to take part in an interview to talk about your experience of migrating to the UK. This will last approximately 1 hour. We will ask you a range of questions about your experiences and about your health. Part of the interview will be about your family, both in your home country and in the UK. To help talk about this, we will use a diagram to show your family tree. The interview will be informal and you will be able to stop at any time. You will not have to answer any questions that you do not want to answer.

The interview will be audio-taped because it is hard to take note of what people say and listen carefully at the same time. Afterwards, the interview will be typed up. We do this to help us remember what people say and to ensure a full and accurate account of the views that are presented.

The interview will take place at a time that is convenient for you, either in your home, or another convenient location.

Will my taking part in the study be kept confidential?
Yes. Everything that you tell us during the interview will be completely confidential. All papers and notes relating to this study will be kept in a locked filing cabinet at the University of Manchester. Typed notes and electronic audio files will be stored on a password protected computer. Notes and computer files will not be played or shown to anyone outside the research team. We have to keep these notes on file for ten years so that research reports can be made and so that the accuracy of the information can be checked. After ten years, all information will be destroyed.

When we type up the recordings made during the interviews and write about the results of the research, all personal details will be removed so that no-one will know who you are. No real names will be used. If you are interested, we will send you a summary of what we find out in the study.

What will happen to the results of the research?
Results from the study may be published in social science and health care journals or presented at conferences. No information that could identify participants will be included in the results. It is important to tell people about the findings of this study to help researchers and health professionals to understand more about the ways in which the experience of migration affects long-term condition management.

Are there any benefits to my participation?
There are no direct benefits to your participation in this study. However, you may find it an interesting experience. Taking part will give us a better idea of the views and experiences of
people with type 2 diabetes who have migrated to the UK. It will also help researchers and health professionals to understand more about the ways in which migration affects long-term condition management.

**Are there any risks involved in participating?**
There are no known risks associated with participating in this study. Everyone who takes part in this study will remain anonymous. Interviews will be arranged at a time and a place that is convenient to you. You can stop taking part in the study at any time. Some people may find it distressing or upsetting to talk about their experience of migrating to the UK and about their health. You will not have to answer any questions that you do not want to, or discuss any issues that you do not feel comfortable talking about.

**What happens if I do not want to take part or if I change my mind?**
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form to show that you agree to take part. If you decide to take part you are still free to withdraw from the study at any time without reason. If you decide to withdraw after the interview, the recording of the interview will be deleted and will not be used in this study.

**What do I need to do next?**
A researcher will contact you to see if you would like to take part in this study. If you agree to be interviewed, we will arrange an interview at a time and location that is convenient for you. Before the interview, we will ask you to sign a consent form. If you do not want to take part, then please tell the researcher.

Thank you very much for taking the time to read this information sheet.

**Further information and contact details**
If you have any questions regarding the study, please contact Naomi Wood or another member of the research team at the Centre for Primary Care, University of Manchester.

Naomi Wood, PhD Student  
Phone number: 0161 275 57630  
Email: naomi.wood-2@postgrad.manchester.ac.uk

Dr Caroline Sanders  
Email: caroline.sanders@manchester.ac.uk

Dr Julia Segar  
Email: julia.segar@manchester.ac.uk
B.2 Participant Information Sheet (Cantonese)

您被邀请参与这项研究。在您决定参与之前，明白为什么要做这个研究和会涉及到一些重要的是很重要的。请细阅以下资料，如果您有需要，可以跟其他人讨论。如果有任何不清楚，您亦可发问或向我们索取更多资料。参与这项研究是自愿的，你没有任何义务必须参与。

谁进行这项研究呢？
这项研究是由曼彻斯特大学博士学士研究生进行。Naomi Wood是博士学士研究生，计划监任是Caroline Sanders博士和Julia Segar博士。他们组成这项研究团队，他们的联络资料列在单张末页。这项研究是由曼彻斯特大学的人口健康研究部(Institute of Population Health)基层护理中心(Centre for Primary Care)资助。

这项研究目的是什么？
这项研究的目的是去更多理解有关移民的经验和对他们的长期健康问题的影向。我们将会在常乐社区中心访问一些来自中国大陆和香港的会员。我们会进行观察，和记录在中心进行的日常活动。针对这个问题，会更加深入了解先前有关移民健康的研和有关不同背景人士的护和治疗的研究。

为什么我被邀请参与？
您被邀请参与这项研究，因为您是常乐社区中心的会员，同时亦因为你是从中国大陆或香港移居英国。

我是否需要一定要参与？
您参与这项研究是完全自愿的。完全是由您自己来决定参加与否，请仔细阅读这份资料单张便可了解这项研究牵涉些什么。您也可以跟你的家人和朋友商量。在参与这
項研究前，我們會邀請您簽署一份同意書，表明您已經同意參加。如果您決定參加，您亦可以在任何時間退出這項研究而不需給予任何理由。

如果我決定參加，會有什麼事發生？
如果您決定參與這項研究，您會被邀請接受訪問，談論您移居英國的經驗。這持續大約1小時。我們會問及您一些問題有關於您的經歷和您的健康。我們也會問及關於您在自己家鄉，和在英國的家人。訪問是非正式的訪談，您就可以在任何時候停止。您不必回答任何您不想回答的問題。訪問會用錄音形式，因為很難一邊筆記摘錄，同時一邊仔細聆聽別人的談話內容。訪問後，將談話內容記錄，這樣可以幫助我們記錄別人說些什麼，和確保提出的意見是一個全面性和準確性的記述。訪問會在您方便的時間進行，在常樂社區中心或其方便您的地方。除了進行訪問，我們也會觀察和筆記每天在常樂社區中心的日常活動和事件。因此Naomi Wood會經常在中心現。

我參與這項研究會保密嗎？
会在接受訪問時，您告訴我們的一切將會完全保密。所有文件及有關這項研究的筆記將會鎖在文件櫃，保存在曼城大學裏。筆記和錄音文件會儲存在有密碼保護的電腦內。筆記和電腦文件，是不會涉露給研究小組以外的任何人士。為了可以完成研究報告和審查資料的準確性，我們需要把這些筆記文件存檔十年。十年後，所有資料將被銷毀。我們會刪除在訪問錄音和研究結果裏 所有的個人資料，因此，沒有其他人會知道您是誰。無論是在訪問資料，或任何有關在中心舉行活動的筆記和觀察記錄，我們是不會使用真實姓名。

怎麼樣處理研究結果？
研究結果可能會公佈在社會科學和醫療保健刊物或在會議上提出。沒有任何資料可以識別參與者在研究結果裏。公佈有關這個研究結果是非常重要的，因為它可以幫助研究人員和醫療人員更加了解關於移民的經歷及其影響他們對長期健康問題的處理。如果有有興趣，我們給您一份研究總結。

我的參與有什麼得益？
您參與這個研究對您來說沒有直接的得益。然而，您可能會發現這是一個有趣的經歷。您的參與可使我們更加了解人們移居英國的意見和經驗，這可幫助研究員和健康專業人士去加深了解移民，及其影響他們對長期健康問題的處理。

我的參與會涉及什麼風險？
您的參與是不會涉及已知有相關的風險。每個參與者會使用匿名。訪問會安排在方便您的時間和地點。您可以在任何時候停止參與。有些人可能會感到憂傷和不樂當他們談及自己移居英國和身體健康的經驗。您不需要回答一些您不想回答的問題，或談論一些使您覺得不舒服的事情。

如果我不想參加，或者如果我改變主意又怎麼樣？
這是由您來決定參加與否。如果您決定參加，這份資料單張給您保存，同時您需要簽署一份同意書表明您同意參加。如果您決定參加，您仍然可你在任何時候退出，
而不需要提出任何理由。如果您在訪問後決定退出，訪問錄音會被刪除，並不會在本研究中使用。
如果您不希望被插人在任何筆記和觀察在中心舉行的活動，請告知工作人員或Naomi Wood。

下一步我該做什麼？
如果您有意參與這項研究，研究員會聯絡您。如果您同意接受訪問，我們會安排方便您的時間和地點來作訪問。在訪問前我們需要您簽署一份同意書。如果您不願參與的話，請告知研究員。

多謝您花寶貴的時間閱讀這資料單張。

進一步的資料和聯絡詳情
如果您對這項研究有任何疑問，請聯絡Naomi Wood或曼徹斯特大學基層護理中心的研究小組成員。

Naomi Wood, 博士研究生PhD Student
Phone number 電話: 0161 275 57652
Email: naomi.wood-2@postgrad.manchester.ac.uk

Caroline Sanders 博士
Email: caroline.sanders@manchester.ac.uk

Julia Segar 博士
Email: julia.segar@manchester.ac.uk
Appendix C: Consent Forms

C.1 Consent Form (English)

Participant Consent Form

THE IMPACT OF MIGRATION ON MANAGING A LONG-TERM CONDITION: AN ETHNOGRAPHIC STUDY OF DIABETES MANAGEMENT AMONGST PEOPLE WHO HAVE MIGRATED TO THE UK

Participant identification number:

Please read through the following statements carefully and initial each box to show that you agree to take part. If you do not want to take part, please hand the form back to the researcher without initialling any boxes.

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, to ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I have the right to withdraw from the study at any time without giving a reason.

3. I understand that the information collected will be submitted for examination to the University of Manchester, and that it may be presented and/or published in academic journals and at conferences, but that no individual will be identifiable from the information.

4. I understand that the interview will be audio recorded.

5. I agree to take part in the above study.

Name of participant ____________________________ Date ____________ Signature ____________________________

Name of researcher ____________________________ Date ____________ Signature ____________________________
Participant Consent Form

THE IMPACT OF MIGRATION ON MANAGING A LONG-TERM CONDITION:
AN ETHNOGRAPHIC STUDY OF CHINESE MIGRANTS IN MANCHESTER

移民對處理長期健康問題的影響：
關於華人在曼徹斯特的人類學研究

Participant identification number:
參與者識別號碼

請細讀下面的陳述，並在方格上簽署表示你同意參與，如果你不願意參與，請交回這表格給研究員，而不需要在方格上作任何簽署

6. 我確認我已經閱讀和明白資料單張上有關上述的研究。
   我也有機會去酌量這些資料，發問和已經得到滿意的答覆

7. 我明白我的參與是自願的，我有權在任何時間退出而不需要給予任何理由

8. 我明白收集到的資料會呈交曼徹斯特大學作考試用，或會許用作公佈和/或刊印在學術刊物和會議，但個人資料是不會從中識別

9. 我明白會用錄音形式訪問

10. 我同意參與上述研究

參與者姓名

研究員姓名

____________________

日期

簽署

____________________

日期

簽署

____________________

日期

簽署
Appendix D: Poster

D.1 Poster (English)

Naomi Wood

PhD Student - University of Manchester

Research Study:
The impact of migration on managing a long-term condition: an ethnographic study of Chinese migrants in Manchester.

I am a PhD student at the University of Manchester and I am conducting a research study about migration and long-term condition management. The purpose of this research is to understand more about the ways in which the experience of migration affects the management of long-term conditions. To do this, I would like to meet and talk to people who have migrated to the UK from China or Hong Kong. I am interested to hear about your experiences of living in the UK, about the changes that you faced in coming to live here, and the ways in which this has affected your health.

I will be spending time at the community centre, joining in with some of the activities here, and hoping to talk to you about your experiences. I will also be keeping a diary as a record of the time I spend at the centre. This will contain information about the centre and the activities here, and about the things that I learn from you about your experiences of living in the UK.

I hope that some of you would like to help me with my study and I look forward to talking to you.

If you prefer not to be included in any of my notes or observations please tell me or a member of staff at the community centre.
D.2 Poster (Cantonese)

我是曼徹斯特大學博士學位研究生, 我在進行有關移民和長期健康問題處理的研究。這個研究目的是為了更加了解多些移民的經歷影響他們處理長期健康問題的方法。要做到這一點, 我希望跟一些從中國或香港移居英國的人士見面和交談。我有興趣聆聽有關你生活在英國的經歷, 有關你移居英國面對的改變, 和這些對你健康的影响。

我會抽些時間在常樂中心參與一些活動, 和希望和你傾談有關你的經歷。我亦會用日記, 記錄在中心的時間, 這包括中心和活動的資料, 和從你處學到的有關生活在英國的經歷。

我希望你們當中會有人協助我這個研究, 我渴望跟你傾談。如果你不希望被收錄在我的筆記或觀察內, 請告訴我或常樂職員

Naomi Wood
Appendix E: Examples of Fieldnotes (excerpts)

FN1-27.08.13
[My first Tai Chi class]. Everyone followed the routines being led by the teachers - there was no sort of demonstration or explanation of the movements (or philosophy or techniques) even in Chinese, at least not during the movements anyway […] In between routines the teachers relayed messages to me through two of the ladies who spoke English - just little pointers. The teachers also looked at me and nodded/smiled and said ‘ok?’ in between the routines, and occasionally gave me a nod or a smile of encouragement during the sets of movements.

FN2-29.08.13
Some of the same people at the lunch table today. Sat between two men - one of them greeted me as I sat down and said in English ‘nice to see you again’. I was surprised because I didn’t recognise him on first sight - but I think he poured me some tea last time at lunch. He was quite chatty and friendly and we spoke during lunch. He talked a bit about coming to the UK a long time ago […] He put food in my bowl, as did other people at the table. I think one of the Tai Chi women was at the table, but I haven’t really spoken to her and don’t know her name. More leisurely meal this time - some people finished quite quickly and cleared away their bowls and left the table. I sat with the two men and the Tai Chi lady until we had all finished eating.

FN3-03.09.13
Today was my 3rd Tai Chi class. A few members of the class had gathered at a table in the main part of the centre and were drinking tea and chatting. I recognised Mrs P and a couple of others and one of the teachers. I was a little early and the class hadn’t yet started. There were a few elderly people around and a few tables with mahjong boards set up. After a few minutes we went outside, round the back to the basketball court, for the class. On the way out of the door, a lady who I hadn’t seen before said hello and shook my hand and introduced herself as Mrs E. She asked if I was interested in Tai Chi so I explained that I am doing my PhD and interested in migration and health and had met Mrs Z who invited me to the class.
Mrs E came over to the table and sat down with us. She seemed to be clutching her stomach and grumbling/complaining of an ailment to the others. She said something to me about old people always complaining (can’t remember her exact words - it was an odd turn of phrase) and laughed, (wryly, I thought). When she sat down she said across the table to me ‘how’s it going?’ Others also began to arrive for the TC class and greeted me with a smile/wave/hello, including the TC teacher. Mrs E asked me across the table if I have any children and advised me not to leave it/wait too long […] She talked a bit about her life (unprompted by me) that when she was younger […] she wasn’t happy and worried a lot about her life, ‘what my life’ (what am I doing with my life? – that’s what I understood her to mean by that). This changed when she had children and she was a lot happier with them in her life/looking after them. She commented about old/young Chinese mentality/way of thinking – work hard when young and live well when older, and that a lot of Chinese people do live well when they are older […] She said that she does things to make herself happy and that happiness (‘be happy’) is the most important thing.

It was very wet today so class was inside. There weren’t very many people today, although a few more arrived as we started. There were a few tables of mahjong in progress during the class and a few other milling around so it was quite noisy with the cooking noises from the kitchen all at once. I got a personal demonstration from Master today - must have been doing it really badly! - with a translation from Mrs P of the instructions. I found it hard to follow today having missed a week of classes, and maybe somehow the change of space. There was more general discussion and demonstration of sections of the movement today than there has been before. Mrs P explained that the palms should always face each other, about two breaths out at the end of the set, about protecting the ‘private parts’ with one of the moves with the fan, using the palm with the fan and two fingers with the sword, and about keeping the body straight throughout the moves. She also said some of them can’t bend/stretch so well to do some of the movements because they are ‘old’ and have arthritis/joint problems.

I sat at the TC class table for lunch today. Mrs F stood up to serve the soup and did so with quite a bit of jollity and some laughter from the others! Mrs F gave me rice and some fish and vegetables, as did the lady on the other side, as usual. Mrs F said that the fish was
steamed and that ‘you’ (English people) fry fish instead of steaming it. I asked Mrs P if this was the same kind of thing she cooked/ate at home and she said yes, ‘more or less’.

**FN6-08.10.13**

It was busy for lunch today and there was some confusion about where I should sit, and about whether there was space or not with the TC women at their table. Eventually, a space was found for me and a lady reached across to put some bits of meat in my bowl before I had even sat down. The soup and rice had already been dished out while I was waiting for a seat. One of the men also proceeded to fill my bowl up until it was heaped and I joked that I would have to eat something quick to make some space in the bowl. He laughed at that and one of the others said (Michael) said ‘he’s a good server’ and laughed too. I hadn’t met Michael before but he introduced himself fairly quickly. He asked how long I’ve been doing TC and that he’d been watching me in the class outside and was surprised when I said only a few weeks. He told me that the other man used to do Kung FU and that he was very good at it! We talked about Michael’s family and I asked when he came to the UK [he went on to tell me his story].

**FN22-28.01.14**

Mrs E was already there when I arrived and she asked how my project was going and how many interviews I wanted to do. She said not to be shy, just to ask – that it’s not hard (for them) to say what they think and what they’ve experienced, but she did say that Chinese people can be ‘closed’ and prefer to keep things to themselves […] She asked if I thought she is ‘old-fashioned’ and said that her children think she is and that she argues with them about this. I asked if she thought it is different/easier for her children’s generation, having been brought up here but also having Chinese culture from/in their families. This was because she said that Chinese/the Chinese way has a lot of rules and traditions, which are perhaps more important/stronger for her generation, and why her children think she is ‘old fashioned’. She said yes, it is easier for her children’s generation.

**FN27-27.02.14**

At lunch, Mr Y sliced the fish down the middle with his chopstick and lifted the bone right out in one piece […] When the soup was dished out Mrs V said to give me two chunks of carrot - one for me and one for baby. Mrs Lee and Sophie (after Mr Y had left the table) were both giving me food and asking if I wanted more. At one point Mrs E commented
that I was very lucky because with Chinese food there is a lot of variety and that there is always something different for lunch at the centre. (Food seems to be important for them – as both a social and a cultural thing - also notes from focus group about lack of Chinese food in nursing homes/meals on wheels).

**FN32-19.03.14**

After the interview today Mrs Z started to talk about Chinese philosophy and how this informs peoples’ attitudes towards/understandings of health. This was particularly in relation to mental health, which she said doesn’t really exist in Chinese (society/understanding). She said that the idea of ‘health’ is more holistic, that there is just one word for it, and that it incorporates both mental and physical health and these are not separated […] She talked about the concepts in Chinese medicine not translating into Western medical models; that she was Western trained in Hong Kong (as a nurse) and although the basis of her training was different to the concepts of Chinese medicine (like wind and damp) the shared language made it easy to talk about those things and understand/be understood, but when she came here, this wasn’t the case with English. The Chinese concepts were harder to talk about and explain without the shared understanding of Chinese language. We also talked a bit about generational differences in talking – she said that she thinks it is problematic for older and younger generations to communicate, and that a lack of communication in that way causes problems […] She said that the Chinese believe in learning to your age; when young learn to your age and when old learn to your age. She also talked about letting bad things, or problems, come and go, as a sort of acceptance rather than resistance – that Chinese people/philosophy approaches problems in this way.

**FN41-22.04.14**

I went to put my umbrella in the corner to dry with the others, and when I came back Mrs S came over to greet me. She put her arm round me and rubbed my bump for a while and then Mrs X came over for a rub too - it was like they were queuing up for a turn! There was some discussion around the table about the size of my bump, that it isn’t very big for 8 weeks to go, but Mrs P defended me, saying that I’m tall so the size of my bump is fine. I sat down after that, and then Mrs E started singing at the top of her voice in my direction. She had a piece of paper in her notebook (I’ve seen her with this notebook before, she seems to keep all sorts of different bits and pieces in it, including my PI sheet) with the
words of the song she was singing […] Then she got out a piece of paper to show us with this written on it in English: ‘Tai-Chi is a ‘slow-motion’ exercise, which is good for the brain and body. The more often you do it the more beneficial it is. The body becomes more flexible, and the brain stays active.’ This is exactly as she had written it down – I asked her if I could write it down too and she seemed pleased with that. I’m not sure if she was asking what I thought about it, if I agreed, or whether she was just showing it to me […] she also talked about needing to learn, as she often does (‘gotta be learn’).
Appendix F: Interview Schedule

Introduction

- Reiterate the nature of the study, the reason for contact with the particular participant and the proposed length of the interview.
- Remind the participant that their interview is being tape recorded and that all identifying information will be removed from interview transcripts.
- Reiterate that the participant does not have to answer any questions that they do not want to, and that they can stop or take a break at any point during the interview.
- Allow participant an opportunity to ask questions and check that they are happy to continue with the interview.

Migration history
Can you tell me about how you came to live in the UK?

- Length of residence in the UK
- Country of origin
- Main reason for migration: How? Why? By choice?
- Life-stage/timing of migration: When? At what age? Why at that point?
- With/without family, or to meet up with family: Where are family members and why?
- Migration history: One move, or many? How? Why?

Experience/views/perception of living in the UK (including issues of social/cultural change/adaptation)
What was the biggest difference for you when you came to the UK?

- Can you remember anything that you found particularly difficult when you first came to the UK?
- Do you find that difficult now? Why/why not? How did you get used to it?
- Are there any changes that you found easy to get used to, or that you particularly liked? Why/why not?
Day-to-day life: changes to living and working conditions
Can you tell me about your day-to-day life in the UK? For example -

- Household composition and type/quality of housing
- Employment/work
- Family traditions
- Diet/eating habits/food choices
- Hobbies/activities/leisure time/exercise
- Any involvement in local community/neighbourhood

Is this different to the place you lived/work/your hobbies in China/Hong Kong?
- Are these the same things that you would do in China/Hong Kong?

Health: General
How would you describe your health at the moment?

Health: Long Term Conditions
Do you have any long-term conditions (e.g. diabetes, heart disease, etc…)?

- When did you first get [specific LTC]?/How long have you had [specific LTC]?
- Why/how did you get [specific LTC]?
- How does [specific LTC] affect you/your day-to-day life?
- What treatment do you have for [specific LTC]?
- Why that particular treatment?
- Where/how do you have that particular treatment?
- Does anybody help you with the treatment for [specific LTC]? Who? What do they do? Why that person?
- What other treatments have you been offered for [specific LTC]? Why do/don’t you use that treatment?
- What other support do you have for your [specific LTC]?
- What else do you do to take care of yourself?
- Do you use any Chinese medicine? Why/why not?
Family

Who are the members of your family?

- Where are they (UK/China/Hong Kong/elsewhere)?
- How/how often do you see them (if in UK)?
- How/how often do you keep in touch with them (if outside the UK)?
- Which of your family members would you ask for help with your LTC? Why that person? What help do they give you? How often? Where? (refer back to discussion in previous section about who helps with treatment for LTC)
- Would you like to include anybody else in your family tree (e.g. any friends, neighbours etc)?

Closing

- Remind the participant of their right to withdraw from the study, and that any identifying information will be removed from interview transcripts.
- Remind the participant of contact details (on PI sheet and poster/leaflet) and encourage them to contact me at any stage if they have questions, or would like any further information.
Appendix G: Study Participants

Summary of participants who were formally interviewed in this study.
*This data was not formally collected for Mrs Z, the Tai Chi Master (as the interviews followed a slightly different format, as described in Chapter 4) or other centre members with whom I spoke informally, but who are included in this thesis.
*The age of participants given here is the age at the time of the interview (in 2013/14).

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Country of origin</th>
<th>Year of arrival in UK</th>
<th>Main reason for migration</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs A</td>
<td>53</td>
<td>Hong Kong</td>
<td>1978</td>
<td>To earn money/get a job.</td>
<td>Arthritis in knee, shoulder and feet.</td>
</tr>
<tr>
<td>Mrs B</td>
<td>70</td>
<td>Hong Kong</td>
<td>1977</td>
<td>Marriage: to join her husband's family.</td>
<td>High blood pressure, high cholesterol, diabetes, hepatitis B.</td>
</tr>
<tr>
<td>Mrs C</td>
<td>72</td>
<td>Hong Kong</td>
<td>1971</td>
<td>To earn money/get a job.</td>
<td>Depression.</td>
</tr>
<tr>
<td>Mrs D</td>
<td>64</td>
<td>Hong Kong</td>
<td>1972</td>
<td>Marriage: her husband was already living in the UK.</td>
<td>Diabetes, ongoing stomach pain.</td>
</tr>
<tr>
<td>Mrs E</td>
<td>72</td>
<td>Hong Kong</td>
<td>1965</td>
<td>Marriage: her husband was already living in the UK.</td>
<td>Diabetes, heart trouble.</td>
</tr>
<tr>
<td>Mrs F</td>
<td>60s</td>
<td>Hong Kong</td>
<td>1970s</td>
<td>Marriage: her husband was already living in the UK.</td>
<td>Diabetes, high blood pressure, high cholesterol.</td>
</tr>
<tr>
<td>Mrs G</td>
<td>76</td>
<td>Vietnam</td>
<td>1980</td>
<td>Refugee.</td>
<td>High blood pressure.</td>
</tr>
<tr>
<td>Mrs H</td>
<td>57</td>
<td>Hong Kong</td>
<td>1971</td>
<td>To join family: her father was living and working in the UK and she and her brothers and sisters and mother came to join him.</td>
<td>No health problems at the moment.</td>
</tr>
<tr>
<td>Mr I</td>
<td>80</td>
<td>China</td>
<td>1963</td>
<td>Marriage: his wife is Chinese but born and bred in the UK and they met while she was on holiday visiting relatives in Hong Kong.</td>
<td>High blood pressure, high cholesterol.</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Country</td>
<td>Year</td>
<td>Reason for Moving</td>
<td>Health Issues</td>
</tr>
<tr>
<td>--------</td>
<td>-----</td>
<td>------------</td>
<td>------</td>
<td>-------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Mr J</td>
<td>70</td>
<td>Hong Kong</td>
<td>1976</td>
<td>Marriage</td>
<td>No health problems at the moment.</td>
</tr>
<tr>
<td>Mrs K</td>
<td>75</td>
<td>Vietnam</td>
<td>1978</td>
<td>Refugee</td>
<td>Ok at the moment. Pain in one of her knees.</td>
</tr>
<tr>
<td>Mrs L</td>
<td>54</td>
<td>Hong Kong</td>
<td>1982</td>
<td>Marriage</td>
<td>Heart condition, diabetes.</td>
</tr>
<tr>
<td>Mrs M</td>
<td>64</td>
<td>Hong Kong</td>
<td>1979</td>
<td>Marriage</td>
<td>No health problems at the moment.</td>
</tr>
<tr>
<td>Mrs N</td>
<td>61</td>
<td>Hong Kong</td>
<td>1972</td>
<td>To join family</td>
<td>Diabetes.</td>
</tr>
<tr>
<td>Mrs O</td>
<td>61</td>
<td>Vietnam</td>
<td>1978</td>
<td>Refugee</td>
<td>No health problems at the moment.</td>
</tr>
<tr>
<td>Mrs P</td>
<td>66</td>
<td>China</td>
<td>1979</td>
<td>Marriage</td>
<td>Depression, anxiety, difficulty sleeping, stomach problems, tinnitus, high blood pressure.</td>
</tr>
<tr>
<td>Mrs Q</td>
<td>66</td>
<td>China</td>
<td>1973</td>
<td>Marriage</td>
<td>High cholesterol.</td>
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<tr>
<td>Mrs R</td>
<td>65?</td>
<td>Hong Kong</td>
<td>1973</td>
<td>Marriage</td>
<td>High blood pressure.</td>
</tr>
<tr>
<td>Mrs S</td>
<td>58</td>
<td>Hong Kong</td>
<td>1975</td>
<td>Marriage</td>
<td>Ongoing problem with her nose and throat, problem with her gall bladder, diabetes.</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Country</td>
<td>Year</td>
<td>Reason for moving to the UK</td>
<td>Health status</td>
</tr>
<tr>
<td>-------</td>
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<td>---------------------</td>
</tr>
<tr>
<td>Mrs T</td>
<td>56</td>
<td>Hong Kong</td>
<td>1972</td>
<td>To join family: she came to the UK with her family when she was 13.</td>
<td>No health problems at the moment.</td>
</tr>
</tbody>
</table>
Appendix H: Data Analysis

H.1 Preliminary Themes for Analysis

- Ideas drawn from interview summaries prior to coding in NVivo
- Used to re-familiarise myself with the data and to guide the coding of the data

<table>
<thead>
<tr>
<th>Points of interest</th>
<th>Common threads</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family</strong></td>
<td></td>
</tr>
<tr>
<td>Roles, responsibilities, expectations, duty</td>
<td>- gender: role of women within the family; caring for children</td>
</tr>
<tr>
<td>Family structure</td>
<td>- generational differences: different expectations for younger generations</td>
</tr>
<tr>
<td></td>
<td>- mixed families, dispersed families, generational change</td>
</tr>
<tr>
<td><strong>Community and belonging</strong></td>
<td></td>
</tr>
<tr>
<td>Friendship</td>
<td>- the community centre as a social space</td>
</tr>
<tr>
<td>Common identity</td>
<td>- shared experiences of migration</td>
</tr>
<tr>
<td>Help and support</td>
<td></td>
</tr>
<tr>
<td>Belonging</td>
<td>- why do the members come to the community centre rather than other social groups / clubs?</td>
</tr>
<tr>
<td>Structure / hierarchy</td>
<td>- some sense of hierarchy and roles observed within the Tai Chi group, e.g. Master and how others behave around/towards her (fish heads, the argument etc)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Common themes</th>
<th>PLACE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- The community centre as a research space</td>
</tr>
<tr>
<td></td>
<td>- The community centre as a place that forms one part of the members lives (how are they different in other places? Some of the participants have English / non-Chinese friends outside of the community centre)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Common themes</th>
<th>IDENTITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Common themes</th>
<th>IDENTITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and happiness</td>
<td>Identification/Place</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Aging and life course expectations</strong></td>
<td>-inevitability, balance</td>
</tr>
<tr>
<td><strong>Resilience, independence and coping with adversity</strong></td>
<td>-how to carry / cope with problems, striving to be happy</td>
</tr>
<tr>
<td><strong>Family &amp; duty</strong></td>
<td>-independence, expressed in terms of family relationships - and support, expressed in terms of friendship and other (non-family) social relationships</td>
</tr>
<tr>
<td><strong>Community &amp; identity</strong></td>
<td>-the community centre as a social place</td>
</tr>
<tr>
<td><strong>LTCs</strong></td>
<td>-arthritis, diabetes, high blood pressure and depression/anxiety; depression and loneliness</td>
</tr>
<tr>
<td><strong>Chinese &amp; other Medicine</strong></td>
<td>-what / how is this viewed / used?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Migration experiences</th>
<th>Identification/Community/Place</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independence, resilience and strength</strong></td>
<td>-coping with adversity</td>
</tr>
<tr>
<td><strong>Language difficulties</strong></td>
<td>-common in early days of moving to the UK</td>
</tr>
<tr>
<td><strong>Loneliness and isolation:</strong></td>
<td>-common in early days of moving to the UK</td>
</tr>
<tr>
<td><strong>Marriage and family as reasons for migration</strong></td>
<td>-duty, roles and responsibilities, gendered expectations</td>
</tr>
<tr>
<td><strong>Change</strong></td>
<td>-in life circumstances, e.g. employment / jobs, family and friends, marriage and children (particularly for women)</td>
</tr>
<tr>
<td>Notions of home and belonging:</td>
<td>-community, family, place</td>
</tr>
<tr>
<td>Identity:</td>
<td>-what it means to be a Chinese person living in the UK (and whether the centre members / RPs consider themselves to be Chinese – and why), changing identities as participants have adapted to life here (think back to stories of early life in UK as young women, newly married - not just about forging identities as foreigners / migrants, but as wives, mothers etc), changes in time and place (not just moving from one country to another, but home country also not the same now as it was at the time of leaving – this expressed by several RPs) and community (shared experiences).</td>
</tr>
</tbody>
</table>
### H.2 Initial coding

<table>
<thead>
<tr>
<th>Open coding - all codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude to life</td>
</tr>
<tr>
<td>Chinese medicine</td>
</tr>
<tr>
<td>Community - support and friendship</td>
</tr>
<tr>
<td>Community centre - other projects</td>
</tr>
<tr>
<td>Daily life in the UK</td>
</tr>
<tr>
<td>Descriptive text</td>
</tr>
<tr>
<td>Differences between life in the UK and in home country</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Employment</td>
</tr>
<tr>
<td>Expressions of distress</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td>Friendship, health and happiness</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Generational change</td>
</tr>
<tr>
<td>Health and wellbeing</td>
</tr>
<tr>
<td>Health services</td>
</tr>
<tr>
<td>Hobbies and activities - outside community centre</td>
</tr>
<tr>
<td>Home (and place)</td>
</tr>
<tr>
<td>Identity</td>
</tr>
<tr>
<td>Independence</td>
</tr>
<tr>
<td>Integration</td>
</tr>
<tr>
<td>Language difficulties</td>
</tr>
<tr>
<td>Life in the home country</td>
</tr>
<tr>
<td>Living conditions in the UK</td>
</tr>
<tr>
<td>Migration</td>
</tr>
<tr>
<td>Migration experiences</td>
</tr>
<tr>
<td>Owning a business</td>
</tr>
<tr>
<td>Participation at community centre</td>
</tr>
<tr>
<td>People</td>
</tr>
<tr>
<td>Relationships with RPs</td>
</tr>
<tr>
<td>Research process</td>
</tr>
<tr>
<td>Role of Mrs Z at fieldsite</td>
</tr>
<tr>
<td>Support</td>
</tr>
<tr>
<td>The Chinese Way</td>
</tr>
<tr>
<td>The English Way</td>
</tr>
<tr>
<td>Views about England</td>
</tr>
<tr>
<td>Views of home country</td>
</tr>
<tr>
<td>Visiting home country</td>
</tr>
</tbody>
</table>
### H.3 Key codes and cross-cutting codes

<table>
<thead>
<tr>
<th>Family code – expanded</th>
<th>Cross-cutting codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family - language</td>
<td>Gender</td>
</tr>
<tr>
<td>Family composition</td>
<td>Generational change</td>
</tr>
<tr>
<td>Family contact</td>
<td>Identity</td>
</tr>
<tr>
<td>Family life</td>
<td></td>
</tr>
<tr>
<td>Family relationships</td>
<td></td>
</tr>
<tr>
<td>Family roles and responsibilities</td>
<td></td>
</tr>
<tr>
<td>Marriage</td>
<td></td>
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<tr>
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<td>Migration experience - other</td>
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