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**UNDERSTANDINGS OF FOOD AND HEALING
SYSTEMS AMONG CHINESE MIGRANTS
IN NEW ZEALAND**

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Abstract

Health and illness are a major concern of peoples' lives in the contemporary western world. The understandings and practices of health and illness vary across cultures and societies. Food and healing systems, among the most important characteristics of culture, are closely related to health and illness. People seek various ways to deal with food and healing to maintain health and treat illness. In modern western cultures, western scientific knowledge dominates peoples' understanding of health and illness, and also their health-related practices. Migrants to western societies from non-western cultures bring with them their traditional understandings and ways of dealing with food and healing systems that may differ from the prevailing knowledge of health and illness in western culture. Living in a new culture and society, migrants are faced with the challenges of making sense of the multiple meanings of health and illness available, and making sense of the ways that they practice health and illness in a different social context. The current study provided an analysis of how Chinese migrants discursively constructed their understandings of dietary practices and healing systems use in New Zealand. Semi-structured interviews were used to produce accounts for analysis. Foucauldian discourse analysis was adopted to examine the relationships between discourse and practice, and between discourse and subjectivity. The analysis shows that Chinese migrants draw upon both traditional Chinese knowledge and western scientific knowledge in complex ways to make sense of their mixed practices of traditional Chinese diet and western diet, and also their mixed use of traditional Chinese medicine and western medicine in New Zealand. The notion of balance in traditional Chinese knowledge is key to their understandings and practices of health and illness. "Balance" is used not only to retain their traditional ways of dealing with food and healing, but also to resist the dominant status of western scientific knowledge in understanding health and illness in western culture. Meanwhile, Chinese participants position themselves as being able to hold a balance between different cultures, suggesting that they practice a traditional Chinese way of being -- living a harmonious and balanced life with their social and natural environments within a new social context. Further, as an ethnic minority group, Chinese migrants draw upon the dominant discourse regarding race relations in New Zealand to understand themselves (Chinese people) as inferior to others (white European people) as a social group. However, traditional Chinese understandings offer them possibilities to resist being positioned as inferior through exercising power discursively. The findings from this research raise questions about how health promotion programs in western countries should address migrants coming from non-western cultures. The implications of the research are also discussed in terms of how discourse health research with ethnic minority migrants should be conducted in western countries.

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Table of Contents

ABSTRACT	I
ACKNOWLEDGEMENTS	II
TABLE OF CONTENTS	III
CHAPTER 1: INTRODUCTION	- 1 -
1.1 THE UNDERSTANDINGS OF HEALTH AND ILLNESS.....	- 2 -
1.2 THE RELATIONSHIP BETWEEN FOOD, HEALTH AND ILLNESS.....	- 6 -
1.3 HEALING SYSTEMS	- 10 -
CHAPTER 2: CONTEXTUALIZATION OF RESEARCH	- 13 -
2.1 HEALTH ISSUES RELATING TO DIETARY CHANGES AMONG MIGRANTS	- 13 -
2.2 THE UTILIZATION OF HEALING SYSTEMS.....	- 15 -
2.3 CHINESE MIGRANTS AND TRADITIONAL CHINESE MEDICINE IN NEW ZEALAND.....	- 17 -
2.4 RESEARCH APPROACH.....	- 20 -
2.5 MY STUDY	- 23 -
CHAPTER 3: METHODS	- 25 -
3.1 CRITERIA FOR PARTICIPANTS	- 25 -
3.2 ETHICAL CONSIDERATIONS	- 26 -
3.3 PROCEDURE.....	- 26 -
3.4 ANALYSIS OF THE TEXT	- 28 -
CHAPTER 4: ANALYSIS	- 32 -
4.1 PART ONE: CONSTRUCTING FOOD, HEALTH AND ILLNESS IN A CHANGED CONTEXT	- 32 -
4.1.1 <i>Straddling the 'east' and the 'west': Constructing a healthy diet</i>	- 33 -
1.1.1.1 "A balance of nutrients" versus "a balance of hot and cold".....	- 34 -
1.1.1.2 "Tonic food has high calorie" versus "barbeque is hot".....	- 36 -
1.1.1.3 A balance of 'Chinese food' and 'western food'.....	- 39 -
4.1.2 <i>The 'east' and the 'west' side by side: Constructing food in relation to illness</i>	- 40 -
4.1.2.1 Constructing how food is related to illness in a 'western' way	- 41 -
4.1.2.2 Constructing how food is related to illness in an 'eastern' way	- 43 -
4.1.3 <i>The construction of selves in relation to food practice: "We are different from them."</i>	- 48 -
4.2 PART TWO: CONSTRUCTING TRADITIONAL CHINESE MEDICINE (TCM) IN RELATION TO WESTERN MEDICINE (WM)	- 51 -
4.2.1 <i>Constructing TCM to legitimise its use</i>	- 52 -
4.2.1.1 TCM as cultural legacy	- 52 -
4.2.1.2 TCM as holistic.....	- 53 -
4.2.1.3 TCM as effective.....	- 57 -
4.2.2 <i>Constructing TCM to limit its use in New Zealand</i>	- 61 -
4.2.2.1 TCM as second-rate	- 62 -
4.2.2.2 TCM as untrustworthy	- 63 -
4.2.3 <i>Constructing a balance between TCM use and WM use</i>	- 65 -
4.2.4 <i>The construction of selves in relation to TCM use: "balance is the way of being"</i>	- 66 -
4.3 SUMMARY	- 67 -
CHAPTER 5: DISCUSSION	- 69 -
5.1 REVIEW OF THE ANALYSIS	- 69 -
5.1.1 <i>Discourse as social bond</i>	- 69 -
5.1.2 <i>Subjectivity revisited</i>	- 71 -
5.1.3 <i>Attend to culture</i>	- 72 -
5.2 METHODOLOGICAL CONCERNS	- 74 -
5.3 PERSONAL REFLEXIVITY	- 76 -
5.4 SOCIAL IMPLICATIONS.....	- 77 -

5.5 FUTURE RESEARCH	- 78 -
5.6 CONCLUSION	- 79 -
REFERENCES.....	- 80 -
APPENDICES.....	- 84 -
APPENDIX I: INFORMATION SHEET.....	- 84 -
<i>Chinese translation of Information Sheet</i>	- 86 -
APPENDIX II: INFORMED CONSENT FORM.....	- 87 -
<i>Chinese translation of Informed Consent Form</i>	- 88 -
APPENDIX III: DEMOGRAPHIC INFORMATION	- 89 -
<i>Chinese translation of Demographic Information</i>	- 90 -
APPENDIX IV: INTERVIEW QUESTIONS	- 91 -
<i>Chinese translation of Interview Questions</i>	- 92 -

CHAPTER 1: Introduction

Health and illness are a major concern in peoples' lives in contemporary western societies. People seek various ways to maintain health and to deal with illness. These range from everyday practices, such as diet and exercise, to the utilization of health care systems, such as consulting with health professionals and undertaking surgery. In the western world, western scientific knowledge dominates peoples' understanding of health and illness, and thus moulds their health-related practices. Meanwhile, contemporary western societies become increasingly culturally diverse, largely due to migration. Migrants from non-western cultures bring with them their own cultural understandings and practices relating to health and illness, which may differ from the dominant western view of health and illness. Food and healing systems are among the most important characteristics of culture and they both are closely related to health and illness. Every culture and society develops its own ways of dealing with food, diagnosing and treating illness. The dietary practices and use of healing systems by migrants in western countries are to a large degree in accordance with their traditional understandings of health and illness. Among the largest ethnic minority groups in many western countries, Chinese migrants come from a culture and society with a rich food tradition and a unique and well-developed healing system (traditional Chinese medicine) that is different from the one in the western world (western biomedicine). As a result, Chinese migrants in western societies will hold a different notion of health and illness, and engage in health-related practices that are unfamiliar to western cultures.

In this chapter, I introduce the understandings and practices relating to health and illness in two different socio-cultural contexts. Firstly, an overview is presented on how health and illness are understood in traditional Chinese culture and contemporary western culture respectively. The social and historical contexts of these understandings are examined. Secondly, I investigate the ways in which food is understood and dealt with in relation to health and illness in traditional Chinese culture and in western culture. Thirdly, I move to focus on healing systems for disease diagnosis and treatment. Here, I discuss the understandings of traditional Chinese medicine as a healing system compared with western medicine.

1.1 The understandings of health and illness

The understandings of health and illness vary across cultures and societies. In traditional Chinese culture, health and illness are suggested to be surrounded by the notions of balance and harmony (Chen & Swartzman, 2001; Jovchelovitch & Gervais, 1999). *Qi*¹ (气²), *yin* (阴) and *yang* (阳) are believed to be the most central and direct constructs for Chinese people to interpret health and illness (Chen & Swartzman, 2001; Koo, 1984; Quah, 2003). *Qi* is perceived as an invisible flow of energy in the body and the life force for Chinese people (Koo, 1984; MacGregor-Reid, 2001). *Yin* and *yang* are regarded as representing two polar opposite elements which form everything that exists in the universe (Kastner, 2004; Koo, 1984; MacGregor-Reid, 2001). *Yin* is considered to stand for the negative, passive or female aspect of nature, whereas *yang* stands for the positive, active, or male aspect of nature (Chen & Swartzman, 2001; Kastner, 2004). *Yin* and *yang* are described like the two sides of a coin, which are always connected, depending on each other but also constraining each other (Kastner, 2004; MacGregor-Reid, 2001). In traditional Chinese understanding, the dynamic interactions of *yin* and *yang* underpin all aspects of the universe. Under the principle of *yin* and *yang*, the human body is seen first and foremost as an energy system in which various substances interact to create the whole physical organism (Williams, 1996). The smooth flow of *qi* and the balance of *yin* and *yang* are viewed as the key to good functioning of the body (Koo, 1984). Illness is considered to be caused by insufficient flow or blockage of *qi*, which results from imbalance between *yin* and *yang* (Koo, 1984; MacGregor-Reid, 2001). Factors that can affect *yin* and *yang* balance include one's congenital tendency towards *yin* or *yang*, a *yin* or *yang*-dominated personality, excessive emotional experience, weather conditions, diet, age, and so on (Jovchelovitch & Gervais, 1999). Also, all these factors are classified according to the *yin* and *yang* dichotomy on the belief that *yin* and *yang* are the basis for everything in the universe. Another important feature of traditional Chinese understanding of health is that the body and mind are thought to be indivisible, yet two distinctly different, aspects of the same life force (*qi*), with the body serving as the root of the mind. Therefore, there is no classification of physical and mental health in traditional Chinese culture, and the mind is seen as an external factor (manifest in emotions) to exert influence on health (Bond, 1996).

¹ The words in italic in this article are spellings for Chinese characters, such as *qi*, *yin*, *yang*.

² These are the writing strokes for Chinese characters, such as 气 (*qi*), 阴 (*yin*), 阳 (*yang*).

The principle of *yin* and *yang* balance is generally considered as embodying the philosophy of Taoism in traditional Chinese culture (Chen & Swartzman, 2001; Kastner, 2004; MacGregor-Reid, 2001; Quah, 2003). Taoism is concerned with the relationship between human beings and the natural world (Chen & Swartzman, 2001). According to Taoism, human beings are a part of nature, and thus subject to the principle of *yin* and *yang* balance. Health and illness are viewed in terms of the interactions between human beings and nature. The impact of nature on health is usually seen as exerted by natural forces, such as weather. For example, damp, hot or cold weather are all considered as able to break the balance of *yin* and *yang* in the body and thus cause illness. The balance between human beings and nature is emphasized for good health.

It is worth noting that in traditional Chinese culture the notion of balance and harmony extends beyond the bodily condition and natural environment. Health is also viewed in a much broader social context due to the influence of Confucianism. Confucianism has imparted rules to govern Chinese people's social life for thousands of years, and it still exerts a significant influence in contemporary social life of Chinese people (Bond, 1991; Chen & Swartzman, 2001). Confucianism emphasizes a harmonious relationship with the social environment for good health (Chen & Swartzman, 2001). It values harmony within the family and respect for the hierarchical structure in society. As Chen and Swartzman (2001) point out, conformity to moral and social standards is regarded as essential to achieving health in traditional Chinese culture. Accordingly, a person is required to have self-control and to obey authority in order to be socially sound and consequently healthy.

The social dimension of health and illness and the notion of a harmonious relationship with others suggests the influence of a collectivistic culture on traditional Chinese society. A collectivistic culture³ is commonly understood as a culture in which others are held to play an important role in defining the self, and collective goals are seen as having priority over individual needs and interests (Armstrong & Swartzman, 2001; Chun & Chesla, 2004). As a result, maintaining the connection with others means constantly being aware of others and focusing on their needs, desires, and goals.

³ The dichotomy of collectivistic and individualistic cultures has been challenged by many critics, such as Oyserman, et al. (2002).

Also, an individual's health is often utilized to serve the functions of families, community and society (Chen & Swartzman, 2001). Armstrong and Swartzman (2001) suggest that the focus on others in a collectivistic culture may lead to a more significant attribution of 'others' in explaining health and illness. For instance, the cause of illness is often interpreted as residing outside the individual and having multiple determinants, such as bad weather and an uneasy relationship with others, leading to an imbalance of the body. In this way, traditional Chinese knowledge is often depicted as viewing health and illness from a holistic perspective, in which physical, natural and social factors are all taken into account in explaining health and illness. Further, traditional Chinese understandings of health and illness are often seen in contrast to contemporary western understandings of health and illness (Chen & Swartzman, 2001; Kastner, 2004; Koo, 1987).

In contemporary western societies, western medicine dominates peoples' understandings of health and illness (Hardey, 1998). In the biomedical model, the body is viewed as a machine made up of separate parts, and the physical structures and components of the body are emphasized (Helman, 2001). Health is seen as achieved by the smooth working of the body while illness is understood as the 'break-down' of the parts of the machine (Helman, 2001). Health and illness are viewed as residing in the body of individuals, and thus constrained to physical conditions of the body. In addition, the biomedical model establishes 'norms' for what health and illness are, which are further standardized by measures (Kugelmann, 2004).

The biomedical model of health and illness is commonly considered as influenced by reductionism in western culture (Armstrong & Swartzman, 2001; Hardey, 1998). From the view of a reductionist, an individual can be understood by studying his or her smallest constituent parts. Therefore, illness can be explained by examining biochemical processes (Armstrong & Swartzman, 2001; Hardey, 1998). Meanwhile, Descartes' mind/body dualism is believed to have an influential impact on contemporary understandings of health and illness in the western world (Hardey, 1998). Hardy (1998) argues that the notion of separating the mind and body has allowed the body to become an object of study within the territory of natural science, whereas the mind within the focus of the humanities. This leads to the contemporary western view of health as encompassing two separate states: physical health and mental health. More

importantly, because natural science is generally viewed as more advanced than the humanities studies in western culture, biomedicine (which is concerned with the physical aspects of health) is suggested to have the predominance over other forms of knowledge in understanding health and illness in western culture (Hardey, 1998).

In spite of its hegemony, the biomedical model is increasingly under criticism for not taking into account the social, cultural, and psychological aspects of illness (Armstrong & Swartzman, 2001). As a result, the bio-psycho-social model has been proposed to replace the biomedical model to explain health and illness in health psychology in the last few decades. However, in this model the physiological aspects of the body are still emphasized and dominate the way that health and illness are interpreted in western culture (Kugelmann, 2004).

In addition, it has been pointed out that the biomedical model of health and illness is associated with an individualistic culture in western societies (Armstrong & Swartzman, 2001). An individualistic culture is commonly understood as a culture in which a person is viewed as independent and autonomous, and thus is required to take responsibility for his or her own actions. The implication is that responsibilities are put upon individuals for preserving their health and avoiding risks for illness. This corresponds to the biomedical view in which health and illness reside within the individual's body. With the increasing concern for health in western societies (Chamberlain, 2004a), health is increasingly perceived as resulting from an individual's choices regarding lifestyle and the ability for self-control; whereas illness, especially chronic illness, is increasingly attributed to the lack of self-control or self-indulgence (Lupton, 2003). In this way, health and illness in western culture are attached to moral meanings.

It is worth noting that self-control is emphasized for the role it plays in health and illness in both traditional Chinese culture and contemporary western culture, although the ways that self-control contributes to achieving health are understood differently in the two cultures. In traditional Chinese culture, self-control is seen more as an exercise of the mind that functions to achieve health by balancing the body and the environment (both natural and social). However, in western culture self-control is more

likely to be viewed as manifesting the ability of self-government over the body, and thus health.

The particular understandings of health and illness that people subscribe to shape their understandings and practices around health and illness, such as food, diet and use of healing systems. In the next two sections, I will in turn introduce how food and healing systems are understood and dealt with in both traditional Chinese understandings and contemporary western understandings.

1.2 The relationship between food, health and illness

Food is an important aspect of culture. Different cultures have different understandings and practices related to food. Food and health have always been closely linked throughout human history (Beardsworth & Keil, 1997). The meanings of food in relation to health and illness vary across cultures and societies, although the value of food is commonly recognized across cultures. When migrants move to a new country, they tend to keep their traditional dietary practices (Helman, 2001). As Helman (2001, p. 60) points out, “food habits are one of the important indicators of acculturation and are often among the last cultural traits to go if immigrants seek to discard their original cultures”. Migrants’ dietary practices partly mirror their cultural understandings regarding the relationship between food, health and illness. Chinese migrants make up a significant part of the population in many western countries, and they bring with them traditional Chinese understandings and practices around food and diet to maintain health and deal with illness. Most of this is foreign to western culture.

In traditional Chinese culture, food is regarded as playing a significant role in health and illness (Kastner, 2004; Koo, 1984; Satia, Patterson, Kristal, Teh, & Tu, 2002). Food is considered essential to the quality of life because health is seen as one of the most important life concerns for Chinese people (Bond, 1996). Chinese people have a long history of using food to maintain health and to treat illness. In traditional Chinese knowledge, food is an important source of *qi* for the body, and food is subject to the ‘hot/cold’ or (*yin* and *yang*) dichotomy (Kastner, 2004). Food that is believed to produce ‘heat’ or *yang* in the body is classified as ‘hot’ or *yang* food, such as lamb, ginger, or chilli. Food that is believed to generate cold or *yin* in the body is classified as

'cold' or *yin* food, such as most fruits, and leafy green vegetables (Koo, 1984). Because health is understood as both a smooth flow of *qi* and the *yin/yang* balance of *qi* in the body, food is vital to good health. The relationship of food with illness is seen as manifest in two aspects: on the one hand, food can result in illness when an irregularity in the quantity and quality of food is thought to disrupt body harmony; on the other hand, and more importantly, food is valued for the roles it play in illness prevention and treatment, as food is believed to help the body stay in balance (preventing illness) or bring it back into balance (treating illness). Given the traditional Chinese understanding of the causation of diseases as an imbalance or insufficiency of *qi*, diseases caused by excessive *hot* or *cold* are treated with foods classified in the opposite nature (Koo, 1984). In this way, food is commonly perceived as a kind of medicine to cure disease for Chinese people. Because of this it is also regarded as one form of therapeutic practice (*shi bu* 食补 or *shi liao*⁴ 食疗) in traditional Chinese medical system. According to traditional Chinese knowledge, the practices of food are influenced by multiple factors. For example, food should be adjusted according to the changing weather conditions or the seasons. In the wintertime, foods of a *hot* nature are recommended, whereas in hot weather, foods of a *cold* nature are preferred. This is based on the belief that choosing food in accordance with the seasons can protect the body from disharmony, and help the body to keep in tune with nature (Kastner, 2004). More so, the ways of preparing and cooking food are believed to affect the *hot* or *cold* nature of a food. Some ways of cooking, such as steaming, boiling in water, and preparation using raw food, are thought to increase the 'cooling' or *yin* nature of foods (Kastner, 2004). By contrast, cooking methods, such as grilling, frying, roasting, and using acrid spices, are believed to increase the 'heating' or *yang* nature of foods (Kastner, 2004). Additionally, certain foods are believed to have a tonic nature (Koo, 1984). Food of a tonic nature is often used to increase *qi* and thus is helpful for the elderly and those recently traumatized (e.g., post-surgical or post-natal) people, whose *qi* level is held to be low (Kastner, 2004; Koo, 1984). As a result, in traditional Chinese culture there are strict dietary rules to follow in terms of the time (e.g., weather, seasons), the types and combinations of food, the preparation, cooking and preservation of food, and certain events when the food must be eaten (e.g. after childbirth or

⁴ *Shi bu* (食补) or *shi liao* (食疗) means food therapy when translated into English literally

surgery), etc, in order to maintain good health, and to prevent or treat illness (Spector, 2004).

By contrast, in contemporary western societies nutritional knowledge derived from scientific research dominates peoples' understandings of how food is related to health and illness. Food is held to relate to health through the nutrients such as carbohydrates, protein, fat, vitamins and minerals. Each nutrient is measured in terms of a unit of energy (calorie). Consequently, these nutrients and their calories are used to construct food as 'healthy' or 'unhealthy'. For example, healthy foods are usually interpreted as those high in fibre, antioxidants, and low in calories, whereas foods high in saturated fat or calories are singled out as the sources for bad health (Chamberlain, 2002).

In western culture, the connection of food with health is inseparable from the growing attention paid to the contribution of diet to disease. A large amount of research is devoted to examining the relationship between diet and chronic diseases, with most focusing on how different nutrients can affect the functioning of the body. For example, diets that are high in saturated fats are widely suggested to be associated with coronary heart disease (Yang & Read, 1996). In comparison with the common understanding of food as medicine in traditional Chinese culture, the practice of linking food to medicine is a relatively recent phenomenon in western culture. Lupton (2003) argues that this is associated with the process of medicalisation in western culture, in which the biomedical discourse has been extended and applied to every area of life, reinforcing knowledge about food and health as under the control of health professionals (e.g., medical doctors, health scientists, and dietitians). As a result, food practices in western society are increasingly governed by dietary guidelines designed by health professionals with respect to different illness conditions (e.g., diabetes, coronary heart disease, and obesity).

It has been noted that health and illness have become a major preoccupation of people in western society (Chamberlain, 2004a). Because individual responsibility is emphasized for health and illness in western culture, and the roles of diet in health and illness are increasingly recognized, diet has become an important aspect of life that is

required to be under surveillance and it involves personal choice between health and illness (Lupton, 2003).

In addition, the meanings of food for health and illness have been complicated due to the changing understanding of the relationship between the body and health. In western culture, the meaning of health is increasingly linked to physical appearance (Lupton, 2003). Health often means a desirable body which is slim and fit, whereas illness is associated with an undesirable body which is obese (Lupton, 2003). In western culture the dominant discourses around diet are about how to exert control over diet in order to have a desirable body that is believed to be healthy (Lupton, 2003). As a result, the obsession with physical appearance has made food become an important area for people to govern their body, and thus health. People eat an 'appropriate' diet to seek a desirable body which is slim and thus healthy, while avoiding an undesirable body which is obese and thus unhealthy.

Further, eating a healthy diet to ensure bodily desirability and health, has become a province of judging an individual as morally worthy or not (Chamberlain, 2002; Lupton, 2003). This is because an individual needs to control diet in order to have a desirable body in western society. Therefore diet is associated with the self-control (taking responsibility for oneself) that is emphasized in western culture. In this way, food is moralized in western society. Individuals are faced with the task of negotiating the complex meanings of food in relation to health, the body and morality. These have made food a source of anxiety for people in western society (Chamberlain, 2002; Lupton, 2003). In addition, these anxieties are exacerbated by the changing nutritional messages offered in dietary guidelines for the public over time (Chamberlain, 2002).

In summary, the meanings of food for health and illness are complicated by culture despite the fact that food has been widely recognized for its importance in health and illness in contemporary societies. However, people are not limited to everyday practices, such as dietary practice, to maintain health and deal with illness. They also seek out and use healing systems that are developed and prevalent in their own cultures and societies to ensure health and illness. In the next section, I will introduce the healing systems in traditional Chinese culture and modern western culture.

1.3 Healing systems

All human societies experience illness, and each culture has devised its own ways of dealing with it. A healing system is understood here as a process of diagnosing and treating illness. Healing systems are culturally driven and inseparable from the socio-cultural contexts in which they exist (Sussman, 2004). It has been noted that healing systems have diversified in contemporary western societies, as shown by the coexistence of a number of different healing systems (e.g., chiropractic, osteopathy, traditional Chinese medicine, homeopathy, and healing systems of ethnic minorities) alongside the dominant biomedical system (Helman, 2001; Sussman, 2004). In the western world, healing systems other than biomedicine are under the rubric of alternative or complementary medicine. Alternative medicine is mostly depicted as taking a holistic approach to health and rejecting the dualisms of mind/body, nature/culture, and individual/society which characterize orthodox biomedicine, despite the fact that the theories and practices of these alternative healing systems differ to varying extents (Crossley, 2000; Lupton, 2003).

Traditional Chinese medicine (TCM) has been used as a healing system for Chinese people for health care and curing illness for thousands of years (Williams, 1996). Today TCM is still widely practiced as a legitimate medical system alongside western biomedicine in China. TCM is commonly regarded as developing from the philosophy of Taoism in Chinese culture, focusing on moderation and balance (Kastner, 2004; MacGregor-Reid, 2001; Quah, 2003). Under this philosophy, the traditional Chinese healing system (TCM) emphasizes rebuilding the inner balance between *yin*, the passive force, and *yang*, the active force. This is achieved by establishing a harmonious relationship between the individual and the environment.

The practices of TCM are often described as including herbal medicine, acupuncture, food therapy (the use of food as medicine, *shi bu*), *qi gong* (a form of exercise and meditation, such as *Tai Chi*) and *tui na* (a form of therapeutic massage) (Kastner, 2004; MacGregor-Reid, 2001; Williams, 1996). Although these practices appear very different, they are perceived as sharing the same underlying assumptions about the body, health and illness in traditional Chinese knowledge (Kastner, 2004; MacGregor-Reid, 2001; Williams, 1996). Some TCM practices (such as food therapy and *Tai Chi*) are commonly practiced by lay people on a daily basis and are perceived

more as ways of health promotion rather than as healing processes, while other practices (such as herbal medicine, acupuncture, and *tui na*) remain the preserve of the professional practitioner of TCM and are commonly regarded as the traditional Chinese healing processes to diagnose, treat and cure illness (Williams, 1996). The traditional diagnostic techniques used by TCM practitioners consist of “looking, hearing and smelling, questioning and touching”⁵ (Williams, 1996, p. 89). TCM regards disease as symptomatic of the patient’s bodily dysfunction and inner disharmony. Thus the diagnosis in TCM takes account of various factors in explaining the causations of ill health, such as one’s organs, emotions, the environment (diet, weather, color, taste, and sound) and spirits (values, life philosophy, and beliefs), and these factors are explained in a holistic and qualitative way (Chen & Swartzman, 2001). The treatment in TCM is portrayed as focusing on strengthening the patient’s entire bodily system and restoring his or her inner balance, instead of tackling only the physical manifestations of the illness. More importantly, TCM as a healing system is generally perceived as giving attention to the prevention of illness (disharmony). Consequently, it highlights lifestyle (e.g., diet and exercise) as essential for good health.

By contrast, in western societies biomedicine is the dominant healing system of illness. Like other healing systems, western biomedicine is a culturally derived system. The tenets of reductionism, naturalism, individualism and mind/body dualism in western culture are believed to underlie its practices of diagnosing and treating illness (Armstrong & Swartzman, 2001; Koo, 1987; Lupton, 2003). In the biomedical model, the cause of ill health tends to be narrowed down to physical factors located within the individual’s body as independent entities and therefore treated separately (Koo, 1987; Lupton, 2003). The diagnostic process involves the examination of the body at the physiological and biological levels. Accordingly, medical care is oriented towards the treatment of acute symptoms using drugs and medical technology rather than the prevention or maintenance of good health (Lupton, 2003). The individual is thought to be in a confrontational relationship with the environment, as disease is understood as invasions from the environment (e.g., bacteria, virus), and thus the treatment focuses on

⁵ In TCM, ‘looking’ is to observe the patient and note anything about his or her physical appearance that may be of significance. ‘Hearing and smelling’ is to listen to the patient’s voice and smell the patients’ odour, urine and feces to tell the diseases. ‘Questioning’ is to ask the patient a series of questions and consider the answers with respect to the principles of TCM. ‘Touching’ involves pulse taking and palpation of the body (See Williams, 1996)

attacking the invasions (e.g., kill the bacteria, cut off the defective parts). In contrast with TCM, in which the individual is asked to build a harmonious relationship with nature in order to regain balance (health), western biomedicine is more often seen as offering individuals a tool to fight their illness and conquer nature.

In summary, the understandings and practices related to health and illness are inextricably embedded in cultural and social contexts, which vary across cultures and societies. This is exemplified in traditional Chinese knowledge and western scientific knowledge. Each of them offers different viewpoints on health and illness and thus shape different practices in respect to food and the healing system. In the next chapter, I will contextualize my research from a cultural perspective of understanding health and illness and look at how my research is shaped by the existing research in the area of health and illness in psychology.

CHAPTER 2: Contextualization of Research

The health of ethnic minority groups is usually found to be worse than that of the general population in the western world. Dietary change has frequently been pointed out as an important factor contributing to the increased disease risks for migrants coming to western countries. Under-utilization of the mainstream health care system is also singled out as contributing to migrants' poor health, even though they are observed to frequently use healing systems other than western biomedicine. Chinese migrants are the largest ethnic minority group in many western countries (e.g., the United States, Canada, Australia and New Zealand). Research indicates that Chinese migrants maintain the traditional Chinese diet as well as adopt the western diet after migrating to western countries. Also they use both traditional Chinese medicine and western medicine for treating illnesses in western countries.

In this chapter, I firstly review the research on migrants' dietary changes as they relate to their health issues. In particular, I discuss the research on Chinese migrants. Secondly, I review the use of alternative medicine in western culture. Here I argue that there is a lack of research on migrants' understandings of alternative medicine. Then I draw attention to the research on Chinese migrants' use of traditional Chinese medicine in western countries. Thirdly, I locate Chinese migrants in New Zealand. I examine the social and cultural context of New Zealand, within which the health issues of the Chinese population are identified. Also, I investigate the place of traditional Chinese medicine and its use in New Zealand. Fourthly, I introduce the research approach to my study. I examine the use of discourse analysis in the research of health psychology. Finally, I point to the rationale and objectives of my research.

2.1 Health issues relating to dietary changes among migrants

A substantial body of research has suggested that migration is associated with changes in disease patterns (Helman, 2001). Migrants are found to have increased incidences of many chronic diseases (e.g., coronary heart disease, diabetes, and certain cancers) compared to people living in their countries of origin (Mulatu & Berry, 2001; Yang & Read, 1996). The health issues of migrants have led to concern about their dietary habits, especially dietary changes after migrating to western countries. This is

because migrants are generally believed to experience dietary changes in varying degrees, and also dietary practices are increasingly considered to be linked with chronic diseases according to western nutritional knowledge. As a result, the research on migrants' health issues often focuses on migrant's dietary changes and suggests how these changes might lead to health issues related to migrants. As noted earlier in chapter one, western scientific knowledge dominates the understanding of food and health in western culture. Therefore, it is clear that most studies on migrants' health issues related to dietary changes are based on western scientific knowledge of food and health, in which food is classified according to nutrients and diet is understood as associated with chronic diseases (e.g., excessive fat is believed to be associated with coronary heart disease).

Research into Chinese migrants' dietary changes shows that Chinese migrants have an increase in fat and cholesterol intakes while decreasing carbohydrate and fibre intakes after migrating to western countries (e.g., Lv & Cason, 2004; Satia et al., 2002; Tan & Waston, 2004; Yang & Read, 1996), given that the traditional Chinese diet is generally viewed as high in carbohydrate and fibre, and low in fat in comparison with the western diet (Yang & Read, 1996). Meanwhile, their dietary changes are suggested to be associated with the observation that Chinese migrants in western countries are at higher risks of certain diseases compared to Chinese living in China (Yang & Read, 1996). However, Chinese people have traditional understandings of food and health (e.g., the balance of *hot* and *cold* food), which are different from western understandings. Research has indicated that Chinese migrants retain traditional understandings of food and health to varying degrees after migration, and their dietary practices are influenced by both traditional Chinese knowledge and western scientific knowledge on food and health (Jovchelovitch & Gervais, 1999; Satia et al., 2002; Satia et al., 2000). For instance, one study illustrates how food is a very important social representation of health and illness for Chinese migrants in England (Jovchelovitch & Gervais, 1999). Through their discussions of what to eat and how to eat to keep healthy and to prevent and cure illness, Chinese migrants drew upon traditional Chinese knowledge about health and illness (Jovchelovitch & Gervais, 1999). It has also been suggested that the extent to which Chinese migrants retain traditional Chinese knowledge and associated practices is a function of factors such as age, educational level and degree of acculturation (Satia et al., 2002). For example, it was observed that

older, less western-educated female Chinese migrants tended to have more traditional Chinese understandings of food and health (e.g., the *yin* and *yang* balance), and they view food in terms of 'hot' and 'cold' nature in health and illness. In contrast, younger and more western-educated Chinese women tended to hold more western scientific ideas about food and health, and to view food as associated with risks of chronic diseases, even although they maintain some traditional Chinese beliefs (Satia et al., 2002). Therefore, existing research has indicated that the dietary practices of Chinese migrants are associated with their health issues (e.g., the changed risks for coronary heart disease and diabetes). Despite the fact that western nutritional knowledge dominates the way that Chinese migrants' diet-related health issues are studied, traditional Chinese knowledge is shown to exert a considerable influence on their diet in dealing with health and illness in western countries.

2.2 The utilization of healing systems

Apart from dietary changes, another important aspect of research on migrants' health issues is the focus on their use of health care systems for diagnosing and curing illness. The under-utilization of mainstream health care system by ethnic minority groups in western countries is well documented (Armstrong & Swartzman, 2001). This type of research suggests that mainstream health services are often inaccessible or ineffective for many ethnic minority groups due to factors such as their low socio-economic status, language difficulties and cultural misunderstandings (Armstrong & Swartzman, 2001). On the other hand, there is a lack of research on migrants' use of alternative medicine although their frequent use of alternative medicine in western countries has been noted. The great amount of research on the utilization of alternative medicine in western countries suggests that the use of alternative medicine is an effect of resistance to western biomedicine (Armstrong & Swartzman, 2001; Crossley, 2000; Siahpush, 1999). Several explanations have been proposed for people seeking alternative medicine. First of all, it is dissatisfaction with the health outcomes of western biomedicine. It is suggested that people seek alternative medicine because they seek to cure an illness that has not been cured by western biomedicine (Siahpush, 1999). Secondly, it is proposed that people turn to alternative medicine because they are not satisfied with the doctor-patient relationship. Western doctors are criticized for their insufficient interaction with their patients, whilst practitioners of alternative

medicine are described as giving patients more attention, and caring more about illness experiences (Crossley, 2000). Thirdly, the holistic view of health adopted by most of alternative medicine is considered as a way of attracting people to use alternative medicine, which tends to take into account physical, psychosocial and environmental factors in explaining the causes of illness. This is held to be in contrast with the mind/body dualism and the reductionistic view of health in biomedicine (Siahpush, 1999). Fourthly, the claim of a close relationship with nature in alternative medicine is also thought to draw people, with western biomedicine increasingly considered as intrusive, and producing more side effects than natural healing (Siahpush, 1999). Last but not least, biomedicine is perceived as exerting increasing control over an individual's life, so the use of alternative medicine is viewed as resisting the loss of control over one's health to the hegemony of biomedicine. In this way, alternative medicine is symbolized as regaining control over one's own health (Crossley, 2000).

These understandings of alternative medicine (e.g., as holistic and caring about patients' subjective feelings) offer insightful explanations for why people seek alternative medicine in western countries. However, I argue that these explanations only address people in western societies who use biomedicine as their primary health care system, and therefore may not apply to migrants from non-western countries. This is because many migrants to western countries have experienced alternative medicine in their countries of origin, and there, these healing systems may have been primary health care systems. Accordingly, migrants may understand these healing systems differently from non-migrants in western countries, especially if they have used alternative medicine as the primary health care systems in their home countries. For instance, they may regard some alternative medicine to be as legitimate as western biomedicine, and they may seek alternative medicine to treat illness in the first instance. Underlying this may be understandings of health and illness that differ from the meanings of health and illness construed in western biomedicine. However, there is a paucity of research on migrants' understanding of healing systems within their own traditions.

It is widely observed that many Chinese migrants tend to use both western biomedicine and traditional Chinese medicine (TCM) to treat illness in western countries (Chun & Chesla, 2004; Ma, 1999; MacGregor-Reid, 2001). A general belief has been noted among Chinese migrants that western biomedicine is more effective for

acute diseases and TCM is better for chronic conditions (Chun & Chesla, 2004). Also it is considered that western medicine works faster to relieve symptoms but creates more side effects than TCM (Chun & Chesla, 2004; Ma, 1999; MacGregor-Reid, 2001; Prior, Chun, & Huat, 2000). For instance, one study into Chinese migrants' management of type 2 diabetes found that traditional Chinese knowledge was frequently drawn upon in discussions of the causation, course, and treatment of the illness (Chun & Chesla, 2004). Therefore, despite the fact that it is regarded as an alternative to western medicine as a healing system, traditional Chinese medicine constitutes an important part in Chinese migrants' practices of health and illness in western countries.

2.3 Chinese Migrants and Traditional Chinese Medicine in New Zealand

New Zealand is a country of migrants. Due to the history of colonization by Great Britain, white European descendent (Pakeha) makes up the majority of the population (70%), followed by indigenous Maori people (14.7%), Asian people (6.6%), Pacific island people (6.5%), and others (2.2%) (Statistics New Zealand, 2001a). As the largest Asian ethnic group in New Zealand, ethnic Chinese contribute to 44 percent of the Asian population and 3 percent of the total New Zealand population (Statistics New Zealand, 2001b). The population of Chinese has more than doubled in the last decade from 44,793 in 1991 to 104,583 in 2001, and is estimated to continue to increase in New Zealand (New Zealand Ministry of Health, 2003). The latest report on the Asian population shows that about 65 percent of all Asian people in New Zealand live in the Auckland region and they make up about 12.5 percent of the population in Auckland (Statistics New Zealand, 2001b). Auckland city is also the largest residence for Chinese migrants in New Zealand (Statistics New Zealand, 2001b).

In New Zealand, white middle-class European culture is generally perceived as the dominant culture, and coexists with other cultures. The issue of race relations has always been a focus of public debate in New Zealand society. Despite the ongoing tension between Pakeha and Maori people that preoccupies the political arena of New Zealand, the recent rapid growth of the Asian population has been frequently associated with negative images of Asian 'migrants', and has also led to changing immigration policies in New Zealand (Abbott, Wong, Williams, Au, & Young, 2000). Despite the

fact that the Asian population is expected to continue to increase through further immigration, research into the health status and needs of the Asian population has been largely neglected.

Recently, in 2002, the Asian communities in Auckland approached the Ministry of Health requesting that the public health needs of Asian people be considered in developing public health strategies in New Zealand. The initial health assessment launched by the Ministry of Health (see the “Asian public health project report”, February 2003) identified the health issues of Asian people, which include diseases such as cancer, coronary heart disease, diabetes and obesity. The report also noted the under-utilization of the mainstream health care system by Asian people (New Zealand Ministry of Health, 2003). The substantial number of Asian people who were assessed in this project is ethnic Chinese in Auckland. However, as far as I know, few studies have looked into Chinese migrants’ dietary changes in New Zealand. One particular study shows that Chinese women in Auckland have an increased fat and cholesterol intake with a decreased carbohydrate and fibre intake (Tan & Waston, 2004). With respect to health service use, no research has been devoted to investigating Chinese migrants’ use of TCM, although a few studies have looked into the practices of TCM by health professionals and the use of TCM among the general population in New Zealand (e.g., MacGregor-Reid, 2001).

As in other western countries, TCM is practiced as an alternative to biomedicine in New Zealand. MacGregor-Reid (2001) summarizes three types of TCM practitioners in New Zealand. First, there are biomedical practitioners, usually general practitioners and physiotherapists, who provide treatments such as acupuncture. They generally apply acupuncture without recourse to the Daoism philosophy which is generally behind its use, and follow the biomedical model of health and illness. Second is a group of lay health practitioners who offer acupuncture, and sometimes other forms of healing systems, such as osteopathy. Unlike biomedical practitioners of acupuncture, this group of practitioners is more likely to follow the traditional philosophy underlying TCM, and they are usually trained as acupuncturists through courses ranging from a few weeks to a few years (MacGregor-Reid, 2001). The third group involves TCM practitioners who provide a range of TCM practices including herbal medicine, acupuncture, and therapeutic massage (*tui na*). Most of this group consists of Chinese

migrants who received formal training in traditional Chinese medicine as well as western medicine (as a medical degree) in China. MacGregor-Reid (2001) further points out that acupuncture is far more accepted than any other forms of practice in TCM by mainstream New Zealand society. For example, only acupuncture, of all forms of TCM, is incorporated into personal accident insurance covered by the government Accident Compensation Corporation (ACC).

In addition, there is no specific legislation to regulate alternative medicine practitioners in New Zealand (with the exception of chiropractors) (MacGregor-Reid, 2001). However, there is a wide range of professional organizations that represent alternative medicine practitioners and offer membership and regulation for these practitioners. For example, there are three professional organizations representing TCM in New Zealand, namely the New Zealand Register of Acupuncturists (NZRA), the New Zealand Chinese Acupuncture Association and Register, and the New Zealand Federation of Chinese Medical Science (MacGregor-Reid, 2001). There is a complicated relationship between these three organizations. Firstly, only NZRA members can claim payment from ACC and it has strict rules to govern entry (which requires sitting an exam in English). Secondly, the first two organizations mainly represent acupuncturists, although some of their members do offer other forms of TCM such as herbal medicine. Only the third organization is established to promote TCM as a system of healing, not just acupuncture (MacGregor-Reid, 2001). Thirdly, whilst the NZRA is open to acupuncturists from all backgrounds, the other two organizations are specifically established for Chinese migrant practitioners mainly because they cannot pass the English exam in order to be registered as a member of NZRA (MacGregor-Reid, 2001).

The influx of Chinese migrants has seen an increase of migrant TCM practitioners. The number of TCM clinics in Auckland has doubled between 1990 and 2000 (MacGregor-Reid, 2001). There were around 100 TCM clinics around Auckland by 2000, and Auckland has the highest numbers of TCM practitioners in New Zealand (MacGregor-Reid, 2001). However, due to the lack of appropriate registration and the increase in the number of TCM practitioners, concerns have arisen about the qualifications and safety of some TCM practitioners in New Zealand (MacGregor-Reid, 2001).

It is observed that there is a large group of Chinese migrants in Auckland who regularly use TCM as a healing system (MacGregor-Reid, 2001). MacGregor-Reid (2001) has shown that apart from the common reasons for TCM use for other western consumers, Chinese migrants present unique patterns of TCM use in New Zealand. Firstly, Chinese migrants view TCM as a norm to treat illness. It is suggested that this is because many of them have used TCM all their lives, whereas other consumers of TCM have to make an active decision about starting their use of TCM. Secondly, most Chinese consumers of TCM choose to see Chinese TCM practitioners who are migrants themselves. This study suggests that this may be due to the fact that these consumers feel more comfortable communicating with a practitioner who shares the same language and ethnic identity (MacGregor-Reid, 2001). Therefore, as in many other western countries, Chinese migrants in New Zealand continue to use traditional Chinese medicine for treating illness. However, there is a lack of research on their understanding of traditional Chinese medicine.

2.4 Research Approach

In this section, I introduce the research approach to my study. I first introduce the epistemology and theoretical perspective that informs my study, which is social constructionism and an interpretative approach to social studies respectively. Then, I present the paradigm shift in methodologies in psychological research. Here I focus on Foucauldian discourse analysis and its use in researching health and illness.

As an epistemology, social constructionism concerns meanings (Crotty, 1998). From the view of social constructionists, “meanings are constructed by human beings as they engage with the world they are interpreting” (Crotty, 1998, p. 43), and therefore meanings cannot be separate from either human beings or the world. Social constructionism challenges objectivism’s ‘truth’ claim of knowledge (Crotty, 1998). According to social constructionism, all forms of knowledge are socially, culturally and historically contingent, and thus there is no ‘truth’ out there to be discovered; rather it is constructed by human beings (Burr, 2003). On the other hand, social constructionism disputes the subjectivist’s view that meanings originate from people’s minds (Crotty, 1998). In the view of social constructionists, meanings are not created, but are dependent on our interactions with the objects in the world (Crotty, 1998).

Social constructionism shapes the interpretive approach to research, in which the aim of research is to look for “culturally derived and historically situated interpretations of the social life-world” (Crotty, 1998, p. 67). In the research field of health and illness, social constructionists point out that the meanings of health and illness have long been governed by western scientific knowledge, and they argue that the understanding of health and illness is “a deeply social matter” (Burr, 2003, p. 40). As a result, social constructionist approaches to the study of health and illness attempt to understand the social, cultural and historical context in which health and illness are constructed (Willig, 2000).

The ‘turn to language’ in the late 1960s and 1970s called for a new paradigm for psychology, which emphasized the important role of language in constituting social and psychological life, in contrast to the laboratory-experimental approach to psychology which was criticized for neglecting the life-worlds that people live in (Parker, 2005). It was within this context of the ‘turn to language’ that discourse analysis emerged as a methodology for qualitative research in psychology (Parker, 2002). Discourse analysis concerns how meanings are constructed through discourse and it is often considered as one key approach to social constructionist research (Willig, 2000). In the Foucauldian version of discourse analysis, discourses can be understood as “ways of speaking about or representing the world” (Burr, 2003, p. 169). More specifically, discourses can be defined as “sets of statements that construct objects and an array of subject positions” (Parker, 1994, cited in Willig, 2001, p. 107). Firstly, discourse constructs a particular version of objects being spoken about (Carabine, 2001). Secondly, discourse constructs subjects (persons), an orientation that is theorized in positioning theory (Willig, 2001). In positioning theory, persons are seen to be constituted by positions in discourses (Harré & Langenhove, 1999). A discourse provides subject position(s) that speakers can take up or resist. Once a position is taken up, the speaker will feel and experience the world as well as him or herself from within the subject position. Therefore, our experiences and identities can be understood in terms of the positions within these discourses that are available to us (Burr, 2003).

From a Foucauldian discourse analyst’s view, discourse, knowledge and power are intricately associated (Burr, 2003; Carabine, 2001). There are a few ways to understand the relationships between these three. Firstly, knowledge is understood as a

particular construction of a phenomenon, which has gained the dominant status as 'truth' at a particular time in a particular culture and society (Burr, 2003; Carabine, 2001). Therefore 'truth' is regarded as the dominant discourse of an event. Secondly, discourse supports or limits what can be said, and thus power functions discursively. Put another way, power is understood as something that is not possessed by a group of people; rather power is exercised when some discourses are privileged while others are marginalized (Willig, 2001). Thirdly, power is important in producing what counts as knowledge; thus power and knowledge always go hand in hand (Burr, 2003; Carabine, 2001). Fourthly, and more importantly, dominant discourses are considered as always being contested by other discourses. Therefore there is always resistance (exercise of power) where there are dominant discourses (Burr, 2003; Carabine, 2001).

In all, Foucauldian discourse analysis concerns the relationships between discourses and social practices, discourses and subjectivity, and the material contexts within which these practices and subjectivity occur (Willig, 2001). Foucauldian discourse analysis is increasingly used as a methodology in the field of health psychology to study how people make sense of health and illness (Willig, 2000). It offers a way to explore how health and illness are constructed through discourse. Willig (2000) remarks that Foucauldian discourse analysis has been applied within this context in two major ways. First, it has been used to identify dominant discourses of health and illness and to investigate the ways in which these discourses construct individuals. Data for this type of analysis are usually derived from "expert writings, official publications, specialist literature, the media, as well as institutional practices" (Willig, 2000, p. 550). Another way that Foucauldian discourse analysis has been used, according to Willig (2000), has been to examine the ways that individuals draw on the dominant discourses in everyday talk and the ways that individuals are positioned in relation to these discourses (through studying their subjectivities and practices). Data for this type of analysis are often generated through interviews, group discussions and diaries. Willig (2000) further argues that Foucauldian analysis of discourses and subjectivities allows us to comprehend "individuals' resistance to dominant discourse, and the emergence of alternative subject positions as well as subversive practices" (Willig, 2000, p. 554).

2.5 My Study

As a qualitative researcher, I am influenced by a social constructionist viewpoint of knowledge, the interpretative approach to research, and the emphasis on the interrelationship between discourse, practice and subjectivity in Foucauldian discourse analysis. I view traditional Chinese knowledge and western scientific knowledge as inseparable from their cultural, historical and social contexts. I have discussed how in contemporary western societies scientific knowledge is privileged and traditional Chinese knowledge is marginalized in the understandings of health, illness and the practices surrounding them. Also, I have examined how individuals' dietary practices and their use of healing systems are constrained by traditional Chinese understandings and western understandings of health and illness, and how the ways of being are offered in both traditional Chinese society (harmony with the natural and social environment) and contemporary western societies (individual responsibility for health and illness).

Meanwhile, research on Chinese migrants' mixed dietary practices (both traditional Chinese diet and western diet) and also their mixed use of healing systems (both traditional Chinese medicine and western biomedicine) suggests that traditional Chinese knowledge and western scientific knowledge of health and illness together shape their health-related practices in western society (Jovchelovitch & Gervais, 1999; Satia et al., 2000). However, little research has been done to explore how they understand their practices in relation to food and healing systems in terms of health and illness, especially through their everyday talk. I suggest that Chinese migrants' accounts of their dietary practices and use of healing systems indicate the ways that they make sense of the complex meanings of health and illness available in different cultures and societies.

In New Zealand, concerns have been raised about the health effects of Chinese migrants' dietary changes and their under-utilization of the mainstream health care system. At the same time, Chinese migrants are observed to continue to use traditional Chinese medicine as a healing system although the safety of TCM treatment is questioned. In my study, I am interested in investigating how Chinese migrants in New Zealand discursively construct the meanings of food and healing systems with respect to health and illness. In particular, I look at the ways that they draw upon discourses

available to them to make sense of their dietary practices and healing systems use in New Zealand. In addition, I am interested in exploring Chinese migrants' subjectivities through the ways that they position themselves and others in these discourses. More specifically, my research objectives are manifest in the following aspects:

Firstly, to investigate the ways in which Chinese migrants understand food, diet and related practices in relation to health and illness in New Zealand.

Secondly, to investigate the ways that Chinese migrants understand the meanings and practices of traditional Chinese medicine as a healing system in relation to western biomedicine in New Zealand.

Thirdly, to investigate the subject positions made available to Chinese migrants, and how they take up or resist these in order to understand themselves and their identities as healthy people.

CHAPTER 3: Methods

In this chapter, I provide details of the research process. Firstly, I explain my recruiting criteria for participants. Secondly, I explicate the ethical considerations that were taken into account. Thirdly, I outline the procedures that I undertook to recruit participants and to collect the data for analysis. Finally, I specify my analytic process of the text that emerged from the interviews.

3.1 Criteria for Participants

My recruiting criteria for participants were ethnic Chinese people who were born and grew up in Mainland China, migrated to New Zealand and have been living here for at least two years. In addition, participants must have used traditional Chinese medicine (TCM) in New Zealand. The recruitment criteria for my participants were based on the following considerations:

Firstly, the understandings of health and illness among Mainland Chinese migrants in New Zealand may differ from those who migrate from outside Mainland China. It has been noted that the health-related behaviours are slightly different between Chinese people from Mainland China and those from Hong Kong, Macao, Taiwan and other Asian areas (Bond, 1996). This may be due to the different extent to which western culture has had an influence on these regions (Bond, 1996). Therefore, due to the heterogeneous nature of Chinese people living in New Zealand, only Chinese migrants from Mainland China were selected.

Secondly, the majority of research on Chinese immigrants in New Zealand has focused on Chinese people originating from Hong Kong and Taiwan as these people were the largest source of Chinese participants from the early 1980's to 1995 (Abbott et al., 2000). Little research has been conducted on Chinese immigrants from Mainland China, who now make up a large proportion of ethnic Chinese New Zealanders (37.2 percent, 38,949) (Statistics New Zealand, 2001b). Also, since 2001 (the last New Zealand census) there has been a larger increase of Chinese migrants from Mainland China than from anywhere else (Ministry of Health, 2003). Therefore, research on

Mainland Chinese migrants is required to meet the health needs of this particular population in New Zealand.

Thirdly, Chinese immigrants new to New Zealand were excluded because it is important that my participants have adjusted to a changed diet, and have become familiar with the New Zealand health care system.

Finally, participants who have used traditional Chinese medicine were selected, as it is assumed that Chinese immigrants who use traditional Chinese medicine have some kind of traditional Chinese understanding of health and illness. To ensure this I sought participants through TCM clinics (see section 3.3).

3.2 Ethical Considerations

This research was peer reviewed and judged to be low risk. Therefore this research did not require an ethical approval from Massey University's Human Ethics Committee (see Appendix I). Participants were fully informed of the purpose, procedure, and use of my research when I contacted them. Each participant was given an information sheet (see Appendix I) and asked to read it and raise concerns before they agreed to take part. They were assured that their names would be kept confidential and they would not be identified in the final report of my research, and the data would not be used for any other purpose than my research. I did mention that I might forward the findings of my research to the Ministry of Health, and relevant organizations and communities working for the health of the Asian population in New Zealand. Informed consent (see Appendix II) was obtained from each participant immediately before the interview started.

3.3 Procedure

Participants were recruited through traditional Chinese medicine clinics in Auckland, New Zealand. I searched the website of New Zealand Association of Registered Acupuncturists (www.acupuncturists.org.nz) to identify ethnic Chinese practitioners of traditional Chinese medicine (TCM) and the locations of their clinics in the Auckland region. I visited some of the clinics, introducing my research to those TCM practitioners. A few showed interest in my research and were willing to assist in

recruiting participants. Some of the TCM practitioners agreed to participate in my study themselves, while others introduced their families and previous patients to me. I left them with the Information Sheet (Appendix I) of my study and asked interested individuals to contact me. I obtained ten participants in total, five males and five females, with an age range of 28 to 75 years. The duration of residence in New Zealand ranged from two years to 18 years. Two participants were TCM practitioners in Auckland, three participants were family members⁶ of TCM practitioners, and five participants were patients of TCM clinics. All the participants were from Mainland China.

Individual semi-structured interviews were used to collect data. A few open questions were used to frame my interview (see Appendix V), which focused on how the participants understood food, health and illness, traditional Chinese medicine, and the relation between these. All interviews were conducted in the participants' homes and *Pu tong hua* (the national standard spoken language in China) was used for conversation. During the interviews Chinese-style refreshments were provided to the participants. The interview duration ranged from 45 minutes to one and a half hours. The interviews were tape recorded and transcribed literally by me into Chinese. I was planning to translate all the transcripts into English, but once I translated the first few transcripts, I found it was very time-consuming and also unnecessary because I realized that the Chinese version of the transcripts would be more appropriate for analysis in order to understand the full meanings of the participants' accounts.

I completed the ten interviews over a period of one and a half months, transcribing and conducting initial data analysis after each interview was completed. Although I did not initially plan the specific number of participants, it became clear after the initial analysis of the ten transcripts that there was substantial commonality in the data to provide a thorough analysis.

⁶ Two are the wives of TCM practitioners and one is a parent of a TCM practitioner. I collected information from only one participant in each household; therefore there was no more than one participant from the same family.

3.4 Analysis of the Text

I broadly followed the analytic steps outlined by Willig (2001) and Parker (2002) regarding Foucauldian discourse analysis.

My first step was to identify the ways in which the objects, such as “diet”, “health”, “the relationship between diet and health”, “traditional Chinese medicine”, were constructed by the participants in different ways in the texts. I engaged myself with the texts, reading and re-reading through them, at the same time writing notes and revising them as I went back to re-read the texts. At this first stage, I focused on how each individual participant constructed those objects in their accounts. Then I combined the different constructions of these objects across participants. Next, I worked my way around these constructions and identified particular accounts that emerged from the different constructions of objects. For example, an economic account of diet became apparent in talk about dietary changes in New Zealand: “food was cheap and convenient in China”, “we often ate out in China whereas mostly cook meals at home here”, etc. An account of the ‘hot/cold’ nature of food and body emerged in talk about diet and how diet is related to health: “celery is cold”, “red meat is hot”, “we need to have cold food in summer while hot food in winter”, “eating too much hot food will get *shang huo*⁷ (上火)”, “If you have a cold body nature your hands and feet will feel cold all the time especially in winter”.

The second step of my analysis consisted of identifying discourses. My way to work out discourses was based on my understanding of discourse as able to “facilitate and limit, enable and constrain what can be said, by whom, where and when” (Willig, 2001, p. 107). First, I drew attention to the differences between constructions of the same object. For example, in talking about “food”, the construction of food in terms of ‘hot/cold’ nature appears to be in contrast with the construction of food in terms of nutrient components (e.g., “carbohydrate”, “fibre”). At the same time, I noticed that the constructions of “illness” were differentiated clearly between “the imbalance of *yin* and *yang*” and “the machinery parts break down”. Next, I looked across the objects to see whether one account of an object can be connected with one of the accounts for another object, and therefore form a coherent meaning system to jointly construct the objects.

⁷ *Shang huo* (上火) means the body gets hot or heated when translated into English literally.

For example, I found that the “hot/cold” account of “food” (one object) and the “*yin/yang* imbalance” account of “illness” (another object) complemented one another to explain “the relationship between food and illness” (another object) in their accounts: “too much hot or cold food will lead to *yin/ yang* imbalance in the body and thus cause illness”. In doing so, I was able to identify two major systems of meanings that discursively constructed the objects in two ways, which I labelled traditional Chinese knowledge and western scientific knowledge respectively. Traditional Chinese knowledge constructs food as having ‘hot/cold’ or *yin/yang* nature, and it constructs health and illness in terms of *yin/yang* balance. The relationship between food, health and illness is constructed in terms of how the ‘hot/cold’ nature of food can affect the *yin/yang* balance of the body. It also constructs traditional Chinese medicine (TCM) as working to restore *yin/yang* balance in the body. In contrast, western scientific knowledge constructs food as nutritional components, and constructs health (illness) in terms of physiological functions of the body.

Once these discursively produced meanings were identified, in the third step I began to explore the ways in which participants used these meanings to construct the objects. This involved an examination of what Willig (2001, p. 110) called “action orientation”. I looked at how constructing an object in a particular way was capable of achieving a function for participants in the discursive context. For example, I interpreted the participants’ construction of TCM as a cultural legacy as being able to help participants to claim legitimacy of TCM in their accounts. It was also at this stage that I extracted specific quotes to illustrate their use of discourses to construct objects.

The next step concerned my exploration of the subject positions offered through these meaning systems. I was aware that both traditional Chinese knowledge and western scientific knowledge provide a range of positions for participants to take up, and the availability of positions is dependent on the social context. For example, discourses around western scientific knowledge construct a person as being responsible for his or her own health and illness. When it pertains to diet, nutritional knowledge based on western science positions a person as one who needs to take control of his or her diet to maintain health. When it relates to illness diagnosis and treatment, western medicine derived from scientific knowledge constructs a person as in a subjugated relation to health professionals. The ill person is positioned as a patient who is subject

to the power of medical professionals. However, because I was interested in the cultural specificity of meanings constructed, I focused on the cultural differences in how discourses construct subjects. It became evident that traditional Chinese knowledge and western scientific knowledge provide two different sets of subject positions for the participants to take up, namely a traditional Chinese person versus a western-educated person. In general, a traditional Chinese person considers food in terms of its 'hot/cold' nature, and speaks of health and illness, and traditional Chinese medicine, according to *yin/yang* balance, whereas a western-educated person understands and practices health and illness in a western way.

Then, I drew attention to the ways that participants constructed their dietary practices and use of healing systems in New Zealand through drawing upon traditional Chinese knowledge and western scientific knowledge. With respect to dietary practices, I found that the ways that participants constructed their dietary practices involved their accounts of the relationships between food and health, and between food and illness respectively. Meanwhile, in terms of healing systems use, participants frequently constructed traditional Chinese medicine (TCM) in relation to western medicine when they talked to legitimise or limit their use of TCM in their accounts.

The fifth step was concerned with the relationship between discourse and subjectivity. I considered the changed cultural and social contexts, within which Chinese migrants deal with food and healing systems, to analyse how participants considered themselves with respect to these health-related practices. In this way, I was able to locate participants' discursive constructions of themselves in relation to others within the context of New Zealand. For example, I explored how Chinese participants, positioned as an ethnic minority group, drew upon dominant discourses about race relations in New Zealand to understand their diet, TCM use, as well as themselves in New Zealand. Also, I considered how the process of migration provided an opportunity for participants to understand the different practice patterns of TCM in Chinese society (as legitimate) and New Zealand society (as alternative). In addition, I focused on how particular constructions of objects and subjects open up or close down opportunities for participants to act in a particular way and for them to experience themselves. For example, in understanding how food is related to health and illness, I explored how the ways that participants constructed health and illness in relation to others had an impact

on their traditional and western dietary practices in New Zealand. In this way, I interpreted that participants' account of "we are not as strong as white European people" as functioning to legitimise their continuing use of traditional Chinese diet while positioning themselves as inferior to the dominant social group in New Zealand. Further, I paid particular attention to how participants took up alternative subjective positions to resist the dominant constructions of themselves in New Zealand society.

CHAPTER 4: Analysis

The analysis includes both my interpretations and discussions of the participants' accounts. This chapter consists of two parts. Part one concerns how participants make sense of their dietary practices with respect to health and illness in New Zealand. I focus on the ways that participants draw on discourses surrounding food and health to construct meanings of food in relation to health and illness. Also I point out how participants understand themselves through their social practices involving food. Part two relates to participants' understanding of traditional Chinese medicine (TCM) as a healing system in relation to western medicine (WM). In part two I draw attention to how participants construct TCM to understand their use of TCM in New Zealand. In addition, I discuss how they view themselves as Chinese migrants in relation to TCM use.

4.1 Part One: Constructing food, health and illness in a changed context

The notion of 'balance' is evident in participants' accounts of their understandings and practices of food with respect to health and illness. Participants state that they have kept with 'Chinese food' on the one hand, but have adopted 'western food' on the other hand after migrating to New Zealand. This is consistent with the findings in previous studies on Chinese migrants' dietary patterns in western countries (e.g., Satia et al., 2000; Yang & Read, 1996). Participants consider breakfast as the most noticeably changed mealtime that is more westernised. Dinner tends to be kept the same in keeping with tradition. Factors, such as availability, convenience, and cost, are frequently mentioned as influencing their dietary practices in New Zealand.

It also becomes clear that participants speak of 'Chinese food' and 'western food' in two ways. First of all, when they mention 'Chinese food' and 'western food', they refer to their food practices, in which 'Chinese food' and 'western food' are differentiated by foodstuffs, preparation and cooking methods. 'Chinese food' is spoken of in regard to "rice as the staple food", "more variety of vegetables", and "stir-fried", etc. By contrast, 'western food' is talked of as "butter and cheese", "more dairy

product”, “salad”, “roast and grill”, etc. This categorization of ‘Chinese food’ and ‘western food’ is in line with the common sense notion of how ‘Chinese food’ is different from ‘western food’ in western culture. The other way that participants use the terms of ‘Chinese food’ and ‘western food’ is implicated in the different understandings between traditional Chinese culture and contemporary western culture on how food is related to health and illness. ‘Chinese food’ is talked of in terms of ‘hot’ and ‘cold’ nature that is constructed in relation to traditional Chinese knowledge, while ‘western food’ is talked about with reference to nutritional components that is constructed through western scientific knowledge. Therefore, food seems to have a double meaning for the Chinese participants and it creates complexity for their food practices.

It is evident that, in order to make sense of the complex relationship between food, health and illness, participants draw on both western scientific knowledge and traditional Chinese knowledge to understand their mixed dietary practices of both ‘Chinese food’ and ‘western food’ (implicated in the above dual meaning). Three main areas are identified based on how participants understand food, health and illness. First of all, the talk is surrounded by the relationship between food and health. Here participants describe what a healthy diet means and how they practice a healthy diet. The second involves their understandings of how food is related to illness and how they use food to prevent and treat illness. Finally, the talk is used to construct differences between themselves (Chinese people) and others (white European people) in terms of food, body and health. The following analysis is presented around these three areas that form the participants’ constructions.

4.1.1 Straddling the ‘east’ and the ‘west’: Constructing a healthy diet

It is clear that participants regard food as having great importance to health. How to eat a healthy diet appears to be a major concern in their life. This can be appreciated by taking into consideration that food is viewed as essential to good health in traditional Chinese culture and good health is a major life concern for Chinese people (Bond, 1996; Chun & Chesla, 2004; Jovchelovitch & Gervais, 1999; Koo, 1984). Participants draw on both western scientific knowledge and traditional Chinese knowledge to understand the meanings of a healthy diet. There are several ways that the two versions of knowledge are used in their accounts. Firstly, western scientific

knowledge and traditional Chinese knowledge are used respectively to make sense of the healthy aspect in ‘western food’ and ‘Chinese food’ in their mixed diet. A healthy diet is understood both as “a balance of nutrient components” and “a balance of hot and cold food”. Secondly, western nutritional knowledge is drawn on to understand ‘Chinese food’⁸. In a similar way, traditional Chinese nutritional knowledge is drawn on to understand ‘western food’⁹. Lastly, traditional Chinese knowledge (especially the notion of ‘balance’) is used to understand the relationship between ‘Chinese food’ and ‘western food’. The following analysis shows how participants use these ways to talk of a healthy diet.

1.1.1.1 “A balance of nutrients” versus “a balance of hot and cold”

In general, participants speak of a health diet in terms of both “a balance of nutrients” and “a balance of hot and cold”. Their dietary practices can be described as composed of ‘western’ and ‘traditional’ parts. This is exemplified in the following extracts from two participants Ms Li and Ms Xu.

Extract 1

Ms Li¹⁰ (35 years old, resident for 5 years)

“I make sure I have certain amounts of protein, carbohydrate, and fibre everyday. I think a balance of nutrients is healthy. A healthy diet means not too many calories. I reckon 1800 calories per day is enough for me. I drink some fruit juice. It is only a small bottle but it has more than 300 calories. So the energy contained in it is very high. I drink it only in the morning, not at night. Otherwise it is easy to put on weight. It is not healthy.”

“I occasionally make some tonic soup for myself. For example, when the weather is damp, I will drink some tonic soup that can get rid of humidity in the body. When I feel lethargic, I will have some food that will strengthen the kidney. It seems people over here (New Zealand) don’t have this way of looking at food. In China there is a lot of information about how to use food as tonics. I lived in the Canton area for a while. People there quite often talk about which food can be used as tonics. So I learned a lot. There are many prepared tonic foods for sale there. They are cheap too.”

“Food of a hot nature is like crispy and tasty food, or spicy food. They can make your body hot, and then you will feel sore and have a hot throat. Some people are very sensitive to hot food. If they eat too much of those hot food, they will get pimples straightaway. In summer time, we need to eat more food of a cold nature and let the body cool down, but in winter time we should avoid cold food.”

⁸ ‘Chinese food’ means both the common sense notion of ‘Chinese food’ in western culture and food that is constructed within traditional Chinese knowledge.

⁹ ‘Western food’ means both the common sense notion of ‘western food’ in western culture and food that is constructed within western scientific knowledge.

¹⁰ All the names used in the extracts are pseudonyms.

“I would like to have organic food. It is healthy but it is too expensive. I cannot afford it at the moment. Not many Chinese people are aware of the benefits of organic food; perhaps it is because their financial situation has not reached that level. If you have a family to feed, especially if you have elderly parents living with you, you will more likely go to Chinese grocery shops. They are cheap. My diet is comparatively westernised. I normally go to the supermarket.”

Extract 2

Ms Xu (38 years old, resident for 8 years)

“Some families spend a lot of money on food and they have lots of meat, but it doesn’t mean they are eating healthily. This is because they probably don’t have enough fibre in their diet.”

“So what do you think is a healthy diet?” (Interviewer)

“A healthy diet should include everything, like protein, vitamins, fibre, and so on. You know, it should be like what the schools are promoting now. My children showed me the pamphlet of the food pyramid guide their schools handed out.”

“We don’t eat lamb so much. I think it is too hot for our body. But in wintertime we will have some lamb. My understanding of hot is that when you feel your mouth is dry, have a sore throat and your excrement is dry. I guess traditional Chinese practitioners will then tell you that *yin* and *yang* is not balanced in your body.”

It is common that, on the one hand, participants speak of food in terms of nutrients such as “carbohydrate” and “protein”, and describe a healthy diet as following a set of nutritional rules. On the other hand, they address food according to its ‘hot’ and ‘cold’ nature and take their use of food in a traditional way to maintain health (e.g., food is used as tonics, food is eaten in accordance with the weather and seasons). This indicates that both western scientific knowledge and traditional Chinese knowledge are drawn upon to understand what a healthy diet means.

Furthermore, the participants’ accounts show the different status of western scientific knowledge and traditional Chinese knowledge in understanding food in New Zealand. For example, in extract 1 Ms Li compares the different frequency in using food as tonics between New Zealand and China: “It seems people over here don’t have this way of looking at food”, “In China there is a lot of information about how to use food as tonics”. In addition, she describes how “a balance of nutrients” is practiced on a daily basis (“everyday”) in New Zealand, whereas “tonic food” is used only “occasionally” here. In extract 2, Ms Xu refers to the diet guide for the public when she mentions the nutritional components of food. These accounts illustrate that western scientific knowledge dominates (over traditional Chinese knowledge) in understanding

the meanings of food to health in New Zealand, and it works to explain why participants draw on western scientific knowledge to understand what a healthy diet means in the first place.

Two subject positions are made available to participants through western scientific knowledge and traditional Chinese knowledge, namely a western-educated person and a traditional Chinese person. A western-educated person would be a person who understands food according to western nutritional knowledge and thus practices food in terms of the nutritional rules set by western nutritional knowledge. By contrast, a traditional Chinese person would understand food in a traditional Chinese way. It is evident that participants take up both positions at different times to make sense of their mixed dietary practices. For example, in Ms Li's case, she takes up the position of a western-educated person when she claims that she knows the benefit of eating organic food, and at the same time she points out that other Chinese migrants are not aware of it yet. In doing that, she positions herself as more western-educated than other Chinese migrants, which explains her claims of practicing a more 'westernised' diet and shopping in western supermarket instead of Chinese grocery shop. Also, her account of how she controls diet to control weight illustrates the dominant discourses around diet in western society are about how to control diet in order to have a desirable (slim) body that is believed to be healthy (Lupton, 2003).

1.1.1.2 "Tonic food has high calorie" versus "barbeque is hot"

The second way in which participants speak of a health diet is to draw on western scientific knowledge to comprehend the meanings of 'Chinese food', and also to draw on traditional Chinese knowledge to understand what 'western food' is. First of all, because participants maintain 'Chinese food' in their diet to a large degree in New Zealand, they are faced with the task of making sense of their traditional practices of food within a context where western scientific knowledge dominates people's understanding of food and health. As a result, they frequently use western scientific knowledge to understand 'Chinese food'. This is illustrated in the following extracts.

Extract 3

Ms Li (35 years old, resident for 5 years)

“We have all sorts of tonic food in China. I guess that tonic food actually is food with high calories. It increases the energy level in your body and makes you stronger.”

Extract 4

Mr Qian (38 years old, resident for 18 years)

“My families make soup once or a couple of times per week. We usually put some tonic food in the soup. For example, if the weather is cold, we will put some *dang gui*¹¹ (当归) in the soup and then stew it for several hours”.

“How do you think the soup works to improve your health?” (Interviewer)

“I believe it is because our digestive function is limited. Soup can absorb *dang gui*, and the nutrition in soup is easier to be absorbed by the body than eating solid food.”

.....

“If you pay attention to diet and exercise, the body will function wellit is just like a machine. If you don’t maintain it, like I don’t eat regularlythe body is definitely going to be worn out very quickly. It is just like I don’t put engine oil in the car or regularly change the oil.”

It is interesting to notice that despite the fact that participants deal with food in a traditional Chinese way (e.g., cook and eat tonic food), they explain how the food works to maintain health in a western way by drawing upon western scientific knowledge. For example, in extract 3 Ms Li explains tonic food as food of high energy. She draws on western nutritional knowledge to construct “tonic food” as food with many calories. In this way, the traditional concept of food is explained by western scientific knowledge, although “tonic food” is generally understood as to increase *qi* and *yang* in the body within traditional Chinese knowledge. By viewing *qi* and “energy” as the same thing, Ms Li is able to use the term “energy” (derived from western nutritional knowledge) to justify how ‘Chinese food’ works to improve the body function (increasing *qi*). Linking back to extract 1, extract 3 shows again that Ms Li positions herself as well-informed about western nutritional knowledge, and thus understands ‘Chinese food’ in a western way. Similarly, extract 4 illustrates that Mr Qian understands the body as machine-like, and thus explains how “tonic soup” works according to a mechanical digestive function of the body.

Further, western scientific knowledge is used to explain the common sense nature of the differences between ‘Chinese food’ and ‘western food’. This is exemplified in the following extract.

¹¹ *Dang gui* (当归) is a herb used in traditional Chinese medicine to tonify blood and strengthen *yang*.

Extract 5

Ms Sun (43 years old, resident for 3 years)

“They almost always use an oven to cook the main meals. We fry food a lot. The nutrition is probably kept better when using an oven to cook, but the food doesn’t taste good. Chinese food tastes better, but frying probably destroys the food’s nutrients.”

Here, ‘Chinese food’ and ‘western food’ are understood in terms of cooking methods. Participants talk about food in regard to “the nutrients”, and the difference between “Chinese cooking” and “western cooking” exists in the extent to which “the nutrition is kept”. This illustrates that their understanding of food and health is embedded in western scientific knowledge.

On the other hand, traditional Chinese knowledge is drawn upon to understand ‘western food’. In western culture, ‘western food’ is generally depicted as unhealthy compared to ‘Chinese food’ because ‘western food’ is higher in energy and fat than ‘Chinese food’ (Yang & Read, 1996). Because participants adopt ‘western food’ into their diet, they have to make sense of the dietary change in their diet. Apart from understanding ‘western food’ in terms of western nutritional knowledge, they also draw on traditional Chinese knowledge to understand the healthy aspect of ‘western food’. This is illustrated in the following:

Extract 6

Ms Zhang (33 years old, resident for 3 and a half years)

“Kiwis always have barbeque with their salads. I think it makes sense. Barbeque can get your body hot, but salad is cold. So your body is balanced.”

“Our diet hasn’t changed much since we migrated to New Zealand. I met a Chinese lady in the park a while ago. Her diet is already very much westernised. I guess some people do adjust themselves to a new environment better than others do. It may be also to do with the living conditions. My husband and I rented a flat and lived by ourselves when we first arrived in this country. We never lived with the local people. So I haven’t learned much about their cooking.”

The extract above clearly shows that the participant (Ms Zhang) positions herself as a more traditional Chinese person than a westernised person. She describes her diet as not so “westernised” compared to other Chinese migrants. She talks about mostly keeping traditional Chinese food in her diet and ascribes her diet in New Zealand to her ability to adjust to a new environment and to the situations she has found

herself in when she first migrated here. She draws on traditional Chinese knowledge to construct the meanings of western food in terms of ‘hot’ and ‘cold’ balance. The construction of some western food as ‘healthy’ (in terms of hot and cold balance) may work to justify participants’ adoption of western food because they may feel they are still eating a healthy diet despite the fact that western food is generally depicted as less healthy than Chinese food. In addition, participants’ construction of western food as healthy in a traditional Chinese way can challenge the dominant view of what healthy food is within western scientific knowledge. This is shown in the next section about how participants construct the relationship between ‘Chinese food’ and ‘western food’.

1.1.1.3 A balance of ‘Chinese food’ and ‘western food’

As introduced in chapter one, the notion of balance underlies the practice of food in relation to health and illness in traditional Chinese culture. Not only food of ‘hot’ and ‘cold’ nature needs to be balanced, but also food needs to be balanced with the natural environment. With respect to how a healthy diet should be practiced for them in New Zealand, it is evident that participants embrace the notion of balance to negotiate their mixed diet of both ‘Chinese food’ and ‘western food’ in New Zealand. ‘Western food’ and ‘Chinese food’ are regarded as complementary to each other because each has ‘healthy’ and ‘unhealthy’ aspects. This is shown in the following extracts.

Extract 7

Ms Li (35 years old, resident for 5 years)

“Some of the western food is healthy, like salad. Nutritional components are better preserved in raw food than fried food. But they put too much cream and cheese in it. The energy is quite high. On the other hand, we have fried vegetables in our cooking. Frying is not good, but we don’t use butter to cook.”

Extract 8

Ms Sun (43 years old, resident for 3 years)

“We have too much fried food in our diet. It is too oily. You will notice the difference in the kitchens. They eat more raw food, but we eat a lot more vegetables and fruits.”

Extract 9

Ms Xu (38 years old, resident for 8 years)

“They have barbeques a lot, and it is not healthy. But they don’t have so much fried food as we do. And they have more raw fruit and vegetables than us. So our diet is no healthier than theirs, neither is theirs. It should be a balance.”

Despite the fact that most participants use western nutritional knowledge to explain the 'healthy' and 'unhealthy' parts in both 'western food' and 'Chinese food', they draw on the notion of "balance" in traditional Chinese knowledge to construct the relationship between 'western food' and 'Chinese food' in their diet as in equal status. In doing so, participants do not favour either 'western food' or 'Chinese food', but they justify their reasons to keep 'Chinese food' as well as to adopt 'western food' into their diet. Underlying that, they take up the position as a traditional Chinese person that is made available in the notion of "balance" in traditional Chinese understanding of health. As a result, they understand food and health in terms of "balance" and construct their mixed dietary practice as embodying the "balance". In this way, they may consider themselves as following a healthy diet.

In all, this section of analysis (4.1.1) shows that Chinese participants take up the positions as both a western-educated and a traditionally well-informed person, and draw upon western scientific knowledge and traditional Chinese knowledge in an integrated way to explain and justify what a healthy diet is for them to practice in New Zealand. Namely, a healthy diet is a balance of "nutrients", a balance of 'hot' and 'cold', and a balance of 'western food' and 'Chinese food'.

4.1.2 The 'east' and the 'west' side by side: Constructing food in relation to illness

Another area of participants' talk about food involves the relationship between food and illness. The illnesses that participants describe as linked with food can be classified into two types: 'western diseases' and 'Chinese diseases'. 'Western diseases' can be viewed as diseases and illnesses that are understood in western biomedicine to have an association with food, such as malnutrition, coronary heart disease, diabetes and obesity. By contrast, 'Chinese diseases' can be understood as those that only appear in the diagnosis of traditional Chinese medicine, such as *shang huo*¹². It is apparent that participants draw on both western medicine and traditional Chinese medicine to understand the roles that food play in the causation, prevention and treatment of illness. More so, the two versions of knowledge are used in complementary ways to construct the relationship between food and illness. On the one

¹² According to traditional Chinese medicine, the symptoms of *shang huo* include sore throat, dry mouth, dry excretion, pimples or catching a cold, etc.

hand, participants draw on western medicine to understand their practices around food in the time of ‘western diseases’. On the other hand, they use the notion of traditional Chinese medicine to understand traditional food practices in the time of ‘Chinese diseases’ and ‘western diseases’. The following analysis presents how participants use these two versions of knowledge to make sense of the meanings of food in relation to illness.

4.1.2.1 Constructing how food is related to illness in a ‘western’ way

It is noticed that the diseases that participants first refer to are often ‘western diseases’ that have become the major health concerns for people living in the contemporary western world, such as coronary heart disease and diabetes. Some participants, especially elderly participants, suffer from these chronic illnesses and therefore talk about their own illness experiences to explain the relationship between food and illness. Western scientific knowledge is drawn upon to understand their illness experiences and how they deal with illness. This is illustrated in the following extract.

Extract 10

Mr Ren (75 years old, resident for 4 years)

“I have lots of diseases, such as diabetes and high cholesterol. Thus I have to pay attention to my diet because diet has direct relationship with diseases. Sometimes if I don’t control myself and have too much sweet food, my blood sugar level will go up quickly. Sometimes if I eat more eggs than usual, my cholesterol level will go up too. My health examination results will tell whether I control myself well or not. I was told by the doctor to follow the rule of less salt, less sugar and less fat in my diet to control my diseases. I only eat a small amount of kiwifruit and orange. I try to avoid other kinds of fruit.”

It is noted that food is increasingly seen as a source of chronic diseases in western societies, and at the same time food is becoming an area of self-control giving the recognized role it plays in diseases. The extract above exemplifies that participants draw upon western scientific knowledge to understand the roles that food plays in causing and treating diseases. Mr Ren expresses that he has suffered a lot of diseases in his life (e.g., “I have had a stroke three times”). He describes “too much sweet food” leads to his “high blood sugar”, also he talks about following a dietary rule “less salt, sugar and fat” to manage his diseases. Meanwhile, the above extract shows that participants position themselves in accordance with the dominant construction of the

relationship between lay people and health professionals in the biomedical discourse in which an unequal power relation is produced. In the biomedical discourse, lay people are constructed as ‘patients’ and ‘inexpert’, whereas medical professionals are constructed as ‘expert’. Medical professionals are viewed as being responsible for illness diagnosis and treatment, and patients’ compliance to medical professionals is emphasized (Lupton, 2003). This unequal relation is demonstrated in the above participant’s talk that “I was told by the doctor” to “follow” the food guidelines. In saying that, the participant positions himself in an inferior position to the medical professionals. In addition, as Willig (2000) points out, the discourses of health and illness in western culture construct diseases as residing within the individuals, and thus emphasize personal control. It is the ‘patient’ who holds responsibility for his or her health and illness, although the patient may have little to say with respect to disease diagnosis and treatment. The above extract illustrates that the participants is positioned as the one who has diseases (“I have lots of diseases”) and thus needs to “control” himself to control diseases.

Another way in which participants draw on western biomedicine to understand ‘western diseases’ is to compare different ‘western disease’ patterns in different cultures. This is shown in the following extract.

Extract 11

Mr Wu (42 years old, resident for 9 years, TCM practitioner)

“We traditionally have more vegetable and less meat in our diet than the European people, so we are at higher risk of stomach cancer and esophagus cancer. Vegetables are high in fibre. They help digestion but wear out the stomach quickly because of the mechanic friction. By contrast, the white European people are more likely to get colon cancer, especially New Zealanders. They consume a large amount of meat and little vegetable. Meat is mainly protein. Protein becomes indole after it is decomposed. It is bad for lower digestive tract and can cause constipation. The constipation can lead to the mutation of intestinal cells and then cancer. That’s why the rate of colon cancer is so high in New Zealand.”

This extract is taken from a participant who received training in both western medicine and traditional Chinese medicine in China. In the extract he explains how food (e.g., “fibre”, “protein”) works to impact on the physical activities of the body (e.g., “mechanic friction of stomach”, “decomposition of protein”) and thus cause diseases (e.g., “stomach cancer”, “colon cancer”). His account clearly demonstrates the dominant construction of food in western culture, in which food is closely associated

with different disease patterns. According to Buriktt (1973, cited in Herman, 1994), 'western diseases' are barely heard in traditional non-western cultures. However, with the growing popularity of western culture in non-western countries, people are adopting a western lifestyle (e.g., western diet), which leads to the rise of 'western diseases' in non-western countries. As a result, 'western diseases' are increasingly becoming the prominent health issues for people living in non-western societies, and western scientific knowledge is increasingly used to understand illness patterns across cultures. Consequently, this serves the function of reinforcing the dominant status of western scientific knowledge in understanding health and illness.

4.1.2.2 Constructing how food is related to illness in an 'eastern' way

However, as Koo (1987) argues, western medicine is limited in offering explanations for the causes of certain diseases, such as rheumatism. Therefore it opens up possibilities for other versions of knowledge to construct alternative meanings of illness. This is illustrated in Chun and Chesla's (2004) study, which showed how Chinese Americans described that type 2 diabetes was related to the imbalance of 'hot' and 'cold' in the body. In my research, it is evident that there are three ways in which participants draw upon traditional Chinese knowledge to construct the relationship between food and diseases. First, traditional Chinese knowledge of food and illness is drawn upon to understand food as a cause of 'Chinese diseases'. Second, participants speak of food as medicine to prevent and treat 'Chinese diseases'. Third, because 'Chinese diseases' are understood as the precedent of 'western diseases', food is also constructed as preventive to 'western diseases'. The following analysis presents how participants speak of food in relation to illness in these three ways.

Firstly, participants draw on traditional Chinese knowledge to construct food as a cause of illness. This is shown in the following extract.

Extract 12

Ms Zhang (33 years old, resident for 3 and a half years)

"I always know vegetables, like cucumber and celery, have a cold nature. I didn't know that cabbage was cold until I gave birth to my daughter in New Zealand. My daughter was about two months old at that time and the babysitter told me that my daughter had lots of wind in her stomach. I took her to see the doctor, and the doctor said that too. Then the babysitter suggested I not eat cabbage if I was breast-feeding

my daughter because cabbage is cold. I realized I did often eat cabbage at that time. Since then I remember cabbage is cold too.
 “What do you mean by cold?” (Interviewer)
 “Cold, for a person, means he or she has weak stomach and spleen, and will have lots of wind after eating.”

In traditional Chinese knowledge, the dichotomy of having a ‘cold’ and ‘hot’ (or *yin and yang*) nature not only applies to food but also to the human body. The body is seen as inclined towards a *yin* (‘cold’) or *yang* (‘hot’) nature. Too much ‘cold’ food is understood as causing ‘cold’ or *yin* in the body, and therefore is not good for a body that is inclined towards a ‘cold’ nature (Kastner, 2004). Meanwhile, excessive consumption of food of either ‘hot’ or ‘cold’ nature is taken to cause the imbalance in the body and thus illness (Kastner, 2004). In extract 12, Ms Zhang explains that it is the excessive consumption of cabbage (“cold”) that leads to her daughter’s illness (“lots of wind in her stomach”). This illustrates how she uses traditional Chinese knowledge of food and illness to make sense of how food causes illness. Also in traditional Chinese understanding, the ‘hot/cold’ nature of the body corresponds to the functions of organs (Williams, 1996). A ‘cold’ nature body corresponds to a weak function of certain organs, such as stomach and spleen. The way that Ms Zhang expresses what ‘cold’ means (a person “with weak stomach and spleen”) demonstrates how she positions herself as a traditional Chinese person. As a result, she sees the body in the traditional Chinese way.

Secondly, participants construct food as medicine to prevent and treat illness. The following extracts exemplify how food is constructed as preventive to illness.

Extract 13

Ms Cao (28 years old, resident for 4 years)

“We normally have some warm food in winter and some cold food in summer. For example, we cook mung bean soup in summer. Mung bean soup can cool your body down.”

Extract 14

Ms Sun (43 years old, resident for 3 years)

“We paid a lot of attention to the hot and cold nature of food when we were living in Singapore before. The weather is hot all the year round in Singapore. So we have to eat lots of cold food to cool down the body.”

Extract 15

Ms Zhang (33 years old, resident for 3 and a half years)

“I feel the water and soil in New Zealand are very cold. Many people say so. I don’t like the winter here particularly. It rains a lot and is very damp. It is different from the weather in the northern part of China where I came from. It is dry there. But you know, it also rains a lot in the southern part of China where Cantonese people live. However one Cantonese lady here told me that even for Cantonese people they feel the winter here is very cold. That’s why they eat a lot of ginger here in winter. Ginger is hot.”

In traditional Chinese culture, the understanding of food as preventing illness is often shown in the way that food is used with regard to weather and seasons. Extreme hot or cold weather are believed to lead to *yin* and *yang* imbalance in the body and thus cause certain diseases. Food that addresses imbalance is understood as prevention for illness. Therefore, it is a tradition for Chinese people to use food of the opposite nature in time of different seasons, especially in extremely cold or hot weather (Williams, 1996). In the extracts above (13, 14, and 15), participants describe how they use ‘hot’ food (e.g., “ginger”) to warm up the body in cold weather, while they use ‘cold’ food (e.g., “mung bean soup”) to cool down the body in hot weather in order to prevent imbalance in the body. More so, they link the use of food with the natural environment in New Zealand (e.g., “the water and soil in New Zealand are cold”). In doing so, participants legitimise their use of food in a traditional Chinese way in New Zealand.

Apart from talking about using food to prevent illness, participants also speak of food as medicine to treat illness. This is exemplified in the following extracts.

Extract 16

Mr Wang (72 years old, resident for 13 years)

“I have ongoing problems with my stomach. I think it is because my stomach is cold (nature). I feel uncomfortable after eating persimmons although I like them. That is because the persimmon is cold. It doesn’t suit my body. At the moment I only eat oranges. I feel good after eating oranges. I heard that oranges are of a warm nature. So it is good for my stomach.”

Extract 17

Mr Liu (37 years old, resident for 2 years, TCM practitioner)

“It is common sense that we use some tonic food when the body needs it. For example, when a woman has just given birth, her body is very weak. Therefore she needs to have something like stewed Chinese date. Also she needs to have some pork trotter soup if she cannot produce enough milk to breastfeed the baby.”

Extract 18

Ms Xu (38 years old, resident for 8 years)

“If I find my children get *shang huo*, I will let them drink a lot of water and have more fibre in their diet than usual.”

“What is *shang huo*?” (Interviewer)

“They (local people) don’t have the concept of *shang huo*. I explain to them that *shang huo* means the body gets hot. But they only know ‘hot’ as chilli and spicy. My understanding of *shang huo* is that when you get the symptoms, such as sore throat and dry excrement. I usually let my children eat celery when they get *shang huo*. Celery has cold nature. The body needs to be regulated to regain balance. If children get *shang huo* and you leave them alone, they will easily catch a cold and get a fever.”

.....

“I guess the cold and hot nature of food probably has something to do with its fibre content. For example, celery has high fibre. Eating fibre helps to relieve constipation and therefore get rid of the heat in the body.”

In traditional Chinese culture, food that is regarded as able to improve the function of organs through regulating *yin* and *yang*, is understood as a kind of medicine. Extract 16 is taken from a 72-year-old Chinese male with chronic gastric problems. He speaks of eating oranges as good for his stomach because orange is of a ‘warm’ nature, which can help to balance his “cold stomach” and thus is “good” for his illness. Also, in traditional Chinese knowledge food of a tonic nature is understood to increase the *qi* level and is helpful for the elderly and recently traumatized people (e.g. post-surgical or post-natal) whose *qi* is believed to be low (Koo, 1987). This is shown in Extract 17, where Mr Liu pictures a woman after childbirth as ill (“her body is weak”) and food (“stewed Chinese dates”) is seen as a medicine to treat the illness. In extract 18, Ms Xu describes how she uses food of a ‘cold’ nature (“celery”) to treat the illness of *shang huo*. She points out the connection between “high fibre” and “cold nature” in the same food (“celery”), and also the similarity between “high fibre helps to relieve constipation” and “food of a cold nature can get rid of hot in the body”. In doing that, Ms Xu justifies the traditional way of using food as medicine by drawing on both traditional Chinese understanding and western scientific understanding regarding how to use food to treat illness. The use of food as medicine to treat illness is also found in the research on the management of type 2 diabetes among Chinese Americans (Chun & Chesla, 2004), where participants describe how they use particular foods, such as corn silk soup, bitter melon and pig pancreas, to lower blood sugar levels.

Thirdly, participants understand ‘western diseases’ as a result of accumulated imbalance in the body. In this way, ‘western diseases’ are linked to ‘Chinese diseases’

(the imbalance of the body), and traditional Chinese way of healing is considered as being able to prevent ‘western diseases’. This is shown in the following extract.

Extract 19

Ms Zhang (33 years old, resident for 3 and a half years)

“When you have some mild symptoms, your body is not balanced. You need to use traditional Chinese medicine to regulate your body to make it balanced. If your body can get balanced before the symptoms become severe, you can avoid serious diseases, such as cancer. That’s because many serious diseases result from an accumulation over a long time. For example, tumor can turn into cancer.”

The extract above illustrates that participants regard “mild symptoms” as “the imbalance in the body”, and “severe diseases” (‘western diseases’ such as cancer) result from “an accumulation” of “imbalance”. Thus participants understand “the imbalance in the body” as the precedent to ‘western diseases’. Because ‘the imbalance in the body’ is also seen as ‘Chinese diseases’, participants can claim that ‘Chinese diseases’ and ‘western diseases’ display different stages of disease progression, and therefore they require different diagnosis and treatment. The way that ‘Chinese diseases’ and ‘western diseases’ are constructed as different types of diseases works for participants to avoid the dual tasks of explaining ‘western diseases’ using the notion of traditional Chinese medicine and of explaining ‘Chinese diseases’ using western biomedicine. More importantly, participants are thus able to justify their using traditional Chinese medicine to prevent ‘western diseases’ because traditional Chinese medicine is believed to prevent ‘the imbalance of the body’ in the first place. Further, because food is understood as able to bring the body back into balance, food is viewed as preventive to ‘Chinese diseases’ (the precedent) and then ‘western diseases’. This is illustrated in extract 18 in which Ms Xu describes how she uses “celery” to treat “*shang huo*”. She states if “*shang huo*” is not treated, children will “easily catch a cold and get a fever”. This once again justifies participants’ use of food in a traditional Chinese way to prevent illnesses in both traditional Chinese concept (“*shang huo*”) and western concept (“fever”).

This section of analysis (4.1.2) indicates that both western biomedicine and traditional Chinese knowledge are drawn upon to understand how food plays an important role in illness. Western medicine is used to understand food in relation to ‘western diseases’, while traditional Chinese knowledge is used to understand how food

is linked to 'Chinese diseases'. Also because 'Chinese diseases' are understood as a precedent of 'western diseases', participants justify the traditional Chinese way of using food to prevent 'western diseases'. In spite of this, it appears that participants do not use the interplay of these two discursive resources to understand 'western diseases' and 'Chinese diseases' in the same way as they understand 'western food' and 'Chinese food'. They do not draw on western medicine to construct 'Chinese diseases' nor do they draw on traditional Chinese medicine notions to construct 'western diseases'. This is in contrast with their use of western scientific knowledge to construct 'Chinese food' and traditional Chinese knowledge to construct 'western food'. In this sense, 'western diseases' and 'Chinese diseases' may be viewed as having less in common than 'western food' and 'Chinese food'. This may reflect the fact that in western societies, foods of different cultures are practiced in a more integrated way than the healing systems of different cultures. This may also suggest that healing systems (diagnosis and treatment of disease and illness) are constrained, to a larger extent than food, by the unequal power relations produced between western scientific knowledge and other forms of knowledge in western culture. For instance, there is no such rubric of 'alternative food' (for foods of other cultures than western culture) as 'alternative medicine' (for healing systems of other cultures). However, this may be changing with the tendency that food is being looked at as a medicine, and thus is increasingly subject to the power of biomedicine in western society (Chamberlain, 2002; Lupton, 2003). As a result, we may anticipate that the understanding of food that is constructed in western scientific knowledge becomes privileged over those that are constructed in other forms of knowledge.

4.1.3 The construction of selves in relation to food practice: "We are different from them."

As Lewis (2004, p. 626) argues, living in a "racialized" society a person cannot avoid the mark of race. The prevailing discourse of race relations in New Zealand constructs ethnic minority groups as disadvantaged compared to the dominant ethnic group (white European people) in every social arena. Throughout the analysis, it becomes obvious that participants perceive themselves as different from white European people in terms of food, health and illness. Participants speak of "we" for "Chinese people", while terms like "they", "others", "white European people" are used to distinguish themselves from the dominant group in New Zealand. More so,

participants make sense of their dietary practices (mixed ‘Chinese food’ and ‘western food’) through comparing themselves with white European people in aspects of food, health and the body. The following extracts show how they construct the differences between themselves and white European people.

Extract 20

Ms Zhang (33 years old, resident for 3 and a half years)

“I think the diet of Chinese people has something to do with their body makeup. We grew up eating grains, whereas white European people grew up eating meat. So they must have developed a stronger stomach than us. They can digest meat easily. We cannot compare with them That is probably why we often cook meat soup in our diet. Soup is much easier to digest than the meat itself. It is more suitable for our body.”

Extract 21

Ms Li (35 years old, resident for 5 years)

“Unlike the white people who grew up with milk and meat, I had nothing like that when I grew up in 1970’s in China. The country was extremely poor at that time. So my body was made weak while I was young. To go back further, my mother lacked nutrition when she was pregnant, so I was born with a weak body already Our body needs tonics, but the white people don’t. They are strong enough.”

Extract 22

Ms Sun (43 years old, resident for 3 years)

“Maybe they don’t have the hot or cold in their body, but we do. I guess that is because we are of different races.”

Extract 23

Mr Wu (42 years old, resident for 9 years, TCM practitioner)

“In our tradition, a woman who has just given birth is prohibited from any cold food. But it seems that the white people don’t care about that. I know some of them have iced water immediately after giving birth, but it seems they are ok. If a Chinese woman did that, she would definitely get sick, especially when she gets older as time goes by. I think it is because of race. I have observed people of different races. Their bodies are different. The white people are stronger than us.”

Participants describe themselves as having weaker bodies in comparison with white European people. They explain that white people have better nutrition in their diet in both historical and current contexts due to economic reasons; therefore white people have a stronger body physique and better health than Chinese people. Participants’ accounts demonstrate that they understand themselves and their health-related practices in relation to the dominant construction of racial relations in western

society. In the prevailing discourse of 'white supremacy' in western culture, white people are constructed as privileged in regard to every social aspect of western society, whereas other racial groups are constructed as disadvantaged groups in society. Food is viewed as a material resource that is unequally distributed to different racial groups historically and socially. The body and health derived from material resources, are thus referred to differently across races. It is obvious that the participants position themselves as a disadvantaged group, whereas perceive white European people as the privileged ones in society. As a result, participants view their body as inferior to that of the white people, and think they need to follow the dietary regimen according to the Chinese tradition (e.g. use food as tonics) whereas white European people do not have to do so. The understanding of themselves as disadvantaged people indicates that participants take up the position made available in the dominant discourse in western culture. However, being positioned as disadvantaged does not seem disempowering because it offers participants the justification to practice traditional Chinese diet in western society. In this way, participants are able to resist the dominant status of western scientific knowledge to understand food and health.

Overall, this part of the analysis (4.1) shows that participants draw on the culturally available discourses to make sense of their dietary practices to maintain health, and to prevent and treat illness in New Zealand. Despite the fact that western scientific knowledge and traditional Chinese knowledge are both drawn upon at different times and occasions, the analysis shows that participants hold on to the notion of 'balance' in understanding how food should be practiced with regard to health and illness. Meanwhile, living in New Zealand society, Chinese migrants are not immune from the prevailing discourse of race relations in which ethnic minority groups are constructed as inferior to white European people. Accordingly, participants understand their diet, body, and health as disadvantaged in society. However, the construction of the differences also indicates that participants attempt to retain traditional diet as well as Chinese identity in their engagement with western culture.

As mentioned before, apart from food, the use of alternative medicine is another important area where Chinese migrants practice health and illness in western societies. The next part of analysis moves to focus on how participants understand their use of traditional Chinese medicine as a healing system in New Zealand.

4.2 Part Two: Constructing Traditional Chinese medicine (TCM) in relation to western medicine (WM)

In traditional Chinese culture TCM is practiced in many forms, such as herbal medicine, acupuncture, and food therapy. The way of using food as medicine is regarded as food therapy in TCM. This suggests that participants' accounts of their dietary practice in the traditional Chinese way (as shown in Part One of the Analysis) can be understood as their using food therapy, and thus practicing TCM. However, it is noticed that participants only state that they are using TCM at the time of mentioning they seek TCM practitioners for herbal medicine, acupuncture, or therapeutic massage. Their use of food to prevent and treat illness (food therapy) is not explicitly spoken of as their practicing TCM. This can be understood by taking into consideration that Chinese people commonly apply food therapy in their diet on a daily basis; consequently participants view their using food in the traditional Chinese way as a common sense notion of food rather than a form of healing practice for illness. This is in contrast to other forms of practice in TCM, such as herbal medicine and acupuncture, which are only obtained through TCM practitioners rather than practiced at home. The way that participants speak of TCM, with reference to TCM practiced by TCM practitioners, suggests that TCM is mainly understood as a healing system for illness diagnosis and treatment, and it is a region dominated by TCM professionals.

Accordingly, this section of the analysis focuses on how participants construct TCM as a healing system for illness. It is found that, on the whole, participants express their support for using TCM as a healing system to maintain health, prevent and treat illness. Yet at the same time, they show reservations about using TCM in New Zealand. Further, it becomes apparent that participants' understandings of TCM are constantly related to western medicine (WM). Firstly, TCM is constructed as advantageous over WM in terms of its "cultural legacy", "holistic approach", and "effectiveness". In this way, participants support the legitimacy of TCM use. Secondly, TCM is constructed as disadvantageous compared to WM in terms of its "treatment limitations" and "untrustworthiness", which leads participants to reserve their decisions about using TCM. Thirdly, based on their understanding of TCM and WM, participants construct TCM use as equal in status to WM use. The following analysis presents how participants construct TCM in these three ways. Also, in the end the analysis shows

how the notion of balance in TCM is used to construct ways of being and seeing for the participants.

4.2.1 Constructing TCM to legitimise its use

In western countries, TCM is practised as an alternative to WM. This is in contrast to its legitimate status as an orthodox medicine alongside WM in China. Because participants have experience of TCM both in China and in New Zealand, they construct TCM as equally legitimate to WM. The legitimacy of TCM use in New Zealand is claimed in three ways. Firstly, TCM is constructed as a cultural legacy. Secondly, TCM is constructed as a holistic approach to illness. Thirdly, TCM is constructed as effective in preventing and treating certain conditions.

4.2.1.1 TCM as cultural legacy

TCM is generally described in the literature as derived from the Chinese philosophy of Taoism and is valued as a representative for traditional Chinese culture (Chen & Swartzman, 2001; Kastner, 2004; Quah, 2003; Williams, 1996). It becomes almost impossible to find any articles on TCM that do not mention its long history and cultural meanings. This indicates that the cultural aspect of TCM has become one of the dominant discourses for TCM. Participants' accounts demonstrate how they draw on the "cultural legacy" discourse to interpret TCM as holding more cultural meanings than WM does. This is illustrated in the following.

Extract 1

Mr Wu (43 years old, resident for 9 years, TCM practitioner)

"*Zhong yi*¹³ (中医) is associated with Taoism in traditional Chinese culture. It is passed down from the many generations. If you explain to Chinese patients the symptoms described in *zhong yi*, it is very easy for them to understand. But when you explain it to white European patients, they won't understand it. That is because they don't have the cultural background."

Extract 2

Ms Feng (28 years old, resident for 4 years)

"As far as I know, western medicine has developed comparatively recently. It only has a history of a couple of hundred years. Is that right? (Interviewer: "Perhaps so.") But *zhong yi* is passed down from ancient times. I feel *zhong yi* is like a system of self-

¹³ *Zhong yi* (中医) means Chinese medicine when translated into English literally. It is equivalent to traditional Chinese medicine (TCM) as known in western countries.

protection. I guess people in ancient times were looking for ways to protect themselves because the living conditions were very harsh. That's probably why they have developed such a detailed knowledge system to protect themselves over a long period of time. I heard African people also have their own herbal medicine. So every culture has its own concepts of medicine. It is something accumulated over time."

Extract 3

Mr Wang (72 years old, resident for 13 years)

"Western doctors could not master *zhong yi* if they didn't grow up in China, because it would become extremely difficult for them to understand *zhong yi* without the cultural background. After all, *zhong yi* is handed down from thousands of years ago. But *zhong yi* practitioners can easily learn western medicine because the scientific technology is so advanced now that it is easy for them (TCM practitioners) to catch up with western medical knowledge."

The talk about TCM is surrounded by its historical and cultural background, such as "associated with the philosophy of Taoism", and "handed down from thousands of years ago", "a part of Chinese culture". Participants understand TCM as a shared cultural understanding exclusive to Chinese people. In extract 1, Mr Wu speaks of his experience about how his Chinese clients and western clients differ in understanding TCM. In extract 2, Ms Feng compares TCM and WM in terms of their length of history, and thus claims the authenticity of TCM as a system of healing. She further points out medical knowledge is culturally specific by drawing upon healing systems practiced in other cultures ("African people also have their own herbal medicine"). Further, in extract 3 Mr Wang argues that the cultural background of TCM is necessary to comprehend TCM, whereas this is not necessary to understand WM. All these indicate that participants comprehend TCM as attached to culture (e.g. "long history of Chinese culture" and "Taoism philosophy"), which WM appears to lack. In this way, TCM is seen as carrying more cultural meanings than WM. By constructing TCM and WM against the backdrop of cultural legacy, participants put TCM in a favourable position against WM.

4.2.1.2 TCM as holistic

In western culture alternative medicine is generally viewed as taking a holistic approach to disease and illness (Crossley, 2000). The claim of "holism" by alternative medicine is regarded as one of the main reasons that attracts people to use alternative medicine in western countries, and facilitates its distinction from orthodox WM (Crossley, 2000; Hardey, 1998). It is evident that participants draw on the "holistic"

discourse of alternative medicine to construct TCM's legitimacy. There are three ways that the "holistic" discourse is used to discuss TCM as a more favourable approach than WM.

Firstly, participants talk about their preference to see the body as a whole rather than as made up of separate parts. Within this context, TCM is understood as dealing with the body as a whole, whereas WM is viewed as targeting separate parts of the body in disease diagnosis and treatment.

Extract 4

Ms Sun (43 years old, resident for 3 years)

"Zhong yi sees the body as a whole and treats the whole body. For example, if you had headache, they won't just treat your head. The acupuncturist will put needles in many parts of your body. For another example, if you have sore feet, it may not be the problem of feet at all. Feet are connected to many parts of the body. There may be something wrong with the liver. Western doctors are not that thoughtful, and they just prescribe painkillers to you, like Panadol. But Panadol is only capable of relieving the pain for a few hours."

In traditional Chinese knowledge the body is viewed as consisting of *qi* which flows to all parts of body, and illness is seen as a process of disharmony that needs alleviating. Accordingly, the treatments of TCM seek to re-establish harmony for each individual with his or her unique environment (Williams, 1996). The extract above illustrates that participants view TCM as diagnosing "the body as a whole" and "treats the body as a whole", whereas WM is seen as only targeting symptoms because western doctors "just prescribe Panadol" and "Panadol only relieves the pain for a few hours". The statement that "western doctors are not that thoughtful" indicates that participants understand the "holistic" approach in TCM as better than the "symptom targeting" approach in WM. By drawing on the traditional Chinese notion of illness, participants understand TCM as diagnosing and treating illness in a holistic and dynamic way. On the contrary, in western medical knowledge, diseases are seen as "machinery breakdown" that requires fixing, and thus WM treatments focus on how to fix the broken parts. In this way, WM treatment is understood as only targeting symptoms. From the above, it is clear that participants draw on the 'holistic' discourse to construct TCM as the more appropriate way to approach the body and treat illness than WM does.

Secondly, the talk of “holism” is reflected in the understanding of the relationship between the body and mind. Participants construct TCM as seeing and treating the body and mind as a whole, whereas WM is viewed as neglecting the mind.

Extract 5

Ms Xu (38 years old, resident for 8 years)

“I find that good *zhong yi* practitioners are usually people who are easy to talk to. They are very understanding and have empathy towards patients. They chat with the patients. That’s why elderly people prefer to see *zhong yi* practitioners. For example, when an elderly woman goes to see a *zhong yi* practitioner with an upset stomach, the *zhong yi* practitioner will usually chat with her, and may ask her whether she had argued with her daughter-in-law recently. Then the patient will probably answer ‘yes’, and then start telling the *zhong yi* practitioner about her family problems. Afterwards, the patient’s symptoms will probably disappear. However, if the woman went to see a western doctor, she would probably just get some prescriptions or be asked to get a gastroscopy. I think a good medical practitioner should look into the psychological factors as well.”

In traditional Chinese knowledge, the body and mind are considered inseparable (Jia et al., 2004). Accordingly, the diagnosis and treatment of TCM take into account physical symptoms, emotional reactions, as well as social and environmental factors (Williams, 1996, Koo, 1987). By contrast, western scientific knowledge is generally regarded as holding a dualistic view of the body and mind, and thus WM treatment is seen to focus on physical aspects rather than on the whole experience of individual patients (Crossley, 2000; Hardey, 1998; Williams, 1996). Also, as Hardey (1998) points out, the construction of alternative medicine as “holistic” in western culture is used to criticize the dualism of the body and mind in biomedicine. The extract above illustrates that participants view TCM practitioners as attending to both physical and psychological aspects of a disease, whereas western medical doctors are seen as neglecting the psychological aspect of a disease. By drawing upon the constructions of TCM (as “holistic”) and WM (as “dualistic”) in western culture to comprehend the treatment differences between TCM and WM, participants once again put TCM in an advantageous position over WM.

Thirdly, participants draw on the “holistic” discourse to construct TCM as embodying a close relationship between human beings and nature, while WM is seen as alienated from nature. As a result, TCM is understood as natural healing, which offers a

safer and non-intrusive treatment in comparison with WM. This is shown in the following extracts.

Extract 6

Mr Liu (37 years old, resident for 2 years, TCM practitioner)

“*Zhong yi* is close to nature. The herbals used in *zhong yi* are taken from the natural world, and returned to human beings as a part of nature. I don’t know much about the history of *xi yi*¹⁴(西医). I guess *xi yi* was perhaps close to nature before. But with the development of anatomy, *xi yi* becomes more and more thorough and then walks away from nature. The more western medicines are invented, the more diseases humans are getting. I think *xi yi* is heading a wrong direction. I prefer *zhong yi*, especially after migrating to New Zealand. While I was working as a *zhong yi* practitioner in China, I was regarded as a medical professional and was called a doctor, and I could prescribe western medicine to treat problems like gastritis. But here I am called an acupuncturist, and I am not even entitled to prescribe a medical examination. So I have to use the natural way to treat patients. But it works very well. I think the natural way to treat disease is even better.”

Extract 7

Ms Li (35 years old, resident for 5 years)

“I think Chinese medicine is gentler than western medicine. Chinese medicine probably doesn’t produce side effects but western medicine definitely will produce side effects although it works fast.”

“What kind of side effects do you think western medicine will produce?” (Interviewer)

“For example, if you have an infection, you can take antibiotics to kill the virus. But the body will become resistant to the antibiotics. So next time when you take the same antibiotics it won’t work well and you have to take more powerful ones. However, what can you do if you are seriously ill while you have already used the strongest antibiotic available? So I think the best way to deal with illness is to balance the body in a natural way in the first place. *Zhong yi* can help balance the body. When your body can’t cope any more, then you use western medicine.”

It is noted that in western culture, humans are seen as different, or separate from nature (Yoon, 1992, cited in MacGreor-Reid, 2001). Nature is regarded as a constraint to the advance of human society; therefore the developments in human society (such as the development of medicine) are viewed as working to change the progress of nature. In western culture, western medicine (WM) is predominantly understood as a tool to fight diseases that are considered as originating from the nature environment (such as bacteria and virus). Instead, in traditional Chinese culture human beings are understood as a part of nature and thus are supposed to live in harmony with nature. Also, things taken from nature (e.g., “herbals”) are held as inseparable from the human body, and therefore are better able to restore the balance in the body and cure diseases (Jia et al.,

¹⁴ *Xi yi* (西医) means western medicine translated into English literally.

2004). The extracts above illustrate that participants draw on traditional Chinese understanding (which emphasizes the harmony between humans and nature) to support the use of TCM while disputing the use of WM (e.g., “The more western medicines are invented, the more diseases humans are getting”). By constructing TCM and WM in relation to the natural world, participants demonstrate the value of TCM over WM.

In addition, the ‘natural’ discourse of alternative medicine has been pointed out as a manifestation of the growing aversion to WM in western culture with regard to its intrusive approach (e.g. surgery) to the body (MacGregor-Reid, 2001). It also becomes one of the main reasons that attract people to use alternative medicine because it is considered as ‘natural’ and thus gentler and less intrusive to the body. Participants’ accounts show that they draw upon this “natural” discourse of alternative medicine to construct TCM treatments as “gentler” and less likely to produce “side effects” compared to WM. In doing so, they support the use of TCM over WM.

4.2.1.3 TCM as effective

In western societies, it is commonly noted that WM offers less of a solution for chronic illness than acute illness (Helman, 2001). This leads to an increasing suspicion towards the effectiveness of WM in treating certain conditions. However, TCM is becoming popular in western countries for its treatment success, such as acupuncture. Another way that participants argue for the legitimacy of TCM is through its claim in effectiveness. There are three ways that participants speak of the effectiveness of TCM. Firstly, TCM is perceived as more effective than WM for certain conditions. This is exemplified in the following extracts.

Extract 8

Mr Qian (38 years old, resident for 18 years)

“*Zhong yi* can regulate the body. If I have chronic illness or muscular pain, I will go to see a *zhong yi* practitioner. And if it is a problem which can not be cured just by taking western medicine for a few days, I think *zhong yi* will be more suitable.”

Extract 9

Mr Ren (75 years old, resident for 4 years)

“*Zhong yi* can cure the root of diseases, but *xi yi* can only treat the symptoms. If you have a bad headache or a fever, and you take some western medicine, the symptoms will go away very quickly. But a headache may indicate something wrong in other

parts of the body. I think *zhong yi* can solve the problem from the root, but *xi yi* is not that effective.”

Extract 10

Ms Feng (28 years old, resident for 4 years)

“I think *zhong yi* is more effective than *xi yi* sometimes. I sprained my ankle a while ago and went to see a western doctor. He just put an ice bag on my foot and bandaged it. They didn’t offer me any other treatments. When I got home, I used some Chinese herbal oil to massage my foot, and felt much better. I think *zhong yi* is much better in these aspects. Also I saw a traditional Chinese medicine practitioner before for my endocrinopathy problem, because western doctor can only treat you using hormone. But *zhong yi* is about regulating the body. I had some herbal medicine and it cured my problem. I felt *zhong yi* is magical.”

... ..

“If I had just a cold or got a fever, I would go to see a family doctor because I think western medicine can easily handle it, like taking a Panadol. But if it was a chronic condition that *xi yi* cannot solve, I will turn to *zhong yi*. You know, sometimes western doctors are not sure what exactly is your problem, and there are a lot of diseases that they don’t know yet themselves.”

Chronic illness is the most frequently mentioned area where participants consider TCM as being more effective than WM. This is also the case in previous studies (Koo, 1987; Prior et al., 2000). The plague of chronic illness in western societies and the lack of effectiveness of WM in treating chronic illness are believed to drive people to seek alternative medicine. Also, participants’ accounts show that they explain the effectiveness of TCM by claiming that TCM is able to “cure the root”, whereas WM is seen as only touching the symptoms of the diseases. The study of Chun and Chesla (2004) also found that Chinese Americans with type 2 diabetes and their spouses speak of TCM as able to cure the underlying causes of an illness whereas WM as only ameliorating the symptoms, although WM is recognized for its rapid effectiveness. This can be understood taking into account that the diagnosis in TCM often sees the symptoms as connected to the inner organs, and the organs are viewed as where the real problems exists (Williams, 1996). In this way, participants claim TCM treatment as more effective than WM (e.g., “I think *zhong yi* can solve the problem from the root, but *xi yi* is not that effective”).

Secondly, the “effectiveness” of TCM is related to its function in disease prevention. Participants understand the main role of TCM is to prevent illness from occurring. This is exemplified in the following extract.

Extract 11

Ms Zhang (33 years old, resident for 3 and a half years)

“I believe *zhong yi* can cure diseases, although many people may complain that it does not work as fast as *xi yi*. I increasingly comprehend that *zhong yi* actually is to regulate the body. When you have mild symptoms, *zhong yi* can regulate your body and make it balanced, thus preventing the symptoms from developing into serious diseases.”

In traditional Chinese culture, the role of medicine is emphasized according to its preventive function (Kastner, 2004). Traditionally, the fewer patients a TCM practitioner has or the less frequently a patient goes to see him, the more the TCM practitioner will get paid and the more reputation he will get. This is because people believe that a good TCM practitioner should cure the diseases and thus patients do not need to go back to see him frequently. In the literature of TCM, the notion of TCM as preventive for illness is often taken to criticise WM, which is mainly viewed as treatments in the face of diseases (MacGregor-Reid, 2001; Williams, 1996). The extract above clearly shows that participants draw upon the preventive notion of TCM to justify their TCM use. TCM is talked about as able to prevent ‘Chinese diseases’ (‘imbalance’ or ‘disharmony’) from developing in the first place through ‘regulating the body’. Because participants also view ‘Chinese diseases’ as the precedent of ‘western diseases’ (as shown in extract 19 in Part One of the analysis), participants claim that TCM are able to prevent ‘western diseases’. Therefore, by focusing on TCM’s preventive function, participants claim the effectiveness of TCM for both ‘Chinese diseases’ and ‘western diseases’. In contrast, WM is seen as ineffectiveness for ‘Chinese diseases’. In this way, TCM is compared favourably against WM.

Thirdly, participants state that TCM can provide diagnosis and treatment for conditions that WM is seen as not able to solve at all.

Extract 12

Mr Liu (37 years old, resident for 2 years, TCM practitioner)

“If you have a sore stomach but the medical examination shows that you have no inflammation or ulcer in your stomach, then you are in the sub-health condition. Acupuncture is a good option for this condition. It can regulate *yin* and *yang*, and thus balance your body. Many people are actually in the sub-health condition when they don’t feel right but can not be diagnosed by western medicine either.”

Extract 13

Ms Xu (38 years old, resident for 8 years)

“*Zhong yi* does have its advantages compared with *xi yi*, like treating the ‘sub-health’ condition. Many people are in the ‘sub-health’ condition. It is when you feel uncomfortable but the medical checks show nothing wrong with your body. If you go to see a western doctor, he will tell that you are fine if the medical examinations can’t show anything wrong. But a *zhong yi* practitioner will tell you what’s wrong with you and help you to regulate your body. You will feel better afterwards.”

Participants speak of the “sub-health” condition as something that WM cannot diagnose (e.g., “medical examinations will show nothing wrong with your body”) and therefore cannot offer treatment. Participants describe the “sub-health” condition as manifesting *yin* and *yang* imbalance in the body, which demonstrates that they draw on traditional Chinese knowledge to construct illness, and thus the “sub-health” can be understood as a ‘Chinese disease’. In doing so, participants compare WM unfavourably with TCM in terms of treatment efficacy because only TCM describes the treatment for *yin* and *yang* imbalance. In addition, it is worth noting that in western culture the view of mind/body separation leads to diseases falling into two distinct parts: the physical part (the body) and mental part (the mind). WM treatment is generally seen as more ambiguous for mental illnesses than for physical diseases. The “sub-health” condition that participants describe may predominantly be seen as manifesting a mental illness in western culture, for which WM is considered as offering less viable treatments. It is within this context that participants speak of WM as less effective for the “sub-health” condition. However, because participants use the notion of TCM (*yin/yang* imbalance) to understand the “sub-health” condition, they argue for the effectiveness of TCM over WM, although they agree that WM is effective for treating physical problems (e.g., the talk of “medical examinations” can show whether “you have inflammation or ulcer in the stomach” but not for the “sub-health” conditions).

Further, TCM is constructed as a healing system treating not only physical but also mental problems, when participants understand the “sub-health” condition as a mental illness. The following extract shows how a participant draws on this construction to prove TCM’s effectiveness.

Extract 14

Mr Wu (42 years old, resident for 9 years, TCM practitioner)

“The treatment in *zhong yi* takes consideration of the effect of emotions on body. Therefore, *zhong yi* can be used to treat mental illnesses, such as depression. *Zhong yi* regulates the functions of organs. I have used the combination of acupuncture and massage to treat many patients with depression in my clinic. The treatment outcome is very good.”

In traditional Chinese knowledge, there is no concept of a diseased mind. Disease and illness are understood as only existing in the physical body. The mind is understood as manifested in emotions, which are seen as the causal factor for diseases rather than being a part of diseases (Bond, 1996). Accordingly, there is no such understanding of “mental illness”, and TCM as a healing system focuses on the physical body. The above extract indicates that TCM is seen as functioning as a psychological remedy despite the fact that, the way in which TCM treats psychological problems is acknowledged in a traditional Chinese way (“*Zhong yi* regulates the functions of the organs”). By using the concept of “mental illness” (e.g., “depression”), participants claim TCM’s efficacy for “mental illness”. It is noticed that the construction of TCM as both effective for physical and mental illnesses accords with the construction of TCM as seeing the mind and body from a holistic approach. In this way, participants once again put TCM in a favourable position over WM through constructing TCM as having psychological healing power that WM lacks.

4.2.2 Constructing TCM to limit its use in New Zealand

So far, the analysis has shown that the participants construct TCM as having advantages over WM in many aspects. However, their accounts also indicate that they understand TCM as limited in comparison to WM in certain ways. Firstly, with respect to treatment efficacy, TCM is constructed as inferior to WM for certain conditions. Secondly, TCM is constructed as untrustworthy compared with WM in terms of reliability. This includes two aspects: one is that TCM lacks the scientific support that WM has; the other is that the practice of TCM in New Zealand lacks the formality and regulation that WM has. The following analysis shows how the participants express their reservation about TCM use in New Zealand.

4.2.2.1 TCM as second-rate

Although TCM is understood as more effective than WM for certain conditions (such as chronic illness, muscular pain, and sprain), participants also view TCM as slow to take effect, and lacking in effectiveness for certain conditions (such as acute illness or conditions that need surgery) in comparison with WM. This is illustrated in the following extracts.

Extract 15

Mr Qian (38 years old, resident for 18 years)

“For acute diseases, I will definitely go to see a western doctor. *Xi yi* works fast to relieve pain, while *zhong yi* takes a while to take effect.”

Extract 16

Mr Liu (37 years old, resident for 2 years, TCM practitioner)

“If a patient has a stomach tumour, I can use the practices of *zhong yi*, like acupuncture to make the patient feel better. But the tumour will still be there and may grow as well. *Xi yi* can operate the surgery to remove the tumour and solve the problem, but *zhong yi* can't do that. It doesn't have the operation technique. So *zhong yi* needs the help of *xi yi*.”

Extract 17

Ms Li (35 years old, resident for 5 years)

“I think *zhong yi* only helps to regulate the body. I don't believe it can cure diseases, because Chinese herbal medicine can't resist the invasion of viruses. Many viruses can only be treated by *xi yi*.”

The understanding of WM as better than TCM for acute diseases, which is also observed in other studies (Ma, 1999; Prior et al., 2000), appears to dominate in the participants' accounts of the advantages of WM. It works to explain their preference for WM over TCM for certain conditions. As illustrated in extract 15, pain relief seems to be the main reason that participants speak of when choosing WM in the first place. Although TCM is praised for its effectiveness for chronic illness, this is downplayed when considering the time needed to prepare the TCM and for it to take effect (Chun & Chesla, 2004). In addition, the lack of new developments in disease diagnosis and treatment in TCM is also mentioned as holding it back (extract 16). In Extract 17 the participant understands diseases in relation to “invasion of viruses” or “bacteria”. This shows that western biomedical knowledge is drawn upon here to explain the causation

of diseases because these terms are only to be found in western biomedicine rather than in TCM. In this way, WM is compared more favourably than TCM.

4.2.2.2 TCM as untrustworthy

Another way that participants talk of TCM as being less favourable than WM is by constructing TCM as less legitimate, and even as untrustworthy. This is demonstrated in two ways. Firstly, TCM is constructed as lacking in scientific support in contrast to WM. WM is viewed as built on scientific knowledge, whereas TCM is seen as not being proved by scientific knowledge. This is illustrated in the following extracts.

Extract 18

Ms Xu (38 years old, resident for 8 years)

“The reason why *xi yi* becomes so prevalent now is because it has science to support it all along. It is tangible and seeable. Although *zhong yi* has thousand years of history and profound knowledge, it is still not widely accepted. Why? The reason is that it doesn't have science to support it, and therefore people don't trust it. ”

Extract 19

Mr Wu (72 years old, resident for 13 years)

“*Zhong yi* approaches individuals. For different individuals the treatment is different. You can use a treatment to cure one patient, but not necessarily the next one. It is not easy to repeat the same result and thus people are sceptical about its reliability. It is also the reason why it is so hard for *zhong yi* to prevail here. It is not like *xi yi* here. For a specific treatment, *xi yi* has to prove how many patients have ever used it, and how many successful cases it has, and so on. Otherwise the doctor will get into trouble. As a result, the treatments here are very conservative. However in China, as long as you can cure the patient, you can use any treatments whether it be *zhong yi* or *xi yi*.”

The extracts above illustrate the notions that TCM is an individualized remedy and the practices of TCM “gives priority to the identification of the unique features of a patient's ailment over the similarities that the case may share with others” (Quah, 2003, p. 2002). On the other hand, participants' accounts show that they understand WM is supported by clinical trials that adopt the tenet of validity within western scientific knowledge. As Quah (2003) argues, the criterion of reliability, as the feature of western scientific knowledge, is endorsed by WM but not by TCM. Therefore, by constructing TCM against WM in light of reliability, participants point out the inferior status of TCM compared to WM in western culture. This is illustrated in their accounts about how the regulation of medical practice in New Zealand operates to subjugate TCM to

WM. For example, the participant (in extract 19) talks about how a western doctor must inform “how many patients have ever used it (a treatment), and how many successful cases it has”, otherwise “the doctor will get into trouble”. However, because TCM does not follow the tenet of WM, it cannot “prevail” here. Participants’ concern for TCM’s credibility manifests the dominant voice in western society, requiring TCM to prove its efficacy in the same way as WM does in order to gain legitimacy (Quah, 2003). Additionally, as mentioned in chapter two, TCM treatments (except acupuncture) are not subsidized like biomedical treatment by the New Zealand government (MacGregor-Reid, 2001). This may also be a contributing negative factor in New Zealand.

Secondly, participants construct TCM as untrustworthy through pointing out the lack of formality in TCM practice in New Zealand. This is exemplified in the following extracts.

Extract 20

Ms Feng (28 years old, resident for 4 years)

“For my daughter (8 months old), I want her to use western medicine because she was born here and will grow up here. *Zhong yi* practiced in New Zealand is not like that in China. There are hospitals specialized in *zhong yi* there. And you know which doctor is an expert and whether he or she graduated from a medical school specialized in *zhong yi*. While over here there are few *zhong yi* practitioners, and I feel their practice is not that formal.”

Extract 21

Ms Sun (43 years old, resident for 3 years)

“I hear that it is very easy to set up a *zhong yi* clinic here. Almost anybody can do that. So many of the practitioners are probably not qualified. I am scared to go to see a *zhong yi* practitioner here.”

Participants describe TCM practiced in New Zealand as not as formal and strict as those in China. They mention that in China TCM practitioners are trained in medical schools, and there TCM is practiced in the same way as WM. Participants’ accounts show that they trust the way that WM is practiced (e.g., “in hospitals”) and also suggest WM is the dominant healing system in both New Zealand and China¹⁵. However, it is within the context of New Zealand that participants express their doubt about the

¹⁵ In China, WM is more prevalent than TCM although TCM is promoted as being as legitimate as WM by the government.

quality of TCM and their reluctance to go to see a TCM practitioner. This is because in New Zealand the subjugated status of TCM to WM precludes TCM practitioners from practicing in the same way as WM practitioners. Also, there is no formal regulation for TCM to control the quality of its practitioners as WM does. Therefore, participants consider TCM as untrustworthy.

4.2.3 Constructing a balance between TCM use and WM use

The practice of TCM as alternative to WM in New Zealand creates conflicts for participants. This is because, on the one hand, according to their traditional Chinese understanding of illness, the healing process should at least partly adopt TCM (e.g., for illness which requires “regulating the body”). However, this is not the case in New Zealand where WM dominates the treatment of illness. Meanwhile, the unequal relation between TCM and WM in New Zealand may be regarded as a violation of the notion of ‘balance’, because according to traditional Chinese knowledge everything in the universe, including TCM and WM, should be in a balanced relationship with each other.

The above analysis (4.2.1) shows how participants have looked upon TCM favourably compared to WM to resist the inferior status of TCM. Further more, the analysis shows that participants call for an equal relationship between TCM and WM. This is exemplified in the following extract, which shows participants’ understanding of how TCM and WM should be practiced in New Zealand.

Extract 22

Mr Wang (72 years old, resident for 13 years)

“I hope *zhong xi* and *xi yi* are combined, because each has its own advantages. Some diseases, such as appendicitis, *zhong xi* doesn’t work as fast as *xi yi*. Tuberculosis was regarded as an incurable disease before. I suffered from tuberculosis once, but I was cured after taking antibiotics. However, when you encounter an illness that needs regulation of the body, *zhong yi* can regulate it, whereas *xi yi* cannot do much about it. Therefore, I think *zhong yi* and *xi yi* each has its strong points. Human beings will benefit more from this medicine if they combine the two.”

The extract above illustrates that participants argue for an equal relationship between TCM and WM as healing systems to treat illnesses by stating that TCM and WM each has “its strong points”. Their argument is not only used to claim the legitimacy of using TCM in New Zealand, but also to resist the dominant view in

western culture that WM is more legitimate than other healing systems. The notion of balance is clearly shown in that participants do not want to throw out either but rather to hold on to both.

4.2.4 The construction of selves in relation to TCM use: “balance is the way of being”

The analysis indicates that participants also use the notion of “balance” in TCM to understand themselves. This is shown in the following extract.

Extract 23

Ms Xu (38 years old, resident for 8 years)

“*Zhong yi* has many good concepts, like *yin/yang* balance. If your body is not balanced, you will become ill. The idea of balance can be applied to life as well. Life is about balance. *Yin* and *yang* represent two sides of forces. They constrain each other, just like the relationship between China and the United States at the moment. Therefore it can apply to both an individual person and the whole universe. I think *zhong yi* is more like a philosophy.”

In traditional Chinese culture, the notion of “balance” is seen not only as a way to maintain health but also a way of living and seeing the world. TCM as a healing system is understood as embodying the notion of “balance” in diagnosing and treating illness. The extract above shows that participants talk of TCM in terms of “*yin/yang* balance”; also they draw on the notion of “balance” in TCM to speak of the “body” (e.g., “your body is not balanced”), “life” (e.g., “life is about balance”) and politics (e.g., “the relationship between China and the United States”). This is further illustrated in extract 23 where the participant describes TCM as “more like a philosophy”. Therefore, TCM is seen as offering a way-of-being and way-of-seeing the world for Chinese people.

In addition, it is evident that through their understandings of TCM as “a cultural legacy”, “a holistic approach”, and “an effective treatment”, participants draw on traditional Chinese knowledge to understand the causation, progression and treatment of ‘Chinese illness’ (“imbalance of *yin/yang*”) for a ‘Chinese body’ (“a flow of *qi*”). The notion of the importance of “balance” in TCM practice (with respect to illness diagnosis and treatment) is prevalent in their accounts. This suggests that traditional Chinese knowledge constructs TCM as a healing system to diagnose and treat diseases for “a

Chinese body”. In other words, the notion of “balance” in TCM is used to position participants as traditional Chinese people. Participants understand themselves as Chinese individuals through understanding their body as ‘a Chinese body’ and through understanding how TCM diagnose and treat ‘a diseased Chinese body’. In this way, participants’ use of TCM can be regarded as practicing a traditional Chinese way of being. Being a Chinese person, they support the use of TCM as an appropriate healing system for illness. This explains why they expect TCM to be practiced as legitimately as WM in New Zealand (just as in China).

4.3 Summary

Overall, participants’ accounts illustrate the dominant discourses surrounding food, health (illness), and healing systems in modern western culture and traditional Chinese culture. As migrants to western society, Chinese participants are exposed to both western scientific knowledge and traditional Chinese knowledge. As a result, they are able to draw upon discursive resources available in both cultures to understand health and illness. More importantly, participants negotiate the two different forms of knowledge to make sense of their dietary practices and use of healing systems in New Zealand. Their statements show they support the mixed dietary practices of Chinese food and western food, and also the mixed use of traditional Chinese medicine and western medicine. This suggests that the notion of “balance” underlies their understanding of health and illness, and thus shapes their dietary practices and use of healing systems. Also it works to resist the prevailing notion in western culture, in which western scientific knowledge is taken as superior to all other forms of knowledge in understanding how food is related to health and illness, and western medicine (shaped by western scientific knowledge) as the better healing system to diagnose and treat illness than all the other healing systems (alternative medicine).

Further, the notion of “balance” -- the traditional way of being and seeing the world for Chinese people, offers participants a position to understand themselves as able to hold a balance between two cultures in a new society. Despite the fact that Chinese migrants position themselves unfavorably against the dominant group in society with respect to health and illness, the alternative position available within traditional Chinese knowledge offers them possibilities to take up positions that are

empowering. The emphasis on “balance” in traditional Chinese culture seems to do justice to, and help them make sense of, their health-related practices (diet and use of healing systems) in a different culture. It enables participants to cope with the dual task of maintaining Chinese identity (tradition) on the one hand, and adjusting to a new culture and society on the other hand. In all, the analysis implies that participants practice a traditional Chinese way of being -- living a harmonious and balanced life with their social and natural environments, in regard to health and illness within a new social context.

CHAPTER 5: Discussion

Reflexivity has been pointed up as a crucial part of critical qualitative research in psychology (Burr, 2003; Chamberlain, 2004b; Parker, 2005; Willig, 2001). It makes the researcher(s) visible in the production of the research, making the assumption that the researcher(s) are by no means separate from the research in every aspect (from the shaping of research, the research process, to the use of the research outcomes). This is in contrast to the way they are positioned in traditional positivist laboratory-experimental models of research in psychology (Burr, 2003). Informed by the above authors, in this chapter I reflect upon my research from several aspects. First, I review my analysis in terms of discourse, subjectivity and cultural context. I link it back to the existing qualitative research on health and illness and point out how my research has contributed to these issues. Second, I examine the research approach to my study. Here I draw attention to the problems that arise in Foucauldian discourse analysis as a methodological framework. Third, I look into how my values, and experiences have shaped the research. Particularly I discuss how the ways that I position myself in relation to the participants have shaped the research process (data collection and analysis). Fourth, I discuss the implications of this research in terms of the representation of the research findings and health promotion programs for migrants from non-western cultures in New Zealand. Questions are raised about how best to promote the health of ethnic minority groups in New Zealand. Fifth, I point to the possible future for discourse analytic research in studying the health and illness of migrants from an ethnic minority background in terms of both the research topic and the research approach. Finally, I offer conclusions from this research.

5.1 Review of the Analysis

5.1.1 Discourse as social bond

Parker (2005, p.88-99) suggests that discourse produces certain kind of “social bond” and “each bond includes certain kinds of people and excludes others”. He further argues that the understanding of discourse as a social bond can help us to examine the ideological effect of discourse by means of exploring the way that some discourse oppresses certain social groups through the power relations it produces discursively. In

my view, in existing discourse analytic research on health and illness, the power effect of discourse largely remains unexamined. This includes both the power relations facilitated (or limited) during the interaction of discourses, and the ways that participants exercise power discursively. In this sense, Parker's (2005) notion that discourse can produce social bonds helps shift attention away from the over-emphasis on language in discourse analytic research; instead bring attention to the power issues in discursive practices. Research can explore how patterns of discourses in western society put people into certain social groups (such as working-class families, and ethnic minority groups), and position them as different from the others in society through examining the ways unequal power relations are produced and how people exercise power discursively.

My research shows that the discourses around health and illness that participants draw upon divide their understandings and practices of food and healing systems into two categories, "traditional Chinese" and "modern western". Meanwhile, the interaction of discourses (e.g., the discourses of traditional Chinese knowledge, western scientific knowledge, and the white supremacy) differentiates the participants ("Chinese people") from "others" ("white European people") as a social group. It also allows participants to form a relationship with "others" in terms of the body and health (e.g., "we are inferior to them with respect to the body and health"). Accordingly, in my research the participants' talk of their "inferiority" to "others" demonstrates how the interaction of the dominant discourses (western scientific knowledge and white supremacy) functions to enhance the unequal power relations between social groups in western culture.

Further, the way that participants make sense of food and the healing system (TCM) in a traditional Chinese way shows that they resist being positioned as "inferior" through constructing their social practices of health and illness by means of traditional Chinese knowledge, and also through constructing themselves as a social group ("Chinese people") that is different from "others". This suggests that participants exercise power discursively to resist taking up the positions available for them in the dominant discourses in western society.

5.1.2 Subjectivity revisited

It has been noted that the 'body' is missing in most qualitative research on health and illness (Burr, 2003; Stam, 1998; Willig, 2000). It has been noted that social constructionist health research should draw attention to the meanings of "being a body" in order to understand how health and illness are constructed, and how "this is reflected in our subjective experience of these bodies" (Willig, 2000, p. 559). My research shows that an understanding of the body is essential to understanding health and illness for the participants. Traditional Chinese knowledge elucidates what the body is (e.g., the body is the flow of *qi*) and how a person's body becomes healthy or sick (e.g., natural and social factors influence the balance of *qi*). Traditional Chinese knowledge constructs a person as one with 'a Chinese body', and the way that participants understand their identity is through their experience of the body ("Chinese people's body is inferior"). Therefore, my research suggests the importance of embodied meanings with respect to the experience of health and illness.

In addition, it is noted that we need to address the role that others play in the understanding of selves when approaching subjectivity (Drewery, 2005). As Drewery (2005) suggests, the 'relationship' is the primary way of being and seeing the world for cultural groups who do not adopt the dominant individualistic view of selfhood in western culture. In my opinion, Drewery's notion of a relational subjectivity may offer an approach to explore collective subjectivities, particularly for collectivistic cultural groups. My research illustrates that participants understand themselves through experiencing the bodily differences between themselves ("Chinese people") and others ("white European people"). This suggests a relational subjectivity, an understanding of selves in relation to others for Chinese participants. Also, it is noted in my research that traditional Chinese culture is collectivistic oriented, which emphasizes "others" in explaining health and illness. Therefore, according to Drewery, Chinese people may experience a relational subjectivity. This is demonstrated in my research through how participants construct themselves (Chinese people) in relation to the dominant group (the white people) in New Zealand society with respect to health and illness.

Meanwhile, as many critics point out (e.g., Bhatia & Stam, 2005), mainstream psychology tends to hold an essentialist view of 'self', in which 'self' is seen as having an essence that is universal and isolated from the influences of power, class, gender, etc.

In contrast, critical psychology challenges the view of an essential 'self' and proposes that the experiences of gender, class, race, colonization, etc, all shape our understanding of 'self' (Bhatia & Stam, 2005). From a discursive perspective, I agree that we should embed the exploration of subjectivity (e.g., 'identity' and 'self') in the broader social contexts (e.g., gender, class, race, and colonization) in order to understand how the subjective experiences of people are discursively constructed in their accounts surrounding these issues. My analysis shows how participants talk about their experiences of health and illness with reference to race. Also participants' understanding of themselves is surrounded by the talk of 'race differences' (e.g., "we are of different races, so our body and health are different from them"). This indicates that the experiences of race in a racialized society shape their discursively constructed 'self'. More importantly, their construction of 'self' in relation to race in a new social context suggests that the traditional understanding of 'self' in mainstream psychology is problematic.

5.1.3 Attend to culture

It has been pointed out that in mainstream health psychology, culture remains mainly as a 'variable', measured and interpreted according to statistical analysis from a positivist and quantitative approach, despite the fact that the 'culture' factor has drawn more and more attention (Bhatia & Stam, 2005). By contrast, most qualitative health research is moving away from measurement and quantification, and instead is being devoted to understanding the experience of health and illness. However, the cultural and social contexts of the experience are often neglected in their interpretations. Here I argue that this is because most research has focused on the dominant group in the western society whilst culture is commonly viewed as a thing that is held by migrants and minority groups not by the dominant group (e.g., one has often heard that Pakeha New Zealanders speak of not having their own culture as Maori people do). This can explain why health research on minority groups often draws attention to cultural issues (e.g., Jovchelovitch & Gervais, 1999; Satia et al., 2002; Satia et al., 2000) whereas research on the dominant group (the white people) in western society often fails to locate the understandings of health and illness within the context of western culture. This can be elucidated further by pointing out that most researchers are white and the dominant western culture has shaped their research (Lewis, 2004; Parker, 2005). However, the social and cultural specificity of health and illness requires that research

in health psychology must attend to the social and cultural dimensions of health and illness. Therefore in my view, to call attention to the cultural aspects of health and illness, researchers first of all need to be aware of their own positions in their research activities. This will help them carry out reflective research and better understand people's experience of health and illness in the context of western culture. More so, attending to culture requires qualitative health researchers to concern themselves with the health and illness of ethnic minority groups in society. As marginalized groups in society, ethnic minority groups are often left out in health research even though their health issues and needs require pressing attention. As noted before, ethnic minority groups often have their own cultural understandings of health and illness that may be different from the dominant view of health and illness in western culture. Attending to the health and illness of ethnic minority groups can help qualitative health researchers to explore the ways in which our understandings of health and illness are shaped within different cultural contexts.

My research demonstrates that Chinese participants' understandings of health and illness are entrenched in cultural and social contexts. Participants make sense of their dietary practices (both 'Chinese food' and 'western food'), and use of healing systems (both traditional Chinese medicine and western medicine) by drawing upon the different knowledges available in different cultures (traditional Chinese culture and contemporary western culture). Also, my analysis shows how Chinese migrants negotiate the different knowledges available in both traditional Chinese culture and western culture. This indicates that social and cultural influences need to be taken into account in order to understand how we come to know what we regard as knowledge of health and illness today in western society, because different cultures construct their own knowledge or 'truth' (dominant discourses) of health and illness, and the practices surrounding health and illness.

In addition, it is worth noting that the role that 'culture' plays in understanding 'self' is still at issue partly because of the problematic concept of 'culture'. I have pointed out above (5.1.2) that the traditional view of 'self' as an essence is being challenged. Likewise, the common notion of 'culture' as an essential characteristic bound within a particular group of people is being contested by many theorists in social sciences, including psychologists (Bhatia & Stam, 2005; Wierzbicka, 2005). They

argue that ‘culture’ has no boundaries, and is moving and hybrid. Accordingly, the use of ‘culture’ to understand ‘self’ is at issue (Wierzbicka, 2005). I agree that the traditional understanding of ‘culture’ should be problematized. However, in my view ‘culture’ is an important framework to understand people’s experience, especially to understand migrants who ‘live in two cultures and speak two languages’ (Wierzbicka, 2005). My research illustrates that Chinese migrants make sense of their health (and related practices), the body, and themselves through drawing upon two culturally specific meaning systems. This strongly suggests that we should not abandon the concept of ‘culture’, but rather should understand ‘culture’ better in order to understand ourselves.

5.2 Methodological Concerns

This research adopted Foucauldian discourse analysis (DA) as the methodological framework to explore the relationships between discourse and social practice, and between discourse and subjectivity. In this research I have discussed the ways in which the different discourses available to participants (e.g., traditional Chinese knowledge versus western scientific knowledge) construct different meanings of health and illness, and the ways in which the discourses provide subject positions (e.g., a traditional Chinese person versus a western-educated person) for participants to shape their practices and subjectivities. In doing so, I adopted the assumption that Foucauldian DA makes, that “discourse plays a fundamental role in the construction of meaning and that human subjectivity is structured through language” (Willig, 2001, p. 121). However, as Willig (2001) points out, the assumption is not without problems. Firstly, in terms of subjectivity, it is disputable whether “discourse is all that is required for a sense of personal identity to be informed” (Willig, 2001, p. 121). Critics argue that our understandings of ourselves are also shaped by ‘extra-discursive’ reality, such as gender, class, race (Bhatia & Stam, 2005). They argue that discourses co-constitute our subjectivity (as well as reality) within the constraint of ‘extra-discursive’ forces, such as materiality and socio-cultural institutions (Nightingale & Cromby, 2002). In my research, I explored the participants’ construction of themselves by looking into their discursive practices. In other words, I analysed their talk to access their subjectivities. However, I am faced with the challenge: Can I claim in my analysis that their discursively drawing upon traditional Chinese knowledge is all that is needed to

consider how participants retain an identity of a traditional Chinese person? Although in my analysis I took account of race and bodily experiences (it would be suggested as the 'extra-discursive' by some, like Nightingale & Cromby) to explain their subjectivity, it was still discursively produced by participants through their talk. On the other hand, if I take the notion of separating discourse and 'extra-discursive' materiality, and investigate how the 'extra-discursive' forces (such as class, race) shape their identity, how do I obtain access to these 'extra-discursive' forces without examining the discourses surrounding them? Therefore, in my view the notion of 'extra-discursive' materiality is not without problems. Further, it raises a second challenge to Foucauldian discourse analysis: how discourse is constrained by materiality remains unclear (Willig, 2001), although psychologists (who take critical realism approach to social constructionism) have pointed out the 'fact' that discourse is shaped and constrained by the materiality of the world (Hook, 2001; Nightingale & Cromby, 2002). With respect to my research, it remains unexplained as to why some participants resist the positions made available in the dominant discourse in western culture while others do not.

In my view, to answer these questions, we need first to address the issue of the relationship between discourse and reality (both social and material aspects). If there are 'extra-discursive' forces, how do they impact on our discursive construction of the world? On the other hand, if nothing is beyond discourse, how should we incorporate people's experiences (e.g., bodily differences) and actions with the discursively constructed world? Theorizing these issues can help to explain the individual differences in resisting the dominant discourses and taking up alternative discourses that are not clarified in Foucauldian DA. Also only when the relationship between discourse and reality (materiality) is theorized, and the constraints that the reality put on individuals are explicated, can we move on to deal with the first issue that challenges my research: whether the discourse of traditional Chinese knowledge is all that is required to form an identity of a traditional Chinese person or there are 'extra-discursive' forces co-constituting reality (including subjectivity) alongside discourse.

5.3 Personal Reflexivity

As a recent Chinese migrant to New Zealand myself, I have experienced dietary changes (e.g., adopting western food into my diet as well as maintaining Chinese food) and have concerns for my own health (e.g., high risk of diabetes) as the result of these dietary changes. I also have had one experience of using traditional Chinese medicine (TCM) in New Zealand. However it was not a pleasant experience and led me to doubt the effectiveness of TCM itself, and the quality of TCM practitioners here. The reported poor health status of the Asian population in New Zealand drew my attention to their health issues. It was these reasons that drew me to this research topic in the first place. I see myself sharing the same Chinese cultural background with the participants because we all grew up and migrated from Mainland China. However, I also see myself as different from the participants. Firstly, there is an age difference as I am younger than the participants. Secondly, we went through different paths to migration and the durations of our residency are different. I came to New Zealand as an international student first, whereas all my participants came here as migrants. So I expected them to have experienced hardship in their early settlement (e.g., job loss, the change of socio-economic status) which I did not experience. Also, all the participants (except one) have lived in New Zealand for a much longer period than I have. Thirdly, I have more experience of western education than my participants do. Fourthly, I used TCM in New Zealand with limited awareness of how TCM works to treat illness, whereas I presume my participants have a deeper understanding of TCM because the majority of them are TCM practitioners, or the family members and friends of TCM practitioners. Based on these reasons, I position myself as more westernised than the participants, and as having less traditional Chinese knowledge of food and TCM compared to them. Taking up the more westernised position made it easier for me to distance myself from the participants during data collection and analysis. For instance, during the interviews I asked detailed questions when they talked about some traditional ways of using food because I was not familiar with the practices myself. In my analysis, I pointed up the cultural differences in meaning construction. I also focused upon traditional Chinese knowledge in constructing meaning because I assumed that the participants held more traditional Chinese understandings than western understandings of health and illness compared to other Chinese migrants in New Zealand (that is why the participants use TCM in New Zealand while other Chinese migrants do not).

I regard this research as a journey for me to ‘rediscover’ traditional Chinese culture. It makes me have a better understanding of traditional Chinese knowledge about health and illness. Further, it has an impact on my own practices around health and illness. For instance, I have started to be aware of the *hot* and *cold* nature (besides the nutrient components) of food in my diet. Also, I have tried acupuncture in a TCM clinic for my back pain (the TCM practitioner was one of my participants). More importantly, I realize that my participants are rather more attentive to the meanings of health and illness from a cultural perspective than I had expected (e.g., they are aware that the knowledge of health and illness is culturally and socially specific). The research journey makes me become more critical towards what we hold as ‘common sense’ or ‘truth’ in nutritional messages and biomedicine in western culture.

5.4 Social Implications

The social implications of my research influence how my research findings can be used. One aim of this research is to help bring to light Chinese migrants’ understandings and practices of health and illness in western societies, which I suppose are unfamiliar to most western-trained health practitioners and health policy-makers. However, it needs to be noted that the participants in this research are located at the lower end of the socio-economic status in their new society. Some of them (housewives and elderly parents) are dependent on other family members financially and have integrated little in society (especially elderly participants). Their understandings and practices of health and illness may be different from those who have jobs with higher socio-economic status, and those who are more westernised. Therefore, the interpretations in this research should not be taken as a representation of all Chinese migrants in New Zealand.

Also, as far as I know, the health promotion programs for ethnic minority groups currently adopt the dominant understanding of health and illness in western culture. Often the health messages delivered to them are merely translations of information from English into other languages, whereas the understandings of health and illness from their original cultural backgrounds are neglected. For example, the food guidance that is provided to Chinese patients with type 2 diabetes from Asian Health Support Service at North Shore hospital in Auckland is a verbatim translation of nutritional messages in

English based upon western nutritional knowledge. My research as well as others' (Chun & Chesla, 2004) has shown that Chinese migrants are not passive receivers of western scientific knowledge, and that traditional Chinese knowledge still plays an important role in their health-related practices in western countries. This suggests that we need to rethink what health changes we want to promote? What is in their best interest? Should we encourage them to use the mainstream health care system or alternative medicine to maintain health? What health messages are the most efficient ones to change their health behaviours? Clearly, my research demonstrates that there should at least be an awareness of cultural meanings of health and illness in health-promotion messages for migrants from non-western cultural backgrounds.

5.5 Future Research

This research shows that dietary practices and use of healing systems are two areas that are important for Chinese migrants' understandings and practices of health and illness. I suggest that we should also look into other major concerns in migrants' life in western countries (e.g., employment, and the change of social status) in order to better understand their health needs and health issues, because these concerns have a significant impact on migrants' health-related practices. In particular, we need to examine the dominant discourses (e.g., in media, government reports) that surround major areas of their life, and the ways in which migrants are positioned. Further, we can explore the ways that migrants draw upon these discourses, and therefore shape their experiences and practices of health and illness.

In regard to the research approach, I suggest using focus groups to study the understandings of health and illness of migrants and ethnic minority groups. As Willig (2001) points out, one advantage of focus groups over semi-structured interviews is that it allows us to explore how the meanings are jointly constructed. The interaction among participants in focus group can provide an opportunity for them to challenge or resist dominant discourses, and take up alternative discourses. This might be especially helpful when our research question concerns how participants draw upon cross-cultural discursive resources to construct meanings. In my view, group discussions could generate more culturally shared accounts than individual interviews.

5.6 Conclusion

Overall, this research has shown that Chinese migrants make sense of their dietary practices and use of healing systems in New Zealand in a complex way. Traditional Chinese knowledge and western scientific knowledge are the main discursive resources for them to understand the practices of health and illness. Despite the fact that the meanings of food and healing systems are complicated and problematized by different culturally derived knowledge, Chinese migrants seem able to negotiate between different forms of knowledge to justify their mixed health-related practices within a cross-cultural context. More importantly, their discursive constructions of food and healing systems act to legitimise their traditional Chinese way of practicing health and illness, and also to retain a sense of living healthily (by maintaining “balance”) in a society that is not only dominated by a different understanding of health and illness (western scientific knowledge), but also dominated by a discourse of race relations that disadvantages them as a social group (white supremacy). Participants’ discursive exercise of power can have a positive impact on their subjectivity. However, I suggest that the dominant discourses which sustain unequal power relations between different social groups needs to be examined in order to reduce the disparities of health outcomes in western societies. Meanwhile, this research has demonstrated how the experiences and practices of health and illness of people are culturally and socially embedded. Therefore, current health promotion strategies (e.g., healthy nutritional messages and better access to mainstream health care system) in western societies (which are mostly based upon western scientific knowledge) need to explore new ways to promote health behaviour changes to meet the health needs of people from diverse cultural backgrounds.

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Appendices

Appendix I: Information Sheet

**A study to understand Chinese immigrants' notions of how food is related to health
and their use of traditional Chinese medicine in New Zealand**

My name is Chen Juan and I am a Masters student from the School of Psychology at Massey University, Albany Campus. I am currently conducting research on Chinese immigrants' notions of how food is related to health and their use of traditional Chinese medicine in New Zealand. I am interested in learning how Chinese immigrants adjust their diet to the life in New Zealand and their experience of using traditional Chinese medicine. This research will be part of the fulfilment of my Masters' degree in psychology at Massey University.

I would like to encourage you to participate in the study, but you are under no obligation to do so. You are required to read this information sheet and sign the informed consent form if you agree to participate in my research. I will interview you at your home. The interview will take approximately one to one-and-a half hours. During the interview I will ask you some questions regarding diet and traditional Chinese medicine.

The interview will be tape recorded, but you can be reassured that your name will be kept confidential, and will not be identified in the final research report. You can also withdraw from the study, or retract any information you have provided, up to one week after the interview. The information collected, will be written into a thesis, and may also be published in a Psychological Journal. The tapes and transcripts from the interview will be locked away, only accessible to my supervisor and myself until the thesis has been graded and will then be destroyed. The transcripts, without names, will also be held on electronic disks for five years, prior to destruction (as required by Massey University).

As a participant in this research you have the right to be given a summary of the findings of the study when it is concluded. Snack food will be provided for you during the interview and you will also be reimbursed 20 dollars for the time you spend on my study.

Thank you for your time. If you have any queries or wish to know more about my study, please feel free to contact me or my supervisor.

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This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researchers named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researchers, please contact Professor Sylvia Rumball, Assistant to the Vice-Chancellor (Ethics & Equity), telephone 06 350 5249, email: humanethicspn@massey.ac.nz.

Chinese translation of Information Sheet

研究课题：新西兰中国移民对饮食和健康关系以及对中药的理解

“研究简介”

我名叫陈娟，我是梅西大学（Massey University）心理学系的一名硕士研究生。目前我正在做一项关于在新西兰的中国移民对饮食和健康关系，以及对中药理解的研究。我很感兴趣中国移民是怎样调整他们的饮食习惯来适应新西兰的生活。我也很感兴趣了解中国移民使用传统中药的体验。这项研究是完成我在梅西大学心理学硕士学位的一部分。

我鼓励您参与我的研究，但是参与是您的自愿。如果你愿意参与这项研究，你需要在阅读这份“研究简介”后在“同意参与表格”上签名。然后我会到您的住所访问您。访问中我们的话题会涉及到你对饮食和健康的理解，以及您在新西兰使用传统中药的体验。访问大概会持续1个到1个半小时。

访问内容会被录音机记录下来以便我的分析，但是您可以放心您的个人资料都是保密的，所有的研究记录都不会揭露你的身份。在访问中和在访问结束后的一周以内，您都有权利要求退出我的研究，并收回你所提供的任何信息。我在访问中收集到的信息会被用来完成我的研究论文，论文也有可能心理学刊物上发表。录音带和我的抄本会被锁上保密，只有我和我的导师才可以打开。在我的研究论文被评分以后，录音带和抄本都会被销毁。同时根据梅西大学的规定，所有保存在电子磁盘上的信息在五年后会被销毁。

作为这项研究的参与者，你有权利获得一份研究结果的概要。访问期间我会提供点心，在访问结束时你也会获得 20 纽币现金的补偿。

感谢您宝贵的时间来阅读我的研究简介。如果您有任何问题或者想了解更多关于我研究的信息，请联系我或者我的导师。

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这项研究经过心理学专家评估，被评价为是对参与者危险很低的研究。因此它没有经过梅西大学伦理委员会的评估，研究者对这项研究中的道德行为负责。如果你对这项研究中的任何行为有疑问，但是不想跟研究者联系，您可以联系梅西大学校长助理: Syliva Rumball 教授，他的电话是：06 350 5249，电子信箱：humanethicspn@massey.ac.nz

Appendix II: Informed Consent Form

**A study to understand Chinese immigrants' notions of
how food is related to health and their use of traditional Chinese medicine in New Zealand**

This consent form will be held for a period of five years

I have read the Information Sheet and have had details of the study explained to me. My questions have been answered to my satisfaction, and I understand that the interview will be tape-recorded and I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ Date: _____

Full Name (Printed): _____

If you would like a summary sheet of the research project to be posted to you after it has been completed, please provide your address below:

Chinese translation of Informed Consent Form

研究课题：新西兰中国移民对饮食和健康关系以及对中药的理解

“同意参与表格”

这份表格会被保存五年

我已经阅读过“研究简介”，有关人士已经给我详细解释了这项研究的细节，并回答了我所有的疑问。我明白访问会被录音，我也明白我可以随时提出其他问题。

我同意在满足“研究简介”列出的条件下参与这项研究。

姓名： _____

签名： _____

日期： _____

如果您想获取一份研究结果的概要，请写下您的邮寄地址，我会在在研究结束后寄给您。

地址： _____

Appendix III: Demographic Information

A study to understand Chinese immigrants' notions of how food is related to health and their use of traditional Chinese medicine in New Zealand

Name: _____ Age: _____

Sex: _____

Educational status: _____

Place of residence in China: _____

Occupation in China: _____

Current address in New Zealand: _____

Occupation in New Zealand: _____

Period of time lived in New Zealand: _____

Marital Status: _____

Household Composition: _____

(e.g., number of children, parents, and parents-in-law)

Chinese translation of Demographic Information

研究课题：新西兰中国移民对饮食和健康关系以及对中药的理解

“参与者简单信息”

姓名：_____ 年龄：_____

性别：_____

教育程度：_____（如：小学，初中，高中，大学，研究生）

国内来自省份：_____ 国内职业：_____

新西兰住址：_____

新西兰职业：_____

在新西兰居住时间：_____

婚姻状况：_____

现家庭成员：_____（如：父母，子女，亲戚）

Appendix IV: Interview Questions

1. What are your food habits in New Zealand? (What do you eat for breakfast, lunch and dinner? Where do you go shopping for food?)
2. How do you see your diet after migrating to New Zealand compared to that before migration? (How do you think migration has impacted on your diet?)
3. What do you think is health and illness?
4. What do you think are the relationships between food, health and illness? (What does 'a healthy diet' mean to you? How diet is related to illness?)
5. What do you do with your diet to keep healthy and deal with illness?
6. Under what circumstances do you use traditional Chinese medicine (and western medicine) in New Zealand?
7. How do you understand traditional Chinese medicine (and western medicine)?

Chinese translation of Interview Questions

- 1.请谈一下你在新西兰的日常饮食习惯？（早餐，午餐，晚餐都吃什么？你一般都在那里购买食品？）
- 2.你认为移民新西兰以后你的饮食习惯改变了吗？（你保持传统的饮食习惯吗？移民对你的饮食习惯和健康有影响吗？）
- 3.你是怎样理解“健康”和“疾病”这两个概念的？
- 4.你是怎样认为饮食和健康的关系，以及饮食和疾病的关系呢？
- 5.你平时是怎样通过调节饮食来保持健康的呢？
- 6.在新西兰你什么时候看中医，什么时候看西医？
- 7.你对中医和西医的理解是怎么样的？