Being Healthy:
A Grounded Theory Study of Help Seeking Behaviour
Among Chinese Elders living in the UK

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Abbreviations
CHD: Coronary Heart Disease
TCM: Traditional Chinese Medicine
TCMPP: Traditional Chinese Medicine Patent Prescription
WM: Western Medicine
SI: Symbolic Interactionism
**Abstract**

**Background:**
The incidence of chronic diseases is relatively higher among elderly groups. However, the research base about aging patients’ attitudes towards help-seeking behaviours remains largely unexplored. When considering the racial, ethnic, and cultural factors which may affect help seeking among elderly people from minority groups, then the issue becomes more complicated with less research evidence available in general. The UK has an increasingly diverse elderly population about whom relatively little is known. To date, no published studies which examine Chinese elders’ help seeking behaviour in the UK have been identified.

**Aim:**
The aim of this study is to investigate the health related behaviour, particular the early help seeking behaviours, among Chinese elders in the UK. By so doing, it is hoped that their help seeking experiences, particularly the potential difficulties and barriers, can be understood in order to ultimately improve the health of Chinese immigrants in the UK.

**Methodology:**
This study used Grounded Theory to explore how Chinese elders in a UK setting faced and resolved their health related problems, particularly when directly facing health related problems. A total of 33 Chinese elders from Manchester participated directly in the study, consenting to semi-structured and open-ended interviews. The data were coded and analysed using constant comparative analysis (Glaser and Strauss 1967; Glaser 1978; Glaser 1992b).

**Results:**
Theoretical concepts derived from data analysis were used to generate a substantive theory of being healthy. The theory consists of four interrelated categories. The first category is self management which describes how elders managed every aspect of their daily life to gain their goal of being healthy. Second was that via normalising/minimising certain symptoms, elders gained a sense of being healthy. The third category, access to health services, discussed the external components which influenced elders’ help seeking behaviour, including their family and the health care services in the UK. The fourth category was being cured, arising from the third category, and presented elders’ viewpoint of getting cured of symptoms but not eliminating the root of disease. It highlighted the dissatisfaction with the interactions between Chinese elders and UK health professionals.

**Conclusion:**
This study provides a theory of Chinese elders’ concerns about health issues in their daily life as well and how they think through, act and react when facing health problems. These understandings of Chinese elders’ health related perceptions and behaviours have the potential to increase the quality of health care services provided by UK health professionals to Chinese patients. The implications for healthcare, nursing, and further theory development and research are discussed.
Declaration

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The author

The author completed her Bachelor degree of Medicine in Preventive Medicine in West China School of Public Health, Sichuan University in July 2007. In September that year, the author gained the offer to study for a PhD at the University of Manchester.

The author’s research interests are primarily focused on the community health, especially help seeking behaviour. This study is the first research study the author has undertaken.
Introduction to the study

This study explores the process by which Chinese elders consider and perceive their role in help seeking within the context of the UK health care service.

In most developed countries, including the UK, public health service systems are well established. With appropriate and timely help seeking behaviour, many health problems are solved, prevented or at least ameliorated. However, delay in help-seeking behaviour is frequently seen among people with certain chronic diseases, such as heart related problems, especially among older patients (Dracup et al. 1997; Goldberg et al. 1998; Horne et al. 2000; Bett et al. 2005; McGinn et al. 2005). This delay could bring fatal consequences and is a major problem for both patients and the NHS (Dracup et al. 1995).

This research is focused on “elderly” or older people. Most of the developed and developing world countries have accepted the chronological age of 60 or 65 years as a definition of “elderly” or older person (World Health Organization 2008). As it is used in this study, an older person is defined as someone with a chronological age over 60 years.

The reasons for the high delay rate among older people with chronic diseases are well investigated to date. Generally, there are three causes. First, there are more barriers for older people in help seeking behaviour, such as barriers to access, denial of need and the social identity of older age (Howse et al. 2005). Second, the rates of these chronic diseases, such as cardiovascular diseases, are much higher in the older population, as the incidence of such diseases increases with age (Department of Health 2007a). Third, the chronic characteristics and atypical symptoms make help seeking behaviour much more likely to be delayed in older people (Goldberg et al. 1998; Tod et al. 2001; King et al. 2007). Aside from these, cultural and ethnic issues also play an important part in delayed help seeking (Scheppers et al. 2006). Indeed, there are already many studies on this topic both among the general population and some minority groups in the UK and in other countries. However, in the UK, there is little data about the situation of older people from the Chinese community and this needs further investigation.
Chinese immigrants have an independent and very different cultural background from the local people of the UK (Office for National Statistics 2004a; Office for National Statistics 2004b). Chinese culture influences, sometimes heavily, almost every aspect of the life of a Chinese immigrant, including his/her help seeking behaviours (Wong and Pang 2000). However, because of the lack of information about ethnic minority groups in the UK, health service research tends to treat them as a sub group of local people in the UK without considering different patient groups within the different communities. Thus, inappropriate services provision can result among these minority people when they seek medical help (Campbell et al. 2001). With regard to the Chinese communities, three cultural ideas, Confucianism, Taoism, and Buddhism, strongly influence their culture (Chen 2001). With the influence of these ideas, the attitude of Chinese people towards the world may be very different from local UK people. This may lead to a unique approach to help seeking behaviour among this group. If the health service was specially designed to take account of the characteristics of Chinese people, a reduced delay in help-seeking behaviours may result (King et al. 2007). Moreover, because of the diversity of health service systems in different countries, the barriers vary from country to country among Chinese people overseas (Hussey et al. 2007). Hence, the results of investigations carried out in other countries may not be transferable to the UK directly. An investigation into the delay in help seeking behaviour among older Chinese immigrants in the UK is timely.

Understanding peoples’ experiences of their illness is important for disease prevention and education. This investigation may help to understand the situation of help seeking among Chinese immigrants in the UK, particularly the barriers to help seeking. If the barriers to help seeking behaviour among older Chinese immigrants in the UK could be identified, better strategies aimed at improving help seeking among Chinese immigrants could be developed. Also according to the findings referring to Chinese elders’ help seeking habits and characteristics (e.g. doing self management in their own Chinese world), corresponding actions in health and social work, such as dissemination of basic information about certain chronic diseases could be taken by some lay health advisors in order to gain an efficient system of engagement with the Chinese community. Furthermore, this study has important implications for nursing practice. Health service practitioners may become aware of specific information on this ethnic group. By so doing, the efficiency and effectiveness of services could be increased based on the understanding of ethnic differences. For instance, professionals may become aware of
specific information which is appropriate for Chinese immigrants, and/or change their service pattern. Nurses may find this kind of information helpful when faced with the interpretation of symptoms by Chinese elders and also how social or cultural issues influence a patients’ recovery. These changes could result in lower mortality for certain chronic diseases and reduce costs for treating patients with chronic illnesses.

**Aims of the study and choice of methodology**

The researcher’s identity as a Chinese person and an immigrant in the UK, as well as the lack of research exploring how Chinese elders manage their health problems in this host society, provided the impetus for the study and informed its overall aims. In addition, the researcher’s personal experience as a medical student in public health fuelled an interest in community health and contributed to this process. Consequently, this study aims to make both a theoretical and methodological contribution by exploring the health related behaviours of Chinese elders in their daily life, particularly help seeking behaviour when facing health problems.

A qualitative approach using Grounded Theory was chosen for the research due to its commitment to gaining insight into the experiences and the main concerns of participants as well as the development of a theory to explain the behaviour pattern in the field. An important principle is that the researcher begins the project without a preconceived theoretical perspective but with an area of interest. In doing so, the relevance of a Grounded Theory is developed, rather than preconceived (Glaser and Strauss 1967; Glaser 1978; Glaser 1992b). The key feature of this study is emergence, of both the research problem and research questions. In this way, the original aims may be modified in order to investigate more fully what is actually happening. At the outset of the study, the researcher entered the field with the intention to explore the potential difficulties and barriers of early help seeking behaviour, especially when facing certain coronary heart disease (CHD) related conditions among older Chinese people within the UK health care setting. As a result of applying Grounded Theory and in response to discovering the main concerns from Chinese elders’ own perspectives, the original aims of the study were refocused on the general health behaviour process, including the management of health related events in daily life and help seeking behaviour when facing certain ailments. As the research progressed these aims became the main focus of the study since data analysis revealed they were central to the emerging theory.
Emergent research problem and questions

As with all orthodox Grounded Theory studies, the initial research problem and research questions emerged in a process of gradual exposure to the concerns of research participants. This study began with an area of interest (i.e. the health related behaviour of Chinese elders during daily life) and the awareness and interests of this phenomenon (i.e. the identity of the researcher as an immigrant in the UK).

The overall aim of this study was to investigate the health related behaviour, particular the early help seeking behaviours among elderly Chinese immigrants in the UK. The overarching research problem to be addressed by this thesis emerged from exploration and was identified as:

How do Chinese elders manage their health related issues and respond to challenges which arise from this host society, particular the UK health care service?

As the study progressed, research questions derived from this main problem were:
What underpins and influences Chinese elders’ health related main concerns?
What is the process used by Chinese elders to manage their concerns and the actions and strategies used to face their health related events?
What challenges do elders encounter during their help seeking process in the setting of the UK?

Organisation of the thesis

The thesis is organised into seven chapters. Chapter one introduces the relevant background to this study, while in chapter two, an initial review of literature is conducted and presented prior to the fieldwork. The next two chapters present a discussion of methodological issues and how these issues applied in this study. The fifth chapter is devoted to the findings, including the core categories and four sub categories, from which the theory developed. Chapter six presents and discusses the emerging theory. The integration of the research findings presented in the previous chapter with the emergent areas of literature, as well as with the body of literature reviewed at the start of the study is also discussed in this chapter. Finally, the seventh chapter concludes the thesis by discussing the significance and implications of the findings in relation to the policy agenda.
An overview of “being healthy” and its theoretical and methodological contributions

The theory generated from this study is named “being healthy”, which explains Chinese elders’ main concern. To meet this goal, Chinese elders had unique processes, including daily actions as well as help seeking behaviour in the setting of the UK. Although this study was primarily conducted in Manchester, the social process of “being healthy” which is the abstract conceptualisation may have general implications beyond the temporal and spatial boundaries of the study.

This study is unique in that it specifically explores Chinese elders’ health related behaviour on a daily basis using the methodology of Grounded Theory. This study has made several significant theoretical and methodological contributions. Findings from this study could contribute to social science, especially nursing knowledge, a nascent understanding of how Chinese elders experience and respond to their health related events in their daily life. The findings provide insight into the nature of the processes involved in how elders think through, act and interact when resolving their health problems. The theory adds to the understanding that the concern of being healthy influences the recognition of decision making, information seeking and help seeking. In addition to theoretical contributions to nursing knowledge, findings from this study have implications for practice, education, theory, and research. Methodologically speaking, this theory conceptualises the emerged concepts that are used to explain the process of maintaining and gaining health and the management of various health events.
Chapter 1 Background

1.1. Introduction

This chapter introduces the central elements related to this study as well as the background and context. These key components include the target population, Chinese people in the UK, and their traditional Chinese culture, particularly related to health issues; the phenomenon of help seeking; as well as the setting of the UK, especially the help seeking behaviour related context within the health care system.

1.2. Chinese people in the UK

Globally China is one of the biggest countries with emigrants throughout the world (Ministry of Health of People's Republic of China 2007). However, it is well known that in receiving countries, newly arrived migrants have often been concentrated in poor, low status regions of major cities (Scheppers et al. 2006).

Since the mid-nineteenth century, people of Chinese origin have represented one of the largest ethnic minority groups in the UK (Huang and Spurgeon 2006). Emigration has taken many forms, and the major type is labour migration in the UK. The Chinese ethnic population (mainly from China, Taiwan, and Hong Kong) are among the UK’s largest visible minority groups. According to the latest census, the size of the ethnic group of Chinese people in England is approximately 247,403, representing 0.4% of the British population, and 5.3% of the non-white population. Chinese immigrants aged 65 and over represent approximately 5% of all Chinese people in the UK (National Statistics Online 2003). About 30% of Britain’s Chinese people were born in Hong Kong, 20% were born in mainland China, whereas only 30% were born in the UK (National Statistics Online 2003). Chinese immigrants from Hong Kong and some parts of Southern China are likely to speak Cantonese, while most immigrants from mainland China tend to speak the official language, Mandarin (National Statistics Online 2003).

Chinese immigrants who live in the UK are widely dispersed but local sizeable populations exist in certain areas in the UK. London has the largest concentration of Chinese people. The northwest of England, which includes Greater Manchester and
Merseyside, have the second largest concentration with approximately 27,000 people of Chinese origin residing in these areas (National Statistics Online 2003).

The structure of Britain’s Chinese community is quite diverse. Chinese people are more likely to possess a university degree, or hold a job in a professional class, than the average White British person but these data conflate the Chinese population as a whole and so do not give the data for first generation immigrants specifically (Office for National Statistics 2004b). However, the number of Chinese immigrants who have no qualifications is relatively high (20%) (Office for National Statistics 2004b), and the unemployment rate is also higher for Chinese people than White British people, with 10% compared to 5% (Office for National Statistics 2004a).

1.3. Chinese traditional culture and its impacts on health issues

Chinese philosophies and religions are unique and have a strong influence on the Chinese way of living and thinking about health and health care. Chinese peoples’ beliefs about health, their understanding of health risk, and their health-related behaviours are distinctive and different from other groups of people (Chen 2001). These unique characteristics of Chinese culture are introduced in the sections below.

1.3.1. Impact of Chinese philosophies and religions on health and illness

A review of the literature on Chinese values and the relation to health shows that philosophies and religion permeate every aspect of traditional Chinese people’s lives (Chen 2001). Illustrating the exclusively cultural factors in China can enrich the understanding of the Chinese immigrants’ behaviours of seeking medical help. Confucianism is the first major religion that has a great influence on Chinese behaviour (Chen 2001). Harmony with all others and a lack of self-centredness are the main principles of Confucianism. Chinese people believe in and seek a satisfying social life and inner peace to promote health and prevent illness (Wong and Pang 2000). Taoism is a second major Chinese religion which affects Chinese culture. Like Confucianism it also emphasizes harmony with nature, and to achieve health, Chinese people pursue the natural rhythms of nature. The theory of “Yin” and “Yang”, which is expounded by Taoism, dominates concepts of health and illness in traditional Chinese thought (Chen 1996). The doctrine of “Yin” and “Yang” conceptualizes the human organism as a
microcosm of the universe which is constantly in a dynamic interaction which aims to maintain a state of balance between its components by oscillating between the two archetypal poles of “Yin” and “Yang”. Health is viewed as harmony between “Yin” and “Yang” and disease manifests when the human body gets out of balance (Wong and Pang 2000). Some Chinese people believe that it is necessary to keep balance to achieve the harmony of nature. An example of this is that many Chinese people choose to die at home where they can be given a sense of normality and a feeling of belonging to nature (Tang 2000).

A third major religious tradition in China is Buddhism which emphasises fate in everyone’s lifetime. “Inn” and “Ko” (cause and effect) are the principles that encourage people to do good from which, in return, there will be a good result in one’s life (for example, good health) and therefore some people may believe that these returns are the main factors that determine health (Dwivedi 2006).

The concept of holism permeates every aspect of these three major religions (Wong and Pang 2000). In the Chinese medical tradition, illness is perceived as a state of disharmony between the individual and his or her natural and social environments. Chinese people believe in general bodily harmony and consider that medicine is not natural. Consequently they worry about the side effects of medicine, such as adverse drug reactions and this therefore may prevent help seeking. There is a proverb in China that "three tenths of medicine is poison" (Gao 2004) and this may hinder help seeking.

Many Chinese elders use Traditional Chinese Medicine (TCM) and the aim is to achieve the best possible adaptation to the individual's total environment. In diagnosing the patient's illness state, the patient is not categorized into a disease type (Wong and Pang 2000). It is an important pathway in seeking medical help in Chinese culture. TCM includes herbal treatments and diet therapy and many Chinese people consider these as natural approaches to promote health when they feel unwell or to treat ongoing diseases (Wong and Pang 2000). Therefore, they tend to seek medical help only when experiencing acute illness or pain (Chen 2001). This may be reflected in relatively low use of some western medical services and may act as a barrier to help-seeking although these effects have not yet been systematically examined through research (Chen 2001; Wade et al. 2007).
1.3.2. Health related Chinese values

*Family-centred*

Although the decision to use health services is stated to be an individual choice, these choices are mainly framed in the social context which ties to culture and family especially among minority people (Leclere et al. 1994). Confucianism has been influencing Chinese culture from the time of ancient China. It emphasises the group or collective, designed to ensure the strength of the family. Beliefs and values related to family are as strong as religious beliefs for Chinese people (Chen 2001). Therefore, illness that occurs in a family member affects not only the individual, but also the whole family (Nilchaikovit et al. 1993). People may not tend to seek medical help because caring for the sick in China is a private, family affair, taking place most often within the confines of the family (Wong and Pang 2000). This indicates another common phenomenon in China today. In China the patient’s own family members are described as “good nurses” partly because they provide all-round care for patients and partly due to the psychological comfort they bring (Pang 1999). In this way, patients prefer home care by their family members and therefore tend to avoid seeking medical help. All of these notions may result in delay or refusal to engage in help seeking behaviours.

*Positive thinking*

Psychological factors are considered as having an important role in causing or fighting disease among Chinese people (Wong and Pang 2000). A hopeful and optimistic mood can give patients inner power and help patients to cope with illness. This is also included in the harmony of “Yin” and “Yang” (Chen 2001). In contrast, negative feelings, such as worry, anxiety, fear and hate can affect this balance and lead to illness. Therefore, some Chinese people deny a potential illness and avoid negative information as a defence mechanism (Liu et al. 2005). However, these defences may prevent them from seeing a doctor and hence become barriers for help-seeking (Lai and Chau 2007).

1.3.3. Healthcare utilisation patterns of Chinese elders

China has a unique health service system which synthesises both Western Medicine (WM) and TCM (Harmsworth and Lewith 2001). These two types of medicine are often practiced simultaneously in Chinese medicine clinical settings. Most of the doctors in Western medicinal settings in China have received training in TCM and the drugs
prescribed by these doctors include both Western and traditional Chinese drugs (Harmsworth and Lewith 2001). In China, many doctors prefer a combination of treatment, using western medicines initially for acute or life-threatening illnesses, followed by TCM for chronic conditions (Hesketh and Zhu 1997). In China, traditional medicine is considered useful in health promotion and managing chronic conditions by most patients and doctors (Ma 1999; Ma 2000). They judge TCM as a relatively milder approach with less side effects than WM (Ma 1999).

Most Chinese people, in particular Chinese elders, are accustomed to the bicultural system of these two types of medicines. It is reported that older Chinese Americans are often influenced by this healthcare utilization pattern when facing health problems (Miltiades and Wu 2008). Some studies in the UK report that the health beliefs and healthcare utilization patterns of Chinese immigrants are unique but little discussion of these differences is provided (Gervais and Jovchelovitch 1998b; Dobbs et al. 2006). It is recommended, therefore that further research which focuses on an understanding of healthcare utilization patterns of Chinese elders among this subgroup in the UK will facilitate help seeking.

1.4. Coronary heart disease

Chronic diseases are diseases of long duration and generally slow progression. Chronic diseases, such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, are the leading causes of mortality in the world, representing 60% of all deaths. Cardiovascular diseases are the number one cause of death globally with more people dying annually from cardiovascular diseases than from any other cause (WHO 2010). In the UK, the commonest chronic diseases are arthritis and rheumatism, and heart problems (including high blood pressure) (Department of Health 2004a).

At the outset of the study, considering the relative high prevalence of chronic diseases among elderly population, cardiovascular diseases, particularly coronary heart disease (CHD) with its high morbidity among elders and its atypical symptoms, was considered a starting point to explore help seeking behaviour.

CHD, also called coronary artery disease (CAD), ischaemic heart disease (IHD), and atherosclerotic heart disease, is the end result of the accumulation of atheromatous
plaques within the walls of the arteries that supply the myocardium (the muscle of the heart) with oxygen and nutrients (Department of Health 2007a). While the signs and symptoms of coronary heart disease are noted in the advanced state of disease, most individuals with coronary heart disease show no evidence of disease for decades as the disease progresses before the first onset of symptoms, often a "sudden" heart attack occurs. After decades of progression, some of these atheromatous plaques may rupture and (along with the activation of the blood clotting system) start limiting blood flow to the heart muscle (Department of Health 2007a).

The term “heart attack” is a useful term for most people as it encompasses the different manifestations of CHD. Myocardial infarction is a pathological term used to describe the macroscopic and microscopic changes that are seen in heart muscle that has been deprived of its blood supply for a few hours. A patient may die suddenly after the onset of symptom because there may be no time for emergency salvage (Sandler 1987; Department of Health 2007a).

The risk factors for CHD are well known. Heart attacks are more common in patients who smoke (Patel et al. 2006), who have a high blood pressure (Critchley et al. 2004), who have high serum cholesterol (Critchley et al. 2004), and who are obese (He et al. 2007). A less important risk factor is family history of CHD (Department of Health 2007a). Although there are wide differences of opinion about the importance of family history in CHD, a family history that includes smoking, hypertension, and hypercholesterolemia, leads to a relatively high incidence of CHD (Wilson et al. 1998). Lifestyle risk factors which are present during one’s childhood and adolescence play a major role and include smoking, unhealthy diet and lack of exercise (Hardcastle et al. 2007).

Stress, as a psychological and social risk factor, is another important risk factor for CHD. Although all disease may be affected by psychological factors, CHD appears particularly susceptible in this respect (Glass 1977; Sandler 1987; Department of Health 2007a).
1.4.1. CHD in the UK & in China

Despite the well described CHD status of the general population of the UK, there are no published data showing the incidence rate and mortality of CHD for Chinese groups in the UK to date. It is known that the incidence of CHD is partly related to lifestyle and partly due to individual physical factors. Hence, the situation of CHD among Chinese immigrants in the UK may have some similarities both to the situation in the UK and that in China.

**CHD in the UK**

CHD is a common disease and the UK’s biggest killer with over 110,000 deaths in England every year (Giuli et al. 2005; Department of Health 2007a). More than 1.4 million people suffer from angina and 275,000 people have a heart attack annually (Department of Health 2007a).

CHD is the most common cause of heart problems with a greater relative prevalence in men than women (Johansson et al. 2001; Congdon 2008). Many studies have also shown that the prevalence rate of heart problems increases steeply with age (Johansson et al. 2001; Giuli et al. 2005; Majeed et al. 2005; Department of Health 2007a; Congdon 2008). A cross-sectional study in 26 general practices showed that the prevalence rate of heart disease increases from 0.2 per 1000 in people aged under 35 years of age to 125 per 1000 in those aged 85 years and over (Majeed et al. 2005). Moreover, there is a sharply increasing proportion among the groups aged 65 and over. In the UK, life expectancy for both men and women has also continued to rise in recent years. In 2003-2005, a man aged 65 could expect to live for another 16.6 years - up from 13.2 years 20 years ago; meanwhile, a woman aged 65 can look forward to 19.4 years extra, compared to 17.2 years in 1983-5 (Office for National Statistics and Government Actuary's Department 2007).

**CHD in China**

In China, heart disease was also the leading cause of death in 2006 (Ministry of Health of People's Republic of China 2007). Mortality rates from CHD are still rising in China, like many other developing countries (Critchley et al. 2004). The incidence of heart disease also increases with age in both genders (Ministry of Health of People's Republic of China 2007). Meanwhile, China has experienced a demographic revolution. Life
expectancy in China was 66.8 years for men and 70.4 years for women in 1990 while in 2000 the rates were 69.6 years for men and 73.3 years for women (Ministry of Health of People’s Republic of China, 2007). The study which was conducted in the capital city of China, Beijing, also showed the age-adjusted CHD mortality rates increased by 50% in men and 27% in women between 1984 and 1999, and the rising cholesterol levels and the prevalence of obesity and diabetes accounted for 77% of the additional deaths, reflecting an increasingly “Western” diet with the characteristic high fat content (Critchley et al. 2004).

**CHD among Chinese people in the UK**

As mentioned earlier, there are a considerable number of Chinese immigrants living in the UK. However, there has been little research applied to this sub-ethnic group, and no published data of the incidence rate, mortality and morbidity due to CHD for Chinese groups in the UK to date. There is correlational research about CHD mortality for Chinese immigrants in the US which has shown a higher mortality and considerable heterogeneity among ethnic subgroups and that the burden of coronary heart disease is rising among ethnic minority populations in the US (Palaniappan et al. 2004). However, there may be some differences among these ethnic groups in different districts because of various factors (Congdon 2008). It can be speculated that the US finding may apply to the UK and therefore it could be expected that some older Chinese immigrants’ health status is likely to be challenged by the increasing effects of CHD.

**1.5. Help seeking for health behaviour**

Adequate and quality primary health care services are an essential determinant of the health of a population and are especially important for vulnerable groups, such as the poor, women and older people (Florey et al. 2007).

According to the Cambridge Dictionary, the core term, help seeking behaviour, describes the action of finding and getting assistance by expressing needs or desires (Cambridge Dictionaries Online 2008). The complexity of the behaviour is tied to the complex internal and external factors which differ from individual to individual. In general, these behaviours are viewed as characteristics of individuals and as concepts derived from both sociological and psychosocial areas.
1.5.1. Determinants of help seeking for health behaviour

In classic social psychology literature, Kessler (1981) proposed that there are three stages to voluntary help seeking for problems: recognition that there is a problem, belief that outside help is needed and eventual contact with a helper or helping agency (Kessler et al. 1981). However, research studies show that there can be real or perceived barriers to help seeking at each of these three stages, the most fundamental being that an individual denies or does not recognize that there is a problem.

There have been attempts within social and health psychology to understand and explain the help seeking process. Many models and theories have been established and used for predicting or changing health related behaviours. Among these models, six distinct factors have been highlighted, including accessibility of health care services, attitude to health care, perceptions of disease threat, knowledge about disease, social network characteristics and demographic factors (Conner and Norman 2005). Except for the factor of service accessibility, the other five factors highlight the importance of cognitions or thoughts. Attitudes to health care, perceptions of disease threat, knowledge about disease, social network characteristics are all social cognitive factors (beliefs, attitudes, knowledge) which influence choice and decisions which in turn are influenced by demographic factors and psychological factors.

One of the most widely used models of health related behaviour is the Health Belief model (HBM) (Abraham and Sheeran 2005; Conner and Norman 2005). This social cognitive model attempts to link behaviour and thoughts (cognitions) with external factors to explain health related behaviours. The HBM, which is a health behaviour prediction model, suggests that perceived susceptibility, perceived severity, health motivation, perceived barriers and perceived benefits, are all social cognitions which influence health behaviour. These cognitions are influenced by two main variables, demographic variables and psychological factors (Abraham and Sheeran 2005).

Based on the understanding of people’s health related behaviours by HBM, the following sections outline the main potential determinants which may influence individuals’ cognition in the propensity to undertake help seeking for health behaviours in general and among Chinese people in particular.
**Demographic variables**

Education has been noted to be a significant factor among elderly people in help seeking. It is well documented that higher educational levels influence the utilization of health services in general (Alderman and Lavy 1996; Mackenbach et al. 1999; Adler and Newman 2002). The Chinese government also reported the increased likelihood of children being taken for medical care by mothers with higher educational levels (Ministry of Health of People's Republic of China 2007).

Age is another important demographic determinant impacting health care seeking, particularly influencing a person’s willingness to seek help (Vogel et al. 2007). Older people are often less likely to seek help than adolescents (Howse et al. 2005). The evidence suggests that older people’s refusal or non-uptake of health services, despite acknowledgement of the need and entitlement, are multiform in the UK (Howse et al. 2005).

There are many issues interacting with age. One significant factor is educational opportunity. Greater educational opportunities and better access to knowledge about modern health care facilities ensure higher utilization of services (Heck and Parker 2002). Older people are reported as a group with less education than their young counterparts (Office for National Statistics 2004b). Preferred sources of care may exist. Some older people have refused help from professionals and have a preference for care from their family members and friends (Seale 1996). They may choose to be cared for by families because they feel less at ease with strangers (Howse et al. 2005). One of the other important causes of the non-use of health care services in the UK is that elders often experience barriers to access and they may lack information about the available help (Lindesay et al. 1997). These barriers cannot completely explain help-avoidance among older people. Older people may refuse to accept or seek help because they do not feel or admit that they have the need for assistance (Hooper et al. 1996; Buetow et al. 2001; Tod et al. 2001). They may reject a diagnosis, minimize the implications or be totally indifferent to it (Salander and Windahl 1999). Another way to understand refusal to admit need is the idea of social identity of older age. A study in the UK has shown that some older people regard the disease process as a natural part of aging and a normal symptom for themselves, and consequently, feel that there is little doctors can do for them (Morgan et al. 1997). Accordingly, the factor of age which is affected by many possible factors may act as an essential barrier influencing help seeking.
Gender is also an essential factor influencing health care utilisation behaviours for non-immigrants as well as immigrants (Garrett et al. 1998). Studies that looked at the impact of gender on the demand for health services show that the masculine gender socialization has a complex effect on men’s help seeking behaviour. When facing serious illness, men were often reported as using much more treatment than women (Lane and Addis 2005). However, a gender bias is also seen in the health status of women. A British study has shown that females give poorer self evaluation of health, show higher rates of acute illness, have more (but less severe) chronic conditions, use more outpatient services and consume greater amounts of both prescription and non prescription drugs (Macintyre et al. 1996).

**Perceived susceptibility**

Fears of negative repercussions which are impacted by psychological factors are identified by some research studies as the primary barriers to seeking help (Vogel et al. 2007). Especially prevalent among Chinese people, they usually deny a bad feeling or avoid possible depressing information as they fear the potential negative consequences (Stevenson et al. 2003). Moreover, they may believe that if they do not recognise that there is a disease, then there is no disease. However, when the diagnosis of a disease is made, the disease cannot be denied. Therefore they always try to avoid diagnosis. This kind of physiological pattern may hinder help seeking behaviour severely (Pang 1999).

**Perceived severity**

The nature and severity of the illness may also shape patterns of use. Chronic disease, such as CHD, often shows no typical symptoms and usually no instant feedback; thus it is reported as one essential problem that treatment-seeking delays are significantly high in many countries, such as the US and the UK (Evangelista et al. 2000; Tod et al. 2001). Potential patients may ignore chronic illnesses and pay attention to acute illness; and this influences help seeking behaviour and acts as a barrier (Chen 2001; Wade et al. 2007).

**Perceived barriers**

A lack of knowledge of helping resources, from both health psychology and medical literature, has been reported to be a major practical barrier in seeking medical help (Seale 1996; Morgan et al. 1997; Howse et al. 2005); and it is especially common
among people from ethnic minorities in the UK (Lindesay et al. 1997). There is often minimal contact with the host society (Huang and Spurgeon 2006), so some ethnic minority groups may not recognize their own entitlement within and from the health care infrastructure (Tamsma and Berman 2004). It may act as a barrier for seeking medical help among these groups (Howse et al. 2005).

Transport and physical access are perceived barriers, especially for older people. These factors, including distance, ease of physical access, availability of transport, absent from work and travelling time, all influence whether and what kind of health service is sought (Blazer et al. 1995). In the US irregular public transport was reported as a barrier to health care for ethnic minority patients in their endeavours to seek medical help (Garrett et al. 1998; Scheppers et al. 2006). Older immigrants often need to use more public transport in the UK (Department of Health 2001). It can be speculated that transport may also affect the help seeking process in the UK.

Quality of service has many components and is a complex issue to assess. From the point of view of the health care seeker it is clear that patients who perceive a facility or practitioner to offer a poor service are deterred from using that service (Howse et al. 2005). Previous unsatisfactory contacts with health services are reported as a barrier in many countries, including the UK (Scheppers et al. 2006). The cumbersome processes of making and obtaining appointments and prolonged waiting times create difficulties in accessing health services. Long waiting times for appointments and during visits to clinics hinder patients from using the services that they are entitled to. In sum, disapproving perceptions and attitudes with regard to health services can hinder patient utilization (Jirojwong and Manderson 2002).

The belief that nothing and or no one can help also acts as a perceived barrier for help seeking and is a very popular view among the general elders in the UK (Howse et al. 2005). Many older people who have chronic illnesses may like to describe it as the process of aging (Howse et al. 2005). A Chinese researcher, based on his observation and literature review, indicated that older Chinese people often avoided seeking health care when they believed no one can help or nothing would be changed (Chen 2001).
1.5.2. Culture based variables of help seeking behaviour among ethnic groups

Besides the factors identified in those widely used health behaviour models, such as HBM, there are other issues which are specifically noted among ethnic groups, including Chinese immigrants.

**Intercultural communication**

When an individual enters a host culture as an immigrant, culture shock is the first likely response and the situation can be highly stressful (Furnham and Bochner 1986). No matter how effective preparations have been, common factors can present as challenges. The major essential barrier is communication (Jandt 2004). As an element of culture, communication, which impedes immigrants’ integration to the host society, is affected by culture’s influence on perception and stereotypes (Jandt 2004).

When facing the use of health services, lack of local language skills jeopardizes effective communication between ethnic minority patients and health care personnel (Watt et al. 1993; Jirojwong and Manderson 2002). Linguistic barriers are described as the difficulties patients encounter in expressing feelings and reading messages and instructions (King et al. 2007). However, due to the lack of a common language, people struggle to express their inner feelings or to ask questions; moreover, communication problems hamper the health professionals’ attempts at obtaining vital medical history and medical risks for the patients. Ethnic minority patients’ cultural perceptions about symptoms may mean that they present their symptoms in a different way, which makes it difficult for health care personnel to arrive at an appropriate diagnosis (Smith et al. 2000). The clinical symptoms described by the patient are often from a layman’s perception of illness which is subjective; however, this description may differ from the clinical reality of the professionals which is generally objective. The different ethnic norms and values exasperate the minority patients and the health care providers’ attempts at providing help. In this way, the gulf of ineffective communication based on the diversity of culture separates the patients and health care personnel (Scheppers et al. 2006).

**Cultural attitudes**

In many countries, health seeking behaviours are related to various factors associated with culture and tradition (Brown et al. 2005; Huang and Spurgeon 2006; King et al.
People’s beliefs about health and health related behaviour are influenced by cultural factors (Vogel et al. 2007). Chinese people also have specific philosophies of health and illness, so they tend to commonly use TCM and regard it as an essential method of the provision of health promotion and preventive care (Wong and Pang 2000).

**Home based care**
UK studies show home based care using traditional or modern medicines, such as home remedies, is often the first resort in illness, especially for mild and non-serious conditions (Stevenson et al. 2003; Howse et al. 2005). Many people from ethnic minorities first try to solve health problems on their own, or in the circle of their family members. The home remedy treatments may hinder the acceptance of health services by patients and can act as a barrier, especially among many ethnic groups (Leclere et al. 1994; Panos and Panos 2000; Howse et al. 2005; Scheppers et al. 2006). With the use of TCM approaches over WM, this may be a strong cultural factor affecting Chinese people’s help seeking behaviour (Ma 1999).

**1.6. Defining barriers to utilisation of health care services in this study**

Help seeking behaviour, as one of the most important elements in health-related behaviours, influences people’s health and well-being. Research studies about help seeking behaviours differ according to whether they look at the process or the end point of health seeking (MacKian 2001). Facility based studies, which may mainly look at the utilisation of health services, record the end point of the process for those individuals who enter a formal system of care. Studies that examine the process of health care seeking tend to explore the factors that influence the illness response, factors which may, or may not, involve the use of particular services, and may result in a single or a succession of help seeking behaviours. Therefore, studies of this kind root the health care seeker in a social background that explores which decisions are made and actions taken during this process.

Help seeking behaviours directly relate to health care utilization and are based on the variable backgrounds of the different medical systems, cultures and economic conditions in different countries among different ethnic groups. The use of health services among ethnic minority groups is lower when compared with their non-
immigrant counterparts (Garrett et al. 1998; Panos and Panos 2000). Ethnic minority patients seem to be confronted with barriers when involved in health care seeking. A barrier in this study means the restriction of the utilization of health services. It is a limitation or condition that makes it difficult for patients to make progress to achieve the objective to prevent or treat health problems. Potential barriers focus on all possible barriers in relation to this process. Barriers can relate to patients themselves which are associated with patients’ characteristics, such as age, income and ethnicity; health care providers which are tied to their attitudes and skills; and health service systems which include policy and organization. In this study, the aim was to explore and identify as many barriers as possible perceived by potential patients, including the end point as well as the process of help seeking. In this way, the factors that hinder the use of health services among older Chinese immigrants will be investigated from their own perspective.

1.7. Health care system in the UK

Help-seeking behaviours are based on a number of factors and the variable structure of the different medical systems in different countries. Racial or ethnic differences may amplify the differences in the treatment and subsequent outcomes for health related indices (Evangelista et al. 2002; Department of Health 2009). The World Health Organisation’s objective of “health for all” suggests that we should ensure that ethnic minorities have equal access to health services, regardless of their standing in society (Blais and Maiga 1999; Scheppers et al. 2006). All UK citizens and legal residents can access health care services as a right of citizenship (McLean et al. 2006).

Based on the Equal Opportunities Policy, the NHS has made a pledge to ensure people of all backgrounds have access to information and high quality services in society in order to reduce the health inequalities that exist (Department of Health 2008; Rawlinson 2008; Department of Health 2010). The most recent White paper by the Coalition Government on Equity and Excellence within the NHS claims that great efforts should be made in order “to ensure that no individual or section of the community is left out” (Department of Health 2010). However, access to healthcare is a complex concept that continues to evolve (Gulliford et al. 2002; Woods et al. 2006). Furthermore, gaining access does not necessarily represent equal quality of health care (Wright et al. 2006; Hussey et al. 2007). Equity implies fairness in access to healthcare services for people
who require them and this service does not vary in quality because of a patient’s characteristics, such as socioeconomic status or ethnicity (Oliver and Mossialos 2004; Szczepura 2005; Department of Health 2008).

In the UK, the Department of Health claimed that inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age (Marmot 2010). Particularly, the term inequality mainly refers to differences in socioeconomic status (Exworthy et al. 2006). In short, people with higher socioeconomic position in society have a more flourishing life and better health than those in lower socioeconomic condition and so it is known that the lower a person’s social position, the worse his or her health will be (Marmot 2010). This may be because more people from deprived socio-economic backgrounds have a lower than expected use of health services in the UK (Goddard and Smith 2001; Sutton et al. 2002). The inequalities in health results in 1.3 to 2.5 million people dying prematurely each year (Marmot 2010). Now The UK government is tending to focus on disparities in socioeconomic status and race/ethnicity during the process of tackling inequalities (Exworthy et al. 2006). The fair distribution of health, well-being and sustainability are important social goals and reducing health inequalities is a matter of fairness and social justice (Marmot 2010). Whilst the local and national government have made commendable efforts to reduce these inequalities, there remains much disparity in gaining access and negotiating the way through the health care service among the vulnerable groups, including the elderly, socioeconomically disadvantaged and ethnic minority groups (Gulliford et al. 2002; Szczepura 2005; Randhawa 2007; Marmot 2010).

Ethnic minority people in the UK are often described as sub groups with lower levels of income, education and employment than local people (Office for National Statistics 2004a; Office for National Statistics 2004b). It is reported that their poor socioeconomic status often leads to poor health outcomes among ethnic groups which include higher mortality, morbidity, lower levels of self reported health and an increase in mental health problems (Randhawa 2007; Marmot 2010).

For ethnic minority groups, there are many factors affecting their healthcare seeking in this host society, such as the existence of deep rooted cultural practices (Backett and Davison 1995; Chen 2001; Miltiades and Wu 2008), a lack of acculturation (Lai and Chau 2007; Miltiades and Wu 2008) and a limited knowledge of the health services to
which they are entitled (Szczepura 2005; Lai and Chau 2007). Therefore, as the consequence of their migration, health care disparities are usually linked to the dysfunctional communication between healthcare services and ethnic patients as well as poor doctor-patient interactions (Department of Health 2008). From ethnic minority patients’ point of view, it may require a particular set of competencies and resources to identify and evaluate their symptoms and to negotiate routes to health care, meanwhile, using health services requires considerable work on this part of people because it demands a range of resources, including knowledge and information resources, social, language and support resources (Woods et al. 2005). On the contrary, from the health professionals’ perspective, they are required to make decisions based on their own judgements of health needs (Woods et al. 2005). Thus, ethnic minority patients may feel dissatisfied with the inappropriate clinicians’ interpretations of their needs or the interventions the professionals prescribe (Garrett et al. 1998; Lai and Chau 2007). This negative attitude is often associated with their unique culture and life background among minority people and a lack of sensitivity of these cultural norms among health professionals (Woods et al. 2005). Furthermore, the interventions from the health care providers are often based on the evidence and data of the population in general, without sufficient information about the characteristics of the ethnic groups (Exworthy et al. 2006). Additionally, the interaction between clinicians and patients is also often influenced by racism and cultural bias as well as other social and cultural factors (Betancourt et al. 2002). It is clear that such poor help seeking would result in a fairly poor health outcome among these ethnic groups and is likely to increase the severity and rates of complications, placing additional demand on the NHS.

In sum, health inequalities do exist for minority ethnic groups, and the underlying reasons are complicated (Randhawa 2007; Marmot 2010). The extent to which these differences in the health system of the UK result in differing levels of disparity in health care quality is not clearly known (Rawlinson 2008). According to the NHS Direct Equality Scheme, people from minority ethnic groups need to gain more understanding of health care services to improve the health service for them. With great efforts, it is possible to improve the health of ethnic minority groups (Randhawa 2007; Rawlinson 2008). Many studies of the utilisation and receipt of health care have showed some evidence of a distinctive patterning according to ethnicity (Woods et al. 2005). However, there is a lack of direct evidence about interactions between minority users and NHS providers. Thus the data remain difficult to interpret and are inconclusive (Woods et al.
There remains an urgent need to improve data and information collection relating to ethnic monitoring so that the reality and the scale of the challenge in reducing health inequalities are clearly understood (Randhawa 2007). By so doing, the goal of providing good quality of health service to ethnic groups may achieve to a greatest extent.

1.8. Summary

After a general understanding of Chinese people’s traditional customs, particularly in respect of health related issues as well as their help seeking in various social contexts within different health care systems, interest in the health seeking behaviour in the setting of the UK emerged as a timely and relevant concern.
Chapter 2 Initial literature review

2.1. Introduction

2.1.1. The function of a preliminary literature review in this study

This study adopts a Grounded Theory approach, believing that theoretical concepts must emerge from the data. Within the literature of Grounded Theory, substantive differences in relation to the nature and purpose of the literature review are apparent. Glaser & Strauss (1967) and Glaser (1978) suggest avoiding a detailed literature review, emphasising the importance of starting a study with as few pre-formulated concepts as possible. On the contrary, Strauss & Corbin (1990) assert that the literature review should be restricted to a background review. Indeed, as Guba (1990) recommends, it is preferable to acknowledge previous work in order to maintain an open mind and avoid preliminary conceptual closure (Guba 1990).

Bearing these debates in mind, the researcher in this study acknowledged that it was impossible to keep the mind empty of pre-conceptions. Instead, after evaluating the previous studies in the proposed area, it is acknowledged that it is reasonable to keep an open mind whilst being mindful of previous findings. Pragmatically and, practically, it was also necessary to conduct a preliminary literature review to progress through the early stages of the PhD study programme, including gaining ethical approval and passing the transfer viva which forms the progress assessment for the programme.

2.1.2. Preliminary literature review

From the information provided in the previous sections it is noted that whilst some general comments can be made about minority ethnic groups, the position of elderly Chinese immigrants is largely uncharted territory. Furthermore, considering the high incidence of certain chronic diseases among this population, CHD and related conditions are chosen as exemplars to investigate at the outset of this study. Accordingly, a literature review was conducted in this area of interest.
**Broad aims in literature review**

The aim of the literature review is to identify the potential difficulties and barriers and the factors that facilitate early help seeking behaviour among older Chinese people, particularly for CHD related conditions.

**Review objectives**

To find the factors that influence health care seeking behaviour among Chinese immigrants.

**Review question**

Do Chinese immigrants experience unique barriers when seeking medical help?

As a minority ethnic group, Chinese immigrants’ help seeking behaviours are relatively complex and unique. It is not clear whether this sub group of people have the same prevalence of heart problems as local people or to what extent they experience differences in access to health care services when facing possible heart disease. There is little consideration of health seeking issues among the under researched Chinese minority ethnic group in the UK. Thus, the literature review will be used to frame the problems facing Chinese immigrants when approaching health care seeking issues. Theoretical perspectives will be developed inductively from the data itself. The literature does not necessarily guide or direct the study. The literature presents a competent level of knowledge about the subject area. At the phase of data analysis, the literature review will become an aid once patterns emerge from the data, providing a benchmark against which the results can be compared and contrasted with the theories generated from the data.

**2.2. Review procedure**

At the outset, no research methods or outcomes measures were excluded. The review of the literature was conducted in the following stages:

- Search strategy
- Inclusion/exclusion criteria
- Data extraction
- Description and assessment of quality of included studies
- Data synthesis
2.3. Search strategy for identification of studies

The aim of the search was to provide a comprehensive list of primary studies which complied with the inclusion criteria. Four electronic databases were searched. These included: Medline (1950 to March Week 1 2008), Pub Med, Embase (1980 to 2008 Week 11) and PsychInfo (1985 to March Week 2 2008). The search also included The John Rylands University Library Electronic Journals: Journal of immigrant and minority health (2006 to 2008) and Journal of Immigrant Health (1999 – 2005). The search was extended by tracking references from studies that emerged from the search. The search was limited to articles published in English. Initially, the terms “CHD”, “help/health seeking” and “Chinese immigrants” were used to perform the search. However, there were no articles directly related to these combined terms. Then the term “CHD” was cancelled to extend the search area. Ultimately, the terms used in the search strategy are shown in Figure 2-1.

Figure 2-1 Terms for literature searching

| 1. Barriers to access to health care seeking: health seeking or help seeking |
| 2. target population: Chinese immigrants |

2.4. Inclusion criteria / Exclusion criteria

To ensure that studies pertinent to the research question were identified, an appropriate study selection process was required. This was based upon the main principles of conducting a literature review (population, intervention, outcomes and study design) (Bhandari et al. 2002) and the identification of appropriate inclusion/exclusion criteria in this study. Figure 2-2 shows these criteria.

Figure 2-2 Inclusion criteria / Exclusion criteria

<table>
<thead>
<tr>
<th>Selection criteria</th>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>Chinese immigrants living in a foreign country who were born in China</td>
<td>Young people</td>
</tr>
<tr>
<td></td>
<td></td>
<td>People who were not first generation immigrants</td>
</tr>
<tr>
<td>Intervention</td>
<td>Health care seeking behaviour</td>
<td>Other forms of behaviours, such as health education</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Studies were included if the outcomes focused on a measure of the factors that influence help seeking behaviour</td>
<td></td>
</tr>
<tr>
<td>Study design</td>
<td>Qualitative/Quantitative studies</td>
<td>Review articles</td>
</tr>
</tbody>
</table>
Inclusion criteria
This study is focused on help-seeking behaviour, older populations, immigrants and Chinese people, including studies on the barriers to the use of health care services among ethnic minorities. These areas are relatively unexplored (Scheppers et al. 2006), especially among Chinese immigrants. Therefore, studies on these topics were included no matter whether they directly related to help seeking behaviours for CHD or to general situations about help-seeking among older Chinese immigrants. Help-seeking behaviour research related to the general population without age limitation is included as a base for the research of a specific population. Studies related to Chinese immigrant patients with heart disease are included as they may have engaged in help-seeking behaviours before and after diagnosis. General health descriptions of health seeking issues among the Chinese population were included for analysing their help-seeking behaviour. Characteristics of Chinese immigrants in these studies were useful for analysing the behaviour of Chinese immigrants. Moreover, investigations in immigrants groups compared with Chinese immigrants and investigations in ethnic minority populations including Chinese immigrants were useful for informing the help seeking process.

Exclusion criteria
As the area of interest was focused on certain chronic situations, investigations about help-seeking behaviour related to the acutely ill were not included. Moreover, studies were excluded if they were about a specific disease or aspect of care, such as cancer, dental care, mental health problems, depression and tuberculosis. Studies were also excluded if they focused on specific age groups other than older people, such as children.

2.5. Data extraction
Citations and abstracts were assessed to identify all the relevant papers. Full text copies were then requested. The majority of studies were those identifying factors that may influence help seeking behaviours related to heart disease, or studies that assessed barriers for people among this ethnic group.

The search resulted in 260 potentially relevant articles in Medline (no related terms), 16 hits in Pub Med, 146 hits in Embase (no related terms) and 463 hits in PsychInfo (no
related terms). Citations and abstracts were used to identify all relevant papers. After applying exclusion criteria and eliminating duplicates, five papers (Chappell and Lai 1998; Ma 1999; Pang et al. 2003; King et al. 2007; Lai and Chau 2007) were identified that met the inclusion criteria and were directly concerned with the help seeking behaviours among the target population, Chinese immigrants. The data is limited in quantity and most of the identified articles were qualitative studies (Ma 1999; Pang et al. 2003; King et al. 2007). Chinese immigrants are an under-researched ethnic group in many aspects. Qualitative research is concerned with the subjective world and offers insight into social, emotional and experiential phenomena. Thus, to gain more information about this under-researched group in-depth, qualitative methods were utilized by most of these researchers.

2.6. Description and assessment of included papers

2.6.1. Description of included papers

All five papers are introduced in the text below, arranged alphabetically by authors’ name. Details of these included studies are presented in Appendix 2-1.

The publication “Health care service use by Chinese seniors in British Columbia, Canada” was undertaken with Chinese seniors in Canada (Chappell and Lai 1998). A large number of interviews (836 in total) were completed in order to gain data and statistical methods were utilised to analyse these data. The researchers found that these participants accept WM well while some still used WM and TCM simultaneously. All the Chinese seniors involved were over 65 years, and none of them were born in Canada which meant that they were all immigrants. Most were born in mainland China. However, over 60% percent lived in Hong Kong before moving to Canada and basically spoke Cantonese instead of Mandarin. The work of Chappell and Lai (1998) provided solid knowledge of the help seeking pattern among Chinese seniors in this particular region of Canada, and is valuable for other studies in this field.

King’s study, “Chinese Immigrants’ Management of Their Cardiovascular Disease (CVD) Risk” emphasised the impact of gender and culture on CVD risk management (King et al. 2007). Fifteen first-generation Chinese immigrants in Canada were interviewed in this study. The interviews were semi-structured and data were analysed following the principles of Grounded Theory. “Meeting the challenge (of CVD risk)”
finally emerged as the core variable from their analysis. The participants in this research had a mean age of 70.3 years, within a range between 53 and 83, which indicated that most of them were elders. This gave opportunities to understand the in-depth reasons for the higher prevalence of CVD among Chinese immigrants, especially those of older age.

In “Predictors of Health Service Barriers for Older Chinese Immigrants in Canada”, Lai and Chau attempted to identify the predictors of help seeking barriers (Lai and Chau 2007). They performed a survey among Chinese immigrants in Canada. The sampling of this survey covered the main population of Chinese immigrants in Canada (2,272 in total). They found that “female gender”, “being single”, “being an immigrant from Hong Kong”, “shorter length of residency in Canada”, “less than adequate financial status”, “not having someone to trust and confide in”, “stronger identification with Chinese health beliefs”, and “not self-identified as Canadian” were significant predictors relating to non health seeking behaviours. Their results provided a general impression of the basic factors involved in the help seeking of older Chinese immigrants.

A specified piece of research aimed at examining the use of traditional and western health services by Chinese immigrants was reported by Ma (Ma 1999). This work was conducted in Houston and Los Angeles, and qualitative and quantitative methods were combined to provide more comprehensive results. Quantitative surveys were conducted with all 105 selected informants (75 Chinese consumers and 30 Chinese health professionals including western physicians and traditional practitioners), including demographic as well as the relationship between demographic factors and health-seeking behaviours. Qualitative ethnographic methods were later used to explore the previous results elicited from the quantitative phase. The findings showed that Chinese immigrants had high rates of self-treatment and home remedies, medium rates of utilisation of integrated western and traditional health services, and low rates of exclusive utilisation of western or traditional Chinese treatments. With the three different approaches in the qualitative research and quantitative survey applied, these conclusions provided a different approach for this kind of research.

"Health-Seeking Behaviours of Elderly Chinese Americans: Shifts in Expectations" reported an investigation into the health seeking of elderly Chinese immigrants (Pang et al. 2003). The researchers principally used qualitative research; focus group interviews
were conducted with Chinese immigrants living in Los Angeles and a complementary survey was used to compile demographic data. This research focused on culture changes and family related issues. As a result, it suggested that expectation shifts "from filial piety to more dependence on neighbours and friends", and "a genuine adaptability to combining Eastern and Western health care modalities" were the main factors affecting help-seeking. The analysis of data in this research is worth referring to because its target population was restricted to community-dwelling elderly Chinese people which influenced its main finding “shifts in expectations” from family to neighbours and friends.

2.6.2. Assessment of included papers

All five papers were assessed for quality using a method developed by Hawker and research colleagues (Hawker et al. 2002). Traditionally, systematic reviews have been concerned with clinical research and have been used to synthesize evidence arising from the results of Randomised Controlled Trials. However, different types of research questions require different evidence-based research; and Green and Britten (1998) argued that qualitative research findings have much information to offer (Green and Britten 1998). The method developed by Hawker and colleagues is a method of systematically reviewing research conducted using different paradigms. After judgments of whether to reject or accept the paper were made, an assessment form was used to identify the quality of the accepted paper.

In Hawker’s method, a number of areas are rated on a 4-point scale from 1 (very poor) to 4 (good). The areas include: abstract and title; introduction and aims; method and data; sampling; data analysis; ethics and bias; findings/results; transferability; implications and usefulness. The range of possible scores of these nine elements is from 9 (the lowest score) to 36 (the highest score). A summary of total scores with sub scores are presented with a clear indication of the strengths and weaknesses of each identified study according to this judgment method. The screening elements for the assessment form is shown in Appendix 2-2 and the details of the assessment criteria for each area are shown in Appendix 2-3 to make explicit how scores are decided on (Hawker et al. 2002).
A total of five studies were included in the literature review. These studies explored the barriers of help seeking among Chinese ethnic immigrants with/without heart problems, such as CHD. Key areas were extracted. Outcomes were collected on the factors that influenced help seeking behaviour. As the studies used different methods, outcomes measures and samples, it was not appropriate to combine data across studies for meta-analysis.

2.7. Results

Five studies which directly investigated health care seeking behaviours in adults among Chinese immigrants were found. Of the five included studies, two studies were based in the US and the other three were conducted in Canada.

It was clear that the studies were heterogeneous in all aspects of design including methods, results and the way in which key outcomes were assessed and reported. The studies employed a variety of research methods and participants. Qualitative interviews were used by most of these studies. All studies included both men and women participants. Ethnicity was defined by the respondent, on the basis of country of birth, or was assessed by interviewers themselves.

2.7.1. Quality of included qualitative studies

The overall quality of included studies was assessed as shown in Appendix 2-4. The scores for methodological quality ranged from 20 to 27. The mean score was 24. The scoring system employed would suggest that the included papers were of moderate quality. All studies gave relatively clear statements of research aims, and the designs were appropriate in meeting the aims of the studies. Participants were selected because they had knowledge relevant to the study. Data collection procedures and processes were clear in all of the studies. Moreover, the findings were explicitly presented and discussed.

The study conducted by King et al. (2007) was judged to be of high quality. Given its roots in symbolic interactionism, Grounded Theory was used to describe and explain the process, providing reliability and theoretical depth to the analysis. Chinese health care providers who worked in Chinese communities assisted in interpreting the culturally
based insider information. Furthermore, an in-depth description of the analysis process using the constant comparative method was given to ensure the auditability of the study.

Generally, one major drawback of the identified studies was a lack of consideration of the relationship between researcher and participant during the whole research process; the researchers did not describe how they managed reflexivity during the study process (Chappell and Lai 1998; Ma 1999; Pang et al. 2003; Lai and Chau 2007). Ethical issues were not always considered or discussed. Only two studies gave a brief mention of ethical issues (King et al. 2007; Lai and Chau 2007), and the other studies did not address any detail of how research ethical approval and consent was gained from the participants (Chappell and Lai 1998; Ma 1999; Pang et al. 2003).

2.7.2. Descriptive synthesis of the research findings

From the literature, it is clear that help-seeking behaviour was described as a complex process which was affected by multiple factors, such as ethnicity, culture, age, gender and socioeconomic status. Accordingly, the author has categorized the challenges of seeking medical help to three groups: intrapersonal factors, interpersonal factors, and external factors.

**Intrapersonal factors**

All included studies identified that one important intrapersonal factor, Chinese traditional culture, was the predominant influential theme in determining health care choices for the Chinese participants. Their beliefs and perceptions of illness causation and health management were woven into the cultural context of “Yin” and “Yang” balance and holism. King’s study which focused on health related behaviours of Chinese immigrants in Canada pointed out that, peoples’ beliefs about health, their understanding of health risk, and their health-related behaviours are influenced by ethno cultural affiliation (King et al. 2007). This point was confirmed by related studies which examined different aspects of Chinese culture rather than health settings specifically (Chen 1996; Tang 2000; Wong and Pang 2000; Chen 2001; Dwivedi 2006). Chen (2001) provided an exploration based on the literature and direct observation in China to describe how Chinese philosophies and religions influenced the Chinese way of living and their idea about health and health care (Chen 2001).
The essential methods to achieve a balance with nature are achieved through maintaining a balanced diet and the use of traditional Chinese medicine (Wong and Pang 2000). Traditional Chinese medicine is an important alternative pathway for seeking medical help in Chinese culture. This phenomenon was reported by all the included studies. It could be concluded that many Chinese people were primarily involved in this pathway of health care seeking. However, despite such a significant emerging theme illustrating a trend for Chinese immigrants to delay seeking help when experiencing symptoms of ill health, the immigrants in Chappell and Lai’s study uncharacteristically had a strong preference for western over Chinese medicine (Chappell and Lai 1998). This finding differs from the other included studies because the emphasis of this study focused on the end point of the health service use rather than the whole process (Ma 1999; Pang et al. 2003; King et al. 2007).

The second important intrapersonal factor reported in the literature was the participants’ knowledge about the disease (Chappell and Lai 1998; Ma 1999; Pang et al. 2003; King et al. 2007). The knowledge and thoughts about their own health situation influenced their access to medical help and was found to be related to factors such as individual education level, the characteristics of CHD as a chronic disease without typical symptoms and the lack of recognition of medical needs.

The third important intrapersonal factor was the influence of social identity in later life (Chappell and Lai 1998; King et al. 2007). Older people may refuse to accept or seek help because they do not feel or admit that they have a need for assistance. They may reject a diagnosis, minimize the implications or be totally indifferent to it. Some older people regard the disease process as a natural part of aging and a normal symptom for themselves, and consequently, feel that there is little doctors can do for them (Chappell and Lai 1998; King et al. 2007). These are all associated with the aging process and it may explain why elders refuse to admit that they have health care needs.

**Interpersonal factors**

The emphasis on alternative sources of care from family is one of the simplest ways to understand a lack of help seeking (Ma 1999; Pang et al. 2003). Some older Chinese people were found to refuse help from professionals and had a preference for care from their family members and friends. Alongside this, family-centred care was a major Chinese value, which has been mentioned in the previous section and which plays a
crucial role in Chinese people’s decisions about how to manage their health. Respect and treatment of parents and elders on the basis of the teachings of Confucius is deeply ingrained in the Chinese cultural value system. In both King and Chappell’s studies, Chinese family members were exclusively obligated to solve their elders’ problems, consequently they would tend to avoid seeking external help (Chappell and Lai 1998; King et al. 2007). They thought illness that occurred in a family member affected not only the individual, but also the whole family. In contrast, Ma (1999) reported another shift in expectations for family support or values. Findings from this study suggested a change from traditional expectations of filial piety to more dependence on neighbours and friends (Ma 1999).

**External personal factors**

External personal factors are identified as influences outside of the participants’ personal control and include elements such as system-related access to health care resource and the changes of lifestyle to the host society (King et al. 2007). Chinese people are faced with access to health care associated with the background of the western health care systems. Ma (1999) pointed out that such information about Chinese traditional cultural issues was unavailable to western-trained health care providers. However, to improve the quality of health care for Chinese clients, it was important to sensitize health providers to traditional Chinese medicine and related alternative healing practices (Ma 1999).

Another problem associated with help seeking behaviour of access to health care is the lack of information about entitlement (King et al. 2007; Lai and Chau 2007). There was often minimal contact with the host society (Huang and Spurgeon 2006), so some ethnic minority groups may not recognize their own entitlement and right to access the health care infrastructure. An earlier study reported that a lack of information and knowledge about available help was common among people from ethnic minorities (Lindesay et al. 1997) but these findings were not specifically related to Chinese elders. Changes of lifestyle has been linked to a number of factors (Ma 2000). These include practical difficulties such as limited linguistic skills (Chappell and Lai 1998; Ma 1999; Pang et al. 2003; King et al. 2007; Lai and Chau 2007), absence of social support networks (King et al. 2007), and conflicts between a high perceived need for integration and unfulfilled expectations (Chappell and Lai 1998; King et al. 2007). Language has made it difficult for Chinese people to access health services. Chinese immigrants have a strong
preference to use services with Chinese staff, probably because of language problems (Chappell and Lai 1998).

2.8. Discussion and implication

All the included studies reviewed reported the influence of traditional Chinese culture and related issues when comparing Chinese ethnic sub groups facing health care seeking compared to the general population or those defined as local people. Moreover, the research literature emphasized traditional Chinese medicine as the primary pathway for Chinese immigrants, which in turn was an important factor which affected the help seeking behaviour for Western medical services among this ethnic group.

The literature showed that help-seeking was a complex phenomenon in which there were likely to be multiple factors influencing the behaviour process, such as age, gender, socioeconomic status and beliefs. As shown in the section on research findings, there were some outcomes that were in conflict, including the extent of the preference for using traditional Chinese medicine and the extent of the influence of traditional Chinese values. Moreover, these studies did not give sufficient explanation for the findings. The reasons and processes behind these issues have received limited attention. However, such inconsistencies in the research literature are unsurprising given the widespread differences in study design and the samples investigated. Indeed, no two studies have utilized the same method to measure or explore help seeking behaviour. The field work in each of these included studies was conducted in limited areas, such as one Chinese community or one Chinatown services centre in one or two cities. Moreover, many studies have used small samples. It can be speculated that these studies are generally lacking in transferability. Furthermore, another explanation to explain the inconsistencies is that the researchers in these studies were lacking in a consideration of the influence of local environment and social factors and provided insufficient detail to have confidence in transferring their findings to other populations. The participants included in the studies came from different localities and the influence of different districts may have affected the results, despite contentions that Chinese immigrants have a unique background culture which affects their behaviour when seeking help from Western medical services. However, there is a dearth of studies examining the effects of local factors and Chinese immigrants’ help seeking behaviours.
Furthermore, there are no relevant studies about Chinese immigrants in the UK. The outcomes of studies conducted in countries other than the UK cannot simply be transferred to the UK as different developed countries have different health service systems (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security 2004; US Department of Health & Human Services 2005; McLean et al. 2006; United States Agency for Healthcare Research and Quality 2006; Wright et al. 2006; Hussey et al. 2007). This might suggest that there could be different barriers to help seeking among older Chinese immigrants in the UK. It must be understood that the views of Chinese immigrants and their evaluations of medical experiences are indeed subject to constant adjustment through the changes in social situations and it can be speculated that older Chinese immigrants’ help seeking and care utilisation may be affected by many complex factors in the UK.

In summary, from the literature review, few published studies exploring help seeking behaviour among older Chinese immigrants have been identified. Moreover, there is a lack of studies conducted in the UK. Further research is required in order to gain a greater understanding of the diverse nature of cultural factors among Chinese immigrants in different districts and to explore its role in help seeking behaviour among this sub group of people. There is also a need to identify other barriers that may demonstrate different utilization patterns among this specific ethnic group when facing health problems in the UK. It is this omission that this study seeks to address.

2.9. Why do this study in the North West England?

Aside from the knowledge gap, there are some other reasons for this study to be conducted in the UK. As a vulnerable group of immigrants, the lifestyle changes associated with immigrating to a new society puts Chinese people at even higher risk of certain health problems, such as cardiovascular diseases, than the local population (Sheth et al. 1999; King et al. 2007). However, no culturally specific data have been published about such situations among older Chinese immigrants to date in the UK. This study will investigate the help seeking behaviour among this sub ethnic group in the North West England for several reasons. First, the prevalence of cardiovascular diseases (including CHD) is higher in Northern England which was identified in a recent study among the general population in 354 English local authorities after controlling for ethnicity (Congdon 2008). Second, though Chinese immigrants in the
UK form a large ethnic group and this ethnic subgroup is still growing fast (National Statistics Online 2003), the published investigations providing an understanding of their health related conditions are limited. Third, it is important to acknowledge the specific cultural contexts of elderly members of this group in the UK. Understanding their experiences of illness is important for the prevention and education of common chronic diseases. Fourth, Manchester has one of the largest Chinese communities in the UK and therefore knowledge about these communities will provide important data to health care providers. Thus, current and further immigrants will gain information to improve their health. Finally, as a native Chinese person, the researcher will be able to access and communicate effectively with this under-researched group of people and having a non-western background may lead to a thorough interpretation of results based on this cultural background.
Chapter 3 Methodology

3.1. Philosophical and theoretical perspectives

Within the world of research, there is considerable debate arising from differing research paradigms and their theoretical and philosophical underpinnings. This section will examine the underpinnings which influence quantitative and qualitative research studies. It will present a broad introduction, highlighting the links between philosophy and science and will then discuss the specific philosophical perspective which has influenced this study in relation to other research paradigms and will link to the chosen methodology.

3.1.1. The philosophical underpinnings of research

“A paradigm encompasses three elements: epistemology, ontology, and methodology. Epistemology asks, How do we know the world? What is the relationship between the inquirer and the known? Ontology raises basic questions about the nature of reality. Methodology focuses on how we gain knowledge about the world.” (Denzin and Lincoln 1994, p 99)

Epistemology and ontology as the dual fundamental principles form the underpinnings of any instance of social inquiry to study knowledge (Jupp 2006). Ontology deals with the issue of the essential nature of reality and theories of being and is concerned with what is real (Jupp 2006). That is to say, what the form and nature of reality is and therefore what can be known about it (Denzin and Lincoln 1994). In contrast, epistemology is concerned with whether or how people gain the knowledge of reality; it focuses on the process of knowing (Flick 2006; Jupp 2006). What can be known is the core question in epistemology. However, the answer to this question should be constrained by the ontological one. In this way, if there is a real reality, the researcher should ensure the questions of how things really are and how things really work can be found in the research process (Denzin and Lincoln 1994). The methodological question is about how to find out whatever he/she believes can be known by the researcher (Denzin and Lincoln 1994). Again, this answer depends upon, and should be consistent with, the answers to the previous two questions. The methodological issue cannot be simplified to a question of methods; it is the resonance of the researcher’s ontology and epistemology. Denzin and Lincoln (1994) propose that the philosophical concepts of ontology, epistemology and methodology cannot be simply separated (Denzin and Lincoln 1994). The consistence between theoretical and methodological approaches is
important in giving the study its rigour. The ontological and epistemological beliefs of the researcher lead the choice of the philosophical paradigm of the research. Therefore, the type of theoretical perspective that provides the framework for thinking about the social world is throughout affected by the researcher’s philosophy; it also informs and predetermines the research design and methods, as well as the analysis and interpretation of findings (Denzin and Lincoln 1994).

### 3.1.2. Theoretical paradigms

Quantitative and qualitative methods are not readily amenable to full-scale descriptions that all researchers will accept (Avis 2005; Flick 2006). In part, these ambiguities about the nature of different research approaches have arisen from their fundamental underpinnings which in turn relate to philosophical issues (Silverman 2000; Avis 2005).

Traditionally, two broad philosophical paradigms are portrayed as polarised epistemologically and ontologically (Denzin and Lincoln 1994; Rothwell 1998). At one end of the scale is positivism (Hammersley 1993) which is often considered as the philosophical basis for quantitative research and defines reality by means of some objective or universal truth or truths whilst the epistemological aspect of positivism suggests that reality is considered as being discoverable through the application of rigorous scientific methods to the research process (Giddens 1975; Avis 2005). Positivism holds that reality is absolute and exists independent of consciousness; that reality is seen as being beyond the human condition (Giddens 1975; Jupp 2006). Positivist researchers emphasise that the only authentic knowledge is that which is based on actual sense experience applied to the research process with scientific rigour (Jupp 2006). Scientific researchers propose hypotheses as explanations of phenomena, and design experimental studies to test these hypotheses (Gray 2004; Jupp 2006). These steps must be repeatable in order to predict any future results (Denzin and Lincoln 1994).

Thus the goal of positivism generally is to find the external reality which is separated from the subjective imagination and it is testable as well as amenable to being verified, confirmed, or falsified by the empirical observation of reality (Guba and Lincoln 1994). This emphasis is common to all paradigms under the term positivism, including naïve
realism and rationalism. Furthermore, these paradigms predetermine the chosen methodology as being located in quantitative analyses.

However, there are criticisms of the positivist paradigm arguing that the approach is unable to address satisfactorily the nature of facts or the interactive nature of an inquiry (Denzin and Lincoln 1994). The positivist claim to objectivity faces conflict when applying its methods to the study of humans, who are influenced by many interacting variables and therefore prediction or experimentation becomes difficult if not impossible (Denzin and Lincoln 2000). The following section will discuss the other polarised paradigm, interpretivism, which is used to meet a series of criticisms of positivist views.

3.1.3. A sociological paradigm – Interpretivism

Interpretivism is a generic sociological paradigm and is used extensively in social science with its aim to gain understanding of social phenomena (Weber 2004; McAnulla 2006; Williams 2008). It is pluralistic and includes many approaches which insist on the interpretation of the nature of knowledge, such as social constructionism, symbolic interactionism, phenomenology, ethnography and ethnomethodology (Denzin and Lincoln 2000). There is an extensive body of literature offered by various authors which gives different and colourful descriptions of these philosophical issues which in itself is perhaps a reflection of how individuals understand the ideas of interpretivism and the nature of reality.

From an ontological perspective, interpretivists believe that social reality cannot be separated from the social actors such as participants and the researcher. A central concept in interpretivism is that human experience is a process of interpretation of the interaction with the external world as opposed to merely the reception of it (Weber 2004; Williams 2008).

From the standpoint of epistemology, interpretivists recognise that knowledge is derived from socially constructed concepts and meanings (Weber 2004) and that research is socially constructed, the aim being to produce a world of life view of the topic under investigation (Weber 2004; Williams 2008). The nature of the researcher in
interpretivist research means that the researchers themselves are the most important tool. In this way, the researcher and the research object are interdependent (Avis 2005).

Interpretivism is the theoretical basis for qualitative research and always uses an inductive strategy which is based on interpretation and understanding. These interpretations and understandings are the accounts of social life given by social actors (participants). Their everyday beliefs and practices are articulated in order to portray a picture of their real world (Weber 2004). Thus, social scientists report participants’ social life via fieldwork, such as observation and interview (Weber 2004). Further, there are interpretivists who generate theory from the descriptions produced from participants’ accounts (the role of theory in qualitative research will be discussed later in the section of “Theory development”).

According to interpretivism, reflexivity is a very important issue. Reflexivity refers to how people see their own actions, how they perceive that others see their action, how they interpret data from the actions of others and how they modify their actions in order to present themselves in the light that they want to be seen (Higgs and Cant 1998). In this way, the account of behaviour is situated within a social context. This will be presented in detail in the section on “Reflexivity”.

In sum, in contrast to positivism, interpretivism emphasises constant articulation for rigour and discipline when investigating the dynamic and complex nature of society and social interaction. Qualitative research approaches attempt to gather an understanding of human behaviour within a broad context (Avis 2005).

3.2. Choosing a paradigm in this study – interpretivist paradigm

A paradigm is a set of basic beliefs, which are based on ontological, epistemological, and methodological assumptions and premises (Denzin and Lincoln 1994). Therefore in order to ensure a strong research design, researchers must choose a paradigm that is congruent with their beliefs about the nature of reality and the way of knowing it (Mills et al. 2006). In this study, the chosen paradigm is the interpretivist paradigm for reasons outlined below.
From an ontological perspective, the researcher in this study believes that in human inquiry, reality and the individual who observes it cannot be separated. Also, the knowledge of the participants is constructed from their understandings of the meanings of the world and the interactions of the meanings. Epistemologically, the researcher in this study believes that knowledge is built through social interpretation of the world and it is recognised that the knowledge that is built reflects the particular goals of Chinese elders’ health related experiences in the UK as well as the researcher’s own life experiences, including culture and history. It is important to make sense of the Chinese elders’ world intentionally via this interactive investigation. The investigation therefore, will inevitably be collaboration between the researcher and the researched through which an understanding of the real world of the Chinese elders will be explored. Chinese elders posses unique subjective characteristics, which then leads to their unique understanding of their health related behaviours in the UK. In this way, the researcher in this study believes that when keeping her subjective characteristics consistent with Chinese elders’ subjective characteristics via the interaction with them, it will be possible to produce an interpretation and an understanding of this aspect of Chinese elders lives. The interpretation itself, presented by the researcher, should be made clear to others at the end of the investigation.

According to the ontological and epistemological stances, interpretivist methodology is chosen by the researcher in this study. The researcher believes that reality is socially constructed rather than objectively determined, and that events are interpreted by humans who are active, self-aware and capable of perceiving and generating meaning. In this way, via interpretivist methodology, Chinese elders’ interpretations of the meanings of health related events, such as help seeking or the use of health care service can be investigated, rather than the events themselves.

3.2.1. Interpretivism vs. constructivism

The constructivist and interpretivist paradigms are the two classic beliefs under the term interpretivism (Denzin and Lincoln 1994). Though the constructivist and interpretivist perspectives share a common intellectual heritage, they are unique in considering what the aim of human inquiry is and how to know about the world of human action (Denzin and Lincoln 1994).
Constructivism is of more recent vintage than interpretivist thinking. Constructivists believe that what they take to be objective knowledge and truth is the result of perspective. Knowledge and truth are created, not discovered and their pluralistic and plastic characteristics are highlighted in constructivism (Schwandt 1994). The aim of constructivism is to create human knowledge through a process of construction in the research endeavour and therefore has obvious links with positivism or, more accurately, post positivism (Denzin and Lincoln 1994).

Interpretivism is conceived as a reaction to the effort to develop a natural science of the social world. Interpretivism admits the subjective influence in both social knowledge and social research, and considers it inevitable. In this way, a researcher conducts an investigation to understand the meaning of social phenomena rather than describe an underlying law or rule. There are various attitudes towards the relationship between researcher and the objects being researched. However, they all agree that the aim of interpretivism is to discover human knowledge by interpreting social action.

The researcher in this study follows a more interpretivist approach rather than constructivist one. It is believed that Chinese elders know their world best and only through their interpretation of the health related behaviours, the reality is able to be fully understood. In this way, the reality and knowledge of Chinese elders’ health related behaviours are found out by interpreting.

3.2.2. Selection of Grounded Theory as the methodology

Methodology is the theory of methods and defined as the analysis of the principles of methods, rules, and postulates employed by a discipline to study a particular research topic (the nature of the research question) (Creswell 1998). Philosophical and practical issues are considered in selecting the methodology for the proposed study. The most important point is that there should be consistency between the ontological stance, the epistemological underpinnings and belief and the methodology or methodologies.

Through the process of selection of theoretical strategies, the researcher also considered many other qualitative methodological approaches, especially phenomenology, and ethnography. These both have the purpose of describing aspects of a culture from the insiders’ view, which, to some extent are similar to Grounded Theory (Hammersley and
Atkinson 1995; Silverman 2000; Flick 2006). However, rather than concentrating on individual experience (phenomenology and Grounded Theory do focus on individual experience) ethnography focuses on the social world, and the type of findings is the production of an in-depth description of a culture as well as analysis of phenomena in the participants’ cultural settings (Hammersley and Atkinson 1995; Flick 2006). In this way, ethnography is more suited to the descriptive type of question (Morse 1994). The main research method used in ethnography is observation and conversations secured through long periods of immersion in the field. In the case of this study, due to the diverse nature of the participants and their wide distribution over a large area, identifying a field to study was not possible.

Phenomenology focuses on the individual level, it emphasises analysis of the structure of conscious subjective experience as opposed to the social process; it deals with meaning questions, eliciting the essence of experiences (Morse 1994). It has a relationship with philosophy to some extent as well as concentrating on exploring the meaning of the individuals’ lived experiences and aims to find the characteristics and nature of human experiences (Ray 1993; Flick 2006). Through the phenomenological reduction process, it produces an interpretation of human nature and the lived experience in order to identify the nature of that experience (Ray 1993). In sum, this study focused on individual experiences and aimed to analyse participants’ everyday knowledge of the social process related to their help seeking. Therefore phenomenology was deemed to be incongruent with the aims and objectives of the study. Consequently, Grounded Theory was deemed to be the most suitable approach to meet the process questions (Morse 1994).

The selection of methodology needs to be concerned with the congruence with the purpose of the study and the researcher’s perspective (Denzin and Lincoln 1994). In terms of philosophical considerations, to create a comprehensive and meaningful picture of the Chinese immigrants’ social world, particularly in respect of help seeking behaviour, a reflexive stance with theoretical sensitivity was selected to facilitate the whole process of data collection and data analysis. The personal philosophical position of the researcher is that knowledge and social reality is constructed in context. Grounded Theory is a specific qualitative approach which is under the broad umbrella of the interpretive paradigms (Glaser and Strauss 1967). It was adopted because the goal of Grounded Theory is to generate a theory in order to explain a social phenomenon and
offer solutions to problems (Glaser and Strauss 1967). In this study, Chinese elder’s help seeking in the UK was under-researched and therefore Grounded Theory was chosen to identify a series of events in their lives and their real concerns in their social world and was perceived as the best approach to answer the research questions.

3.2.3. The chosen methodological approach of qualitative research

3.2.3.1. Common characteristics of qualitative approaches

The word qualitative implies the process and meanings of social life. In defining the nature of qualitative study, some meta-assumptions have been emphasised (Lincoln and Guba 1985; Higgs and Cant 1998):

- There are multiple constructed realities (i.e. different people have different perceptions of reality through their attribution of meaning to events, meaning being part of an event and not separate from it)
- The process of inquiry changes and both the researcher and participant are interdependent rather than independent of each other
- Knowledge is both context and time dependent and qualitative research searches for a deep understanding of the particular social situations or phenomena located within a context and a timeframe
- It is more useful to describe and interpret events rather than to establish cause and effect

In this way, it is evident that there are a number of common features of qualitative studies (Miller and Dingwall 1997; Higgs and Cant 1998; Silverman 2000; Punch 2001; Denzin and Lincoln 2003). These features are summarised as follows:

- Qualitative researchers are likely to commence with an exploratory research question about how people think and act in certain social settings.
- A qualitative approach is primarily inductive; therefore, theory may be incorporated within qualitative work at any stage
- Qualitative research emphasises the interconnections between participants and their social context rather than ignoring these factors
- Qualitative research focuses on participant’s subjectivity in which interactions with others and situated events influence their lives
- Qualitative research considers the subjective role of the researcher which enhances their sensitivity during the research process.
A key distinguishing feature of qualitative research is the way in which findings are described and predicated (Higgs and Cant 1998). Thus, qualitative research looks at the whole and takes account of the context of the situation; it is a descriptive and exploratory mode of research.

3.2.3.2. Selection of interview as qualitative method

Data collection plays an important role in a research study and the quality and credibility of a study is partially governed by methods which are chosen to perform data collection (Charmaz 2006). Individual interview, participant observation as well as focus groups are the primary means of collecting qualitative data (Morgan 1997; Berg 2004). Participant observation is usually undertaken over an extended period of time (ranging from several months to many years) in order to obtain more detailed and accurate information about people and typically occurs in groups with a greater variety of interactions with the study participants (Morgan 1997; DeWalt et al. 1998). In this study, help seeking behaviour is a private action in private spaces, which may not occur or occur at any one particular time; furthermore it could be a long process. Because of the uncertainty of its occurrence, the method of participant observation was considered impractical to investigate the help seeking behaviour in a relatively short time (e.g. one year) among a decentralized population.

Basically focus groups are interviews, but of several people at the same time, asking about their perceptions, opinions, beliefs and attitudes towards a product, service, concept, advertisement, idea, or packaging. Rubin and Rubin (2004) explained that the goal of focus groups was to let participants spark off one another and sometimes a totally different understanding of a problem emerged (Rubin and Rubin 2004). However, in this study, in order to investigate health related experiences which were quite private for elders, it was more appropriate to collect data via individual interview rather than focus groups. Furthermore, compared with focus groups, traditional interview styles permit a more detailed pursuit of content information (Berg 2004). By applying Grounded Theory as the methodology in this study (this will be discussed in detail in the following section), the generation of relevant data for gaining in-depth and precise information is achieved during the analysis process; and in this instance, face-to-face interviews were chosen for the process of enquiry (Charmaz 2006). Efforts are made to
ensure that relevant and adequate data are gathered so that this transition process is illuminated sufficiently (Glaser 1992a).

3.3. Location of Grounded Theory

Grounded theory is located within the interpretivist research paradigm. In this study, Grounded Theory which was influenced by Symbolic Interactionism will help the researcher to understand the social constructs of the Chinese elders involved. Prior to detailed discussion of Grounded Theory, the philosophical underpinning of Grounded Theory which is located in Symbolic Interactionism is discussed.

3.3.1. Symbolic Interactionism

Grounded Theory and Symbolic Interactionism are both derived from American pragmatism and Grounded Theory is frequently associated with Symbolic Interactionism (Glaser and Strauss 1967; Strauss and Corbin 1998; Cutliffe 2000). Symbolic Interactionism has its roots in the Chicago School of Sociology and particularly from the work of George Herbert Mead. At the core of Mead’s belief, is that he places humans at the centre of social life and emphasises their visibility within the social context. According to Mead, individuals are self aware, able to see themselves from the perspective of others and therefore adapt their behaviour according to the situation. Interaction is key between mind, self and society and Mead considered mind, self and society as inseparable processes (Mead 1939). The development of pragmatism is usually attributed to Herbert Blumer, a student and interpreter of Mead. Blumer (1969) coined the term “Symbolic Interactionism” and put forward an influential summary of the perspective. Based on his thesis, interaction and interpretation are at the heart of Symbolic Interactionism. Blumer (1969) set out three basic premises of the perspective. Firstly, human beings act toward things on the basis of the meanings that those things have for them. Secondly, the meaning of such things is derived from, or arises out of, the social interaction that one has with others and the society one lives in. Thirdly, these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he/she encounters (Blumer 1969). Generally, these three core principles are concerned with meaning, language, and thought, emphasising that there is no single element existing as an independent entity in society.
Symbolic Interactionism is usefully employed in the methodology of Grounded Theory using qualitative methods to study both aspects of social interaction and the individuals acting within the social realm (Gray 2004). It stresses the notions that meanings are mutable for individuals and people act as they do because of how they define situations in the light of changing circumstances. Hence, human behaviours are composed of two parts: considering all the events/things as individual encounters and making actions according to the interpretations of these events/things.

3.3.2. Grounded Theory
3.3.2.1. Origins and history

In the early 1960s, Glaser and Strauss explored the experiences of patients dying in hospital and developed Grounded Theory (Glaser and Strauss 1965). Glaser and Strauss (1967) argued that many existent methods were focused on obtaining facts to verify a particular theory or hypothesis. They argued that this logical deductive stance, developed from a priori assumptions, often acted as a barrier for sociological researchers. To overcome this perceived problem, Glaser and Strauss presented the description of Grounded Theory as a systematic way of formalising the operations needed to develop theory from empirical qualitative data, in a rigorous way that fitted with the demands of empiricism (Glaser and Strauss 1967). Meanwhile, Glaser (2001) emphasised that the data in Grounded Theory contained interviews, observations and documents in whatever combinations (Glaser 2001). Also, Glaser (Glaser 1978) stated four central criteria: fit, work, relevance and modifiability, which required that: the theory would fit the data and the real world; the theory would work across a range of contexts and be able to explain what happens; the theory would be relevant to the people concerned; and the theory “must be readily modifiable, based on ever-emerging notions from more data” (p 4). As Glaser asserted, the goal of Grounded Theory is to develop a theory that accounts for a pattern of behaviour which is relevant and problematic for those involved. It is common for Grounded Theory to focus on the basic social processes employed by individuals to resolve an issue that is challenging for them, and accordingly generate a theory to explain this behaviour and predict future patterns of behaviour (Glaser and Strauss 1967; Glaser 2001).
3.3.2.2. The nature of Grounded Theory

“Grounded Theory is an inductive methodology... It is the systematic generation of theory from systematic research. It is a set of rigorous research procedures leading to the emergence of conceptual categories. These concepts/categories are related to each other as a theoretical explanation of the action(s) that continually resolves the main concern of the participants in a substantive area.” (Glaser 2008)

Grounded Theory is now one of the main methods in qualitative studies, using a systematic approach to analyse and generate qualitative data (Thomas and James 2006). As Grounded Theory rests on an interpretivist ontology, there is an underpinning that people impose their internal perceptions and ideals on the external world and, in so doing, actively create their realities (Suddaby 2006). From this perspective, the key variables of interest are internal and subjective and the purpose of Grounded Theory is to elicit understandings about patterned relationships between social actors and how these relationships and interactions actively construct reality rather than to make truth statements about their reality (Glaser and Strauss 1967).

There are a lot of features that ensure its unique identity. Among them, an evident one is that Grounded Theory creates a theory that provides an insight and explanation into the phenomenon under study (Glaser and Strauss 1967). It is concerned with the whole process of theory generation. A key feature of grounded theory is that it suggests that this process is facilitated through an interaction between the participant and researcher, as well as the data collection and analysis process (Glaser and Strauss 1967; Glaser 1978; Glaser 1998; Bluff 2005).

In sum, Grounded Theory emphasises both the research process itself and the results of the research process (Bryant and Charmaz 2007). It is an inductive and systematic qualitative research process based on the beliefs of Symbolic Interactionism, where theory is generated from the ground up and it is built upon the constant comparative method and simultaneous data collection and analysis.

3.3.2.3. Glaserian and Straussian versions of Grounded Theory

Over the years, two perspectives of Grounded Theory have developed (Strauss and Corbin 1990; Glaser 1992b), the Glaserian approach and the Straussian perspective. The debate between the two originators of grounded theory became more and more
acrimonious (Strauss and Corbin 1990; Glaser 1992b) and the Glaserian and Straussian perspectives of Grounded Theory emerged after the respective publications, “Theoretical Sensitivity: Advances in the methodology of Grounded Theory” (Glaser 1978) and “Qualitative analysis for social scientists” (Strauss 1987).

Following the division between Glaser and Strauss, Glaser (1992) developed his original approach to Grounded Theory. At the same time, Strauss and Corbin (1990, 1998) developed their own detailed, systematic way to conduct Grounded Theory research, particularly the process of analyzing data (Strauss and Corbin 1990; Strauss and Corbin 1998). They formulated a more prescriptive approach to Grounded Theory research which arguably hindered the creation of an inductive and more flexible theory in the Glaserian style and Glaser (1992) claimed this new method should be called “full conceptual description” (Glaser 1992b).

Heath and Cowley (2004) argued the Glaserian and Straussian versions shared the same ontology about the fundamental belief that knowledge might be increased by generating new theories rather than analysing data within existing ones; but the versions differed in the epistemological issues slightly, including the induction, deduction and verification, as well as the form that the emerging theory should take (Heath and Cowley 2004).

Generally, the Glaserian version has a more purist qualitative research approach with an interpretivist stance to inquiry, using qualitative analysis for qualitative data explanation. However, the Straussian version uses a more quantitative means to analyse the qualitative data, reflecting a post positivist stance to inquiry. Because of these diversities based on epistemology, there are debates in current Grounded Theory methods. The literature review and constant comparative method are the two significant features related to the epistemological issues. Glaser and Strauss both acknowledge that no one can enter the field completely free from the influence of past experiences (Glaser and Strauss 1967; Glaser 1978; Glaser 1992b). However, they have different views on the role of the literature review. This issue is detailed as follows.

3.3.2.3.1. Controversy on the issue of literature review in Grounded Theory

The controversy over the issue of the literature review in Grounded Theory mainly focuses on the initial literature review. Glaser and Strauss (1967) emphasised that it was
very important in Grounded Theory to enter the field without a specific focus on a population group and they were against having predetermined ideas when carrying out data collection (Glaser and Strauss 1967). In this way, researchers are advised to collect data in the field first and then to review literature which relates to the areas of study and emerging themes. Later, in the discussion of “the proper pacing of reading the literature with the Grounded Theory process” (p 31), Glaser (1978) maintained the idea that researchers should enter the field as free as possible from preconceived ideas and start data analysis and theory generation. In this way, researchers can avoid narrowing the problem and formulating a theory with insufficient data. In following this process he suggested that researchers would remain open to what is actually happening in order to avoid forcing the data in the wrong direction if they were influenced by concepts derived from the literature (Glaser 1978). Thus Glaser strongly recommended that the literature search should be done when the generation of theory is nearly completed during sorting and writing up phases of the investigation (Glaser 1998).

On the other hand, Strauss and Corbin (1990) took a more liberal position concerning the role of literature in the research process, maintaining that the literature could be used at the beginning of the study (Strauss and Corbin 1990). Not carrying out a literature review might be somewhat idealistic when considering the practical aspects of research projects such as funding, ethics and time. Moreover, some researchers also indicate that an initial literature review combined with the bracketing of prior assumptions can provide the novice researcher with ideas that they can then use to compare with their own categories as they emerge from the study (Morse 2001). This was an important consideration in the conduct of this study.

3.3.2.3.2. Difference in constant comparison

For Glaser and Strauss (1967), Grounded Theory is a general method of comparative analysis. It emerges inductively from the data source in accordance with the method of constantly comparing conceptualized data through different levels of abstraction (Glaser and Strauss 1967). As a method of discovery, the constant comparative method is an amalgam of systematic coding, data analysis and theoretical sampling procedures which enables the researcher to make interpretive sense of much of the diverse patterning in the data by developing theoretical ideas at a higher level of abstraction than the initial data descriptions (Haig 1995).
Glaser (1978, 1992) persisted in this commitment and viewed induction as the key process from the empirical data to theory (Glaser 1978; Glaser 1992a). However, in Straussian Grounded Theory, deduction and verification dominate and analysis in the approach is described, using experience and the literature to extend the analysis and guide the examination of subsequent data (Strauss and Corbin 1990). Heath and Cowley (2004) pointed out the novice researcher would be in danger of verifying existing knowledge rather than discovering new theories and this is an acknowledged danger within the Straussian approach (Heath and Cowley 2004). This “constant comparison” as the core data analysis technique will be outlined under the section of “data analysis” later.

3.3.2.3. Diverse coding procedures

Another very significant point of diversity between Glaserian and Straussian versions is coding procedure as well as theory generation (Heath and Cowley 2004). In the original text, Glaser and Strauss described two levels of coding divided into categories and integrating categories (Glaser and Strauss 1967). However, Straussian style changes the two levels (substantive and theoretical coding) to three levels (open, axial, and selective coding) of coding procedures (Strauss and Corbin 1990). The main controversy here is axial coding. Strauss and Corbin (1990, p 96) defined it as “a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories. This is done by using a coding paradigm involving conditions, context, action/interactional strategies, and consequences.” Whereas open coding fractures the data into categories, axial coding puts the data back together by linking connections between the categories and subcategories. Put simply, Strauss and Corbin (1990) believed that data were systematically examined in relation to a paradigm model (Kendall 1999). Glaser (1978) insists that the codes used and, in fact the actual labels placed on the codes should be driven by conceptual interests that have emerged from the data and not be forced into any particular scheme, such as the paradigm model (Kendall 1999). Therefore, Strauss and Corbin’s method focuses more on operational steps than on theory development and encourages the production of poorly integrated theoretical explanations (Robrecht 1995; Heath and Cowley 2004).
3.3.2.4. Charmaz’s constructivist Grounded Theory

“Neither data nor theories are discovered… we construct our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices.” (Charmaz 2006, p 10)

Another famous version of Grounded Theory is constructivist Grounded Theory which is developed by Charmaz who claimed that her new form of Grounded Theory was more pragmatic and adopted a relativist approach which kept faith with the Glaserian and Straussian approaches (Charmaz 1998; Charmaz 2000; Charmaz 2006).

Though it was a contemporary revision of the two original authors’ versions, Charmaz rejected Glaser and Strauss’s talk about discovering theory as emerging from data separate from the scientific observer; furthermore, she claimed that Grounded Theories were constructed through the researchers’ own involvements and interactions with people, perspectives and research practices.

However, Glaser (2002) argued that constructivist Grounded Theory is a misuse of the word and claimed that Grounded Theory was not constructivist (Glaser 2002). In Glaser’s view, Charmaz remodelled Grounded Theory from a conceptual theory to a conceptual description method with full coverage of the interactive interpretation. Glaser (2002) maintained that constructivist Grounded Theory was not the real Grounded Theory but the Qualitative Data Analysis method with worrisome accuracy at issue. Moreover, Glaser (2002) emphasised that “all is data” (Glaser 2001) and explained that “the participant not only tells what is going on, but tells the researcher how to view it correctly – his/her way” (Glaser 2002). In this way, the quest of gaining mutual interpretation as the answer would be an unwarranted intrusion of the researcher. Glaser however, highlighted that bias was just another variable and a social product and Grounded Theory was abstraction from time, place and people that frees the researcher from accurate description (Glaser 2002). Therefore, Glaser (2002) concluded that constructivism was an effort to dignify the data and to avoid the work of confronting researcher bias; and Grounded Theorists did not construct an image of a reality but discover the reality, the conceptual one, as objective as humanly possible (Glaser 2002).
3.3.3. Choosing Glaser’s Grounded Theory

In sum, as claimed by many authors, it is not the intention to sensationalize the disagreement between prominent sociologists or find the “right” or “real” Grounded Theory as both methods can produce sound work, but caution that the researcher needs to be clear precisely what method is being used (Stern 1994; Melia 1996). To avoid the methodological disputes, researchers should describe the dilemma in the study process in sufficient detail as there are different criteria for evaluating the rigour of the approach (Stern 1994).

In this study, the researcher placed her faith in Glaser’s classical Grounded Theory and used it as the methodology to guide data collection and analysis to generate the theory. The source of this faith is the view the researcher has towards human knowledge about social matters based on her ontological and epistemological perspectives. The researcher believes that the knowledge one possesses comes from interpretation of the phenomena we all observe. The involvement of subjective characteristics during this process cannot be eliminated or ignored. However, the building up of theory is not a constructivist enterprise. The researcher agrees that interactions between the meanings of symbols in human society or group define the meanings of certain processes for this society/group. Also, the researcher shares the view that only the people in a specific group understand the affairs related to this group at the highest level. Therefore, in order to investigate the characteristics of this specific group of Chinese elders, it is important to conduct in-depth interviews to listen to and let them tell the story since Chinese elders know their health world the best.
Chapter 4 Working Methods

4.1. Introduction

The previous chapter concentrated on the theoretical underpinnings of the research approach adopted in this study, this chapter is concerned with the working methods. In qualitative research, the details of the whole procedure of conducting the study are very important since differences exist from study to study as well as researcher to researcher (Berg 2004). Thus, it is usual for qualitative researchers to make clear how they conducted studies to the audiences of the text (Lincoln and Guba 1985). In Grounded Theory study, Stern (1994) emphasised the researchers should include a detailed description of the methods used when presenting the thesis (Stern 1994). In doing so, the researcher offers a detailed account that explains how the study has advanced theory and how the conceptualization of the emerging patterns of behaviour or phenomenon are grounded in the data. This process assists the readers to review the findings with a critical eye and offers them the ability to evaluate the quality of the research findings (Lincoln and Guba 1985; Denzin and Lincoln 2003).

4.2. Personal biography

As the subjective nature of qualitative research enquiry means that the researchers themselves are the most important tool in the process (Williams 2008), their particular social identity and background have an impact on the research process (Lincoln and Guba 1985; Robson 2002; McGhee et al. 2007). Thus, it is important and necessary to provide a personal biography to indicate the characteristics of the researcher’s own personal details which might influence the process as a whole. It is hoped that this will allow readers to evaluate the study. The following is a resume of the researcher mainly focusing on the characteristics which may affect this work.

Before coming to the UK, the researcher gained a Bachelor Degree of Medicine (September, 2002 – July, 2007) in Preventive Medicine, West China School of Public Health, Sichuan University, China. As an intern in the Centre for Diseases Control and Prevention (CDC), Chengdu, the researcher had attended some programmes of work most of which were community based projects. The researcher increasingly identified problems with the community health situation in China and developed a passion for
assisting people with preventative health during the social working process. Therefore, the researcher decided to go to the UK to study for a full time PhD degree in a health care department which began in September, 2007.

As a native Chinese person, the researcher lived in China with her family for about 24 years and has therefore been influenced by the traditional Confucian values. It is very complicated to describe how the Confucianism affects the thinking and behaviour pattern comprehensively. Philosophically, the researcher believes that reality exists and needs to be interpreted in the setting and knowledge is constructed and based on the social context. In this way, the researcher has been influenced by the philosophies of interpretivism, and interactionism. In terms of religion, the researcher is deeply influenced by Confucianism, and to some degree Chinese Buddhism.

The particular danger for the researcher in this Grounded Theory study is outlined here. As a native Chinese person sharing the same cultural background with the participants to some extent, it could be a merit or a drawback in conducting this study. On the one hand, as a Chinese person, it was relatively easier for the researcher to access and communicate with this ethnic group through sharing the Chinese cultural background and the Chinese language. These understandings of participants’ background, attitudes, and actions were essential for knowing the world in which people live, from their own description (Chambliss and Schutt 2006). However, the sharing of the same cultural background may also bring some potential risk for this study. The interpretation might be affected by the researcher’s previous experience and knowledge, and not come from the data themselves. Sharing a common culture may mean that the obvious, mundane or routine is overlooked. In contrast, it could also mean that the researcher has a heightened sensitivity based on a shared understanding. It is noted in the literature, that both these criticisms and advantages could be valid.

4.3. Research questions, study design and aim, sample selection

4.3.1. Research design and aim

This study utilised a Glaserian Grounded Theory approach to explore the elderly Chinese immigrants’ health related behaviours, particularly their help seeking behaviour when faced with certain possible health problems. There were many reasons for choosing Grounded Theory but primarily it was used to gain an in-depth understanding
of people’s experiences, behaviours, motivations or perceptions. The most important reason was the desire to enter into the participants’ social world to see how they construct their reality from their perspective and synthesise the findings in order to contribute to the development of empirical knowledge (Glaser and Strauss 1967). This provided a means to illuminate these Chinese elders’ experiences and allowed the conception of a theoretical understanding of this phenomenon, particularly when there was (as in the study presented here) a lack of information about this sub group. Qualitative interviews provided an opportunity to obtain an understanding and in-depth insight into Chinese elders’ views of this important area of health care provision.

4.3.2. Research questions

In this study, the classic Grounded Theory approach according to Glaser and Strauss (1967) and the later writings and contributions of Glaser (1978, 1992) was adopted. In terms of their position, it is emphasised that the Grounded Theory study begins with general and broad questions. The rationale for this decision is to achieve the main goal, the development of a theory grounded in the data. In addition, Glaser (1998) emphasised the importance of listening for the researcher during the early interviews so that the questions can be modified when the researcher becomes sensitised to the emerging data (Glaser 1998). The initial research questions were purposefully general. The following figure shows the key research questions based on the timeline of the practical development of the study.
Figure 4-1 Timeline of the practical development of the study

1. June 2008
The initial design was to investigate the initial help seeking behaviour when facing some potential symptoms related to CHD among elderly Chinese. The study would be a qualitative study following Grounded Theory to generate a substantive theory.

2. November 2008
After interviewing several participants, the researcher found that elders did not have specific knowledge about CHD and what they were concerned about was their general health and illness. Therefore the research question was modified to one which related to general health behaviour. At the same time, the researcher attended a Grounded Theory troubleshooting seminar. Some Grounded Theory experts in that seminar thought there were some technical concerns with the research questions for this study and suggested the researcher change the interview questions to very open ones which allowed the researcher to investigate the participants’ real concerns about their own world. This was also approved by both supervisors.

3. January 2009
The study remained qualitative in design. The final design included very general questions, about the life of Chinese elders here in the UK and their recent health adapted to the local conditions of Manchester.

Figure 4-2 shows the change of questions from a pre-set way with some professional concern to a very open approach during the initial interviews:

Figure 4-2 Changes of questions

The following initial broad research questions are identified:
- Do Chinese elders have barriers to initial help seeking?
- How do Chinese elders manage their health problems?
- How do Chinese elders manage their health problems related to CHD, if any?

Over the course of the study, the questions were refined and final questions guiding this study were:
- Do Chinese elders have concerns about the health issues?
- How do Chinese elders manage their health problems?
- How do Chinese elders deal with concerns, if they have them?

4.3.3. Sample selection

A theoretical sampling approach suggested by Glaser (1978, 1992) was adopted to guide the selection of the potential participants in this Grounded Theory study. Glaser (1967, 1978, and 1998) highlighted the purpose of theoretical sampling was to discover categories and their properties and to integrate them in order to generate a theory based on their interrelationships. From Glaser’s perspective, theoretical sampling is not a
predetermined procedure but a process where the researcher decides where to proceed in the study based on ongoing data analysis and emerging ideas. It is this joint process which informs which data to collect next and where to find it (Glaser 1978). In this way, researchers are required to be involved in the simultaneous data collection and analysis as the subsequent participants are chosen for their theoretical relevance to the developing categories.

Though the necessity of theoretical sampling is throughout the whole data collection, the initial sampling in the very beginning is actually purposive sampling. In the methodology literature regarding sampling, it is identified that there are similarities between the terms purposeful and theoretical (Coyne 1997). Meanwhile, Coyne (1997) suggested that all sampling in qualitative research could be categorised under the umbrella of purposive sampling and explained that theoretical sampling was purposeful selection of a sample in order to develop categories and generate theory (Coyne 1997). Additionally, within the context of Grounded Theory study, Coyne (1997, p 625) also argued that an element of purposive sampling was involved in theoretical sampling at the initial stage as “the researcher must have some idea of where to sample, not necessarily what to sample for, and where it will lead”, emphasising purposively selecting the first sample where the phenomenon occurred (Coyne 1997). Glaser (1992, p 102) also outlined the rationale behind initial sampling in Grounded Theory, that is, suggesting that “groups are chosen as they are needed”, which is evidently a purposeful selection. In this way, according to the approach of Grounded Theory, sampling diversity is focused during the recruitment procedure in order to gain the point of saturation and generate a theory.

The aim of this study was to increase the understanding of the experience of help seeking behaviour among Chinese immigrants in the UK. In order to develop theoretical categories, a purposive sample was adopted. As little was known about the help seeking behaviour among this sub ethnic group, it allowed recruitment to be initially based on the information from the pre-field work literature review and the feedback from discussions with research supervisors. The literature showed that the incidence of common chronic diseases was high in the elderly group and considering the isolation issues among minority people, through such factors as language barriers, it was known that elders possibly faced more difficulties living in this host society. Therefore, both researcher and supervisors decided to choose Chinese elders as the target study
population to explore help seeking experiences. This study aimed to investigate the barriers for early help seeking behaviour with certain chronic symptoms, such as CHD related conditions; the target population were healthy Chinese elders living in the UK. The inclusion and exclusion criteria are shown below:

Inclusion criteria:
- Healthy Chinese people (self defined by the elder and not in acute treatment) aged 60 years old or over
- First generation Chinese living in the UK

Exclusion criteria:
- People receiving acute medical care for certain chronic disease or treatment for an exacerbation of a chronic condition, including CHD

Inclusion and exclusion criteria were assessed on initial recruitment before consent to interview but there was always the potential for CHD patients to be included among these “healthy” people. Therefore, by exploring their experiences of early help seeking this approach would allow the barriers to early help seeking behaviour with CHD related conditions to potentially be investigated. However, preliminary data analysis showed that elders had few or no worries related to CHD but only some general concerns about help seeking issues.

4.4. The research process

Based on reading many texts related to qualitative study, it was found that there was no well organised pattern, style or fixed set of procedures for conducting a qualitative study which are often described as being flexible, context specific and dependent on the aims for the study. Therefore, accounting for this flexibility the following guide was constructed (Hammersley and Atkinson 1995; Robson 2002; Gray 2004):

- Choice of study sites
- Getting in
- Gaining Access and initial contact
- Gaining Trust and Rapport
4.4.1. Choice of study sites

Glaser (1992) pointed out that the initial selection of potential participants was to maximise the likelihood of collecting evidence on the research topic (Glaser 1992b). The target population, Chinese elders, were a minority group living in the UK and were likely to get together in Chinese communities in Chinatown. The first study site the researcher chose was a large Chinese community centre which was a Chinese Women’s Society. For reasons of confidentiality, the name of this site is not given and only a brief description of the site is provided. The first study site was an Elderly Luncheon Club, for both female and male Chinese elders. This particular site was part of a demographically large Chinese community which provided various levels of support and activities for elderly people, including lunch, exercises and a mini bus service to assist in travel. One significant feature which should be mentioned here is that in this site almost all elders spoke mostly in Cantonese.

At this point in the study, there seemed be no reason to believe that one particular setting was more or less likely to yield useful information than any other potential site. There was also no reason to assume that regional factors which might affect the findings would be particularly different at this site when compared with others. Thus, the selection of this study site was mainly made for pragmatic reasons. That is, the site had a large population of Chinese elders who could be invited to participate in the study. Further, this site also afforded easy access for potential recruits in terms of travelling, therefore saving money as well as time for the researcher.

In contrast to the first site, the other sites were not specially for elderly Chinese people. For example the Chinese Christian church was a Christian club for all age levels and thus there were Chinese people of different ages. Though the samples of Chinese elders were less in number at this site, participants could potentially be recruited by word of mouth. Here the potential participants spoke both Mandarin and Cantonese. A further site was a Buddhist Temple in Manchester, which included Chinese people at all age levels and the situation was similar to the Chinese Christian church. At this site people of a spiritual nature could be recruited. Through this approach participants with diverse backgrounds were engaged in this study. Movement between the sites came from recommendations of participants at earlier sites and is a key aspect of purposive sampling (Glaser 1992b; Coyne 1997).
4.4.2. Getting in

Murphy et al. (1992) described gatekeepers as a key group who could influence the process of a research project (Murphy et al. 1992). Gatekeepers are defined as people who have the power to negotiate access to other individuals within the organization, or to grant formal permission for access as the first points of contact in the organization or social environment (Walker et al. 1999). It is acknowledged in the literature that it is essential to understand both the benefits and the disadvantages of using gatekeepers, most usually community leaders, for accessing participants. Gatekeepers have the potential for introducing the research team to the wider community whilst it is also acknowledged that they can act to block access in their role as community leaders (Walker et al. 1999).

Developing relationships with gatekeepers was crucial in this study (Gray 2004). Berg (1999) highlighted the particular importance of obtaining support from gatekeepers when conducting research in minority communities, emphasising their role as leaders (Berg 1999). Getting in was the first consideration for the researcher. Prior to access to these study sites, telephone calls were initially made to each of the senior staff members or managers who had responsibility for the overall management in the respective organizations. To show respect, after a brief description of the study via telephone, the researcher made appointments to see senior staff members face to face. During the first meeting, the researcher introduced herself, explaining that she was a self-funded researcher. After outlining the nature of the study and the broad aims, the details of the requirements for sampling were outlined. At this point, the researcher stressed that participation in this study was totally voluntary. One copy of the Ethical Approval for this study was given to each senior staff member to show that the study had been peer assessed and scrutinised by senior researchers. Creating a good impression and introducing the ethics of the study has been noted to be an important part of securing the trust and cooperation of gatekeepers in the early stage of the research process (Murphy et al. 1992; Gray 2004).

Through the developing partnerships with these managers and by maintaining a good rapport with these individuals, the study became workable. This resulted in being granted access to different kinds of study sites in order to gain access and collaborate with various participants.
In different settings, the researcher had to work with different gatekeepers. Though the majority were accommodating, which led to effective recruitment via the gatekeepers, it was notable that elders might feel coerced to attend the interview. Therefore a response letter (detailed later) which ensured that the participants had opportunities to decline to be interviewed without being embarrassed or pressurized by gatekeepers was given by a staff member to potential recruits.

4.4.3. Gaining access

It is noted that the essence of gaining access requires the establishment of personal connections and that the “personal relationship” is more important than simply following prescriptions outlined in textbooks about research methods (Lofland and Lofland 1984; Carey et al. 2001). The ways that researchers have gained access varies from study to study and these approaches are often as distinct as the investigative approaches they use (Carey et al. 2001). This Grounded Theory study used the Glaserian principle of “groups are chosen as they are needed” (Glaser 1992b, p 102) and in this study elderly Chinese immigrants were found to be located in certain Chinese communities. These communities were generally separate to the generally culturally mixed services provided in this area for older, indigenous people.

In the first site, after all necessary details were explained to the manager, the manager agreed to support this study in her organisation. This manager facilitated access to two senior colleagues who had direct responsibility for the management of this luncheon club and who were familiar with the Chinese elders. Following their suggestions, the researcher posted two copies of the information sheet on their dissemination boards. Then the researcher was invited to give a very short self presentation and explanation of what the study would involve to all the elders in the club on a designated day in the absence of any staff. The researcher described the nature of the study as a “grounded” free talk, which would involve a semi-structured interview and perhaps a second formal/informal interview to check out the findings once the data were analysed. The researcher took time to explain in plain language during the presentation. At the end of the presentation, the main considerations relating to the whole interview process were discussed and the potential participants were assured that participation was voluntary and their confidentiality would be protected.
The identity of the researcher as a PhD student in School of Nursing, Midwifery and Social Work at the University of Manchester was emphasised in order to show there was no relationship with local GPs or any other health services. Then the researcher delivered the information sheet and response letter which contained contact details to all elders and informed them that they did not need to give any response immediately. At the end of the presentation, the researcher indicated that anyone who was willing to participate in this study could contact the researcher directly via telephone or email as indicated in the information sheet or they could contact staff at the centre via the response letter. Adopting this approach aimed to avoid placing any pressure on the elders by other individuals, including the gatekeepers, staff and even their peers. Before the researcher left the study site on the day of the presentation some elders had already shown an interest in the study and asked questions related to the potential interview, such as the duration of the interview and whether it was hard to answer the interview questions. The researcher explained as clearly as possible and offered reassurance and then thanked them for their support for this study.

Creating a good impression and being open and honest has been noted to be an important element in successful qualitative interviews (Murphy et al. 1992). The researcher ensured that senior staff were thanked for their help and guidance. Following their advice, some information sheets were then left on the reception desk in order to provide some kind of publicity material to those elders who might later show an interest in the study Showing respect and gratitude at an early stage of a study has been found to be useful in facilitating the research process (Gray 2004).

In the other study sites, the researcher followed the same procedure and was allowed access to the societies or organisations. As introduced previously, these sites were not specifically for elderly people but general Chinese groups. As they were organisations which involved different activities or meeting events, such as lectures in health information or legal knowledge, the researcher visited before the activity commenced, approximately once every two or three weeks. If there were Chinese elders present then a member of the club or society would introduce the researcher in order to have a short talk with them, including an introduction, a presentation of the study as well as an emphasis on the autonomy and voluntary nature of the study along with a discussion of the confidential nature of the study. If the elder showed interest in being interviewed,
then an information sheet was given. The elders were informed that details about the
time and location could be discussed later after enough time had been allowed to read
the information leaflets and decide about participating in the study.

None of the senior staff the researcher encountered refused to take part or give support.
The researcher felt this was a reflection of the open and honest account of herself and
the research process. A consequence of this approach was that many elders showed their
interest in this study and indicated that they were willing to be interviewed in the future.

In addition, as most interviews were conducted in Chinese communities, there were
some opportunities to continuously meet more elders. In this way, the researcher visited
these elders in person to deliver an information sheet and to introduce the study. Some
interviewees also referred their friends (in the community) who became interested in
this study. Once again, this recruitment strategy fell well within the recommendations of
Grounded Theory and purposive sampling (Coyne 1997).

The period of time between the delivery of information sheets to the interview stage
varied from two days (the minimum period considered suitable for people to decide
about participating) to more than three months.

4.4.4. Initial contact

In choosing interview locations, both pragmatic issues and concerns about power
relations between participants and researchers should be considered (Elwood and Martin
2000). If participants are allowed to choose where they prefer to be interviewed, it is
better for participants in terms of finding the location and travelling. Furthermore,
participants who are given a choice about where they will be interviewed may feel more
empowered in their interaction with the researcher, so that they may choose a place
where they will feel comfortable to speak freely (Elwood and Martin 2000). Particularly
regarding to Chinese culture, letting the elders decide is an essential way to show
respect and concern.

Following the initial introduction, including the provision of information sheets and the
oral presentation in each Chinese centre or individually by the researcher, most elders
who wanted to take part in the interview contacted the researcher directly via telephone.
Very few elders contacted the researcher via the response letter. The length of time from receiving the information sheets to the first contact moment (contacting the researcher by telephone to discuss further time of the formal interview) was also quite variable depending upon the participants’ decision. Through the telephone, the time and location of the potential interview were arranged. Many elders preferred to be interviewed in the community centres; some gave their home address and wished to have a more private interview at their home. Almost all kindly considered that the researcher was a student and the schedule for a student would be fixed, asking the researcher to decide the interview time. Usually, the elder and the researcher together decided a time appropriate for both of them. Additionally, the details of how to contact the researcher were again provided to participants to make sure they could get in touch if arrangements needed to be altered.

4.4.5. Gaining trust and rapport

When considering interviews as a means of data collection, it must be acknowledged that any physical or functional interactions can affect the data that is obtained (Miller and Dingwall 1997). Two particular matters related to both participants and researchers were considered here, partnership between interviewer and interviewee and the issues of researcher’s characteristics, which may influence this interaction (Chambliss and Schutt 2006).

In order to portray a true version of the individual’s experiences, it is important to establish the research-participant relationship in terms of rapport and trust, thus allowing the creation of a situation where the interviewee feels comfortable and able to talk openly and act at ease (Miller and Dingwall 1997).

In the ideal situation, the interview in a Grounded Theory study is that the researcher assists the participant in conveying almost a monologue on the topic under interest (Berg 2004). However, this is very much dependent on pragmatic issues, such as the focus of the topic and the extent of talkativeness of the elders in this study. To provide an effective way to engage with the elders and achieve a successful interview outcome, the interview depended on the formation and maintenance of good rapport (Berg 2004).
After meeting with the elders, prior to the commencement of the interview, the participants were again asked to inform the researcher personally or by letter, if they felt that they did not want to participate. The researcher emphasised that even when they had agreed to be interviewed, if they changed their mind they were free to withdraw at any time without giving any reasons. This is noted to be good practice and is recommended by ethics committees as a way to ensure that participants do not feel coerced (Gray 2004). The researcher made it very clear that the decision about whether to attend for interview or not was their own and no one else would know, including friends and staff in the various organisations. Confidentiality was again emphasised. Throughout this process the researcher endeavoured to communicate respect and civility during the early interactions with potential participants.

Appearance and demeanour were aspects that the interviewer considered in relation to the development of a rapport. As Stone (1962) pointed out, appearance as well as mood provides information to interviewees whether to agree or not to an interview. In response to this the researcher considered how to present herself when preparing for the interview. The researcher chose to dress simply and neatly, showing a student style and choice of clothing (Chinese people would expect a student to be dressed neatly). Moreover, the researcher spoke politely to participants and answered their questions patiently in order to create a relaxed encounter.

Berg (2004) stated, though no two people were exactly alike, good rapport could be built if the interviewer was able to establish some sense of common ground (Berg 2004). In this study, the researcher, as a native Chinese person, could, to some extent, share a similar cultural background to the elders. Though she was a student and young, and the participants were senior people and had resided in the UK for a longer time, the presence of a fellow Chinese person helped to bridge the potential distance between the elders and the researcher. During most interviews, the researcher found common ground by referring to familiar Chinese culture elements and events that were jointly understood. Further, as an international student just living in the UK for three years, the researcher found some common experiences with the participants, such as initial difficulties in getting used to the UK. In this way, during the interview process, the researcher always possessed some degree of understanding, which improved the development of rapport and relationship with the participant. Securing trust and
engaging with participants is known to be an essential component in gaining trustworthy data (Miller and Dingwall 1997; Berg 2004).

However, as an interviewer, although the researcher was aware that the establishment of rapport with the participant was of course very important, neutrality was also a very crucial issue that could not be overlooked. As Patton (2002) argued, neutrality means the participant could tell the interviewer anything without evoking either the favour or disfavour of the interviewer with regard to the content of the response from the participant (Patton 2002). During the interview process in this study, when listening to the participant, a useful response was often “Oh, I see” or “OK, I understand” which facilitated participants in telling their story. The researcher chose her language carefully to avoid asking leading questions of the participants or showing certain attitudes to them, such as shock or embarrassment. Language, such as “good”, “super” or “you are right”, were avoided during the conversation with participants to prevent leading the elders. The researcher also focused on the content of what the participant was saying using a reflective or summarising style to show rapport, respect and to accurately follow the meaning offered by the elder. Patton (2002) remarked that in doing this the interviewer is able to show respect and acknowledge that what was being said was important because of who was saying it. This is achieved in this study by the use of a non judgemental approach which allows the participants to explore their own story (Patton 2002).

There were other ways to develop trust and rapport that the researcher used during the interview process. For example, when some elders were coughing during the interview, the researcher politely passed the tissues and took them a cup of water, letting them take their time and allowing people rest for a while if needed. The researcher accompanied these elders patiently and slowly when walking into the interview room. In this way, elders thought that they were being taken good care of and respected. By doing so, a good relationship with trust and rapport between elders and the researcher was established.

Additionally, except during the individual interview, the researcher also took measures for gaining a good relationship with these elders. Therefore, it was acknowledged that sharing aspects of their world may help to improve the understanding of their conversations and their individual perspective. After entering the field, the researcher
took part in some of the activities in these organisations, such as participating in Tai-chi and staying for lunch when invited. Most Chinese elders were very happy to develop a good relationship with the researcher and considered her as a younger friend. Thus, most of the interviews were conducted smoothly like a normal conversation with an “insider” or “friend”. This aspect also enhanced the accurate interpretation from elders’ perspectives in the data analysis process and the researcher could place the participant in a space and to some degree life world (social context) during the analysis and writing process. This is an essential component of Grounded Theory construction (Glaser 1978; Glaser 1998).

In Grounded Theory methodology, data collection and analysis as well as data interpretation occur simultaneously. However, in order to give a logical presentation of what has been done during this study, these issues are organized under separate headings in the following sections.

4.5. Method of data collection: interview

The interview is a way of accessing people’s feelings, perceptions, meanings and constructions of reality (Punch 2001). Many definitions of the interview have been offered but the main features of research interviews are (Gillham 2005):

- Questions are asked or the topics raised are generally open ended with the interviewee determining their own answers.
- The relationship between interviewer and interviewee is responsive or interactive, allowing for a degree of adjustment, clarification and exploration.
- There is structure and purpose on the part of interviewer.

In addition, Kvale (1996) described 12 aspects of the mode of understanding in the qualitative research interview. The details are shown as below in Figure 4-3:
Figure 4-3 Aspects of qualitative research interviews

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life world</td>
<td>The topic of qualitative interviews is the everyday lived world of the interviewee and his or her relation to it.</td>
</tr>
<tr>
<td>Meaning</td>
<td>The interview seeks to interpret the meaning of central themes in the life world of the subject. The interviewer registers and interprets the meaning of what is said as well as how it is said.</td>
</tr>
<tr>
<td>Qualitative</td>
<td>The interview seeks qualitative knowledge expressed in normal language; it does not aim at quantification.</td>
</tr>
<tr>
<td>Descriptive</td>
<td>The interview attempts to obtain open nuanced descriptions of different aspects of the subjects’ life worlds.</td>
</tr>
<tr>
<td>Specificity</td>
<td>Descriptions of specific situations and action sequences are elicited, not general opinions.</td>
</tr>
<tr>
<td>Deliberate naïveté</td>
<td>The interviewer exhibits openness to new and unexpected phenomena, rather than having ready-made categories and schemes of interpretation.</td>
</tr>
<tr>
<td>Focused</td>
<td>The interview is focused on particular themes; it is neither strictly structured with standardized questions, nor entirely “non-directive”.</td>
</tr>
<tr>
<td>Ambiguity</td>
<td>Interviewee statements can sometimes be ambiguous, reflecting contradictions in the world the subject lives in.</td>
</tr>
<tr>
<td>Change</td>
<td>The process of being interviewed may produce new insights and awareness, and the subject may in the course of the interview come to change his or her descriptions and meanings about a theme.</td>
</tr>
<tr>
<td>Sensitivity</td>
<td>Different interviews can produce different statements on the same themes, depending on their sensitivity to and knowledge of the interview topic.</td>
</tr>
<tr>
<td>Interpersonal situation</td>
<td>The knowledge obtained is produced through the interpersonal interaction in the interview.</td>
</tr>
<tr>
<td>Positive experience</td>
<td>A well carried out research interview can be a rare and enriching experience for the interviewee, who may obtain new insights into his or her life situation.</td>
</tr>
</tbody>
</table>

Source: (Kvale 1996, p 30-31)

It is evident that the research approach to interviewing suggested by Kvale (1996) is suitable for a Grounded Theory study. A Grounded Theory study explores (Qualitative) participants’ main concerns (Meaning) in their life events (Life world); and it requires the researchers to keep their mind open (Deliberate naïveté) to investigate the issues from their perceptions (Descriptive) in depth (Specificity). Then the researchers need to be sensitive (Sensitivity) during the conversation with the participants (Interpersonal situation), conceptualise the themes (Focused) and then generate a theory which is grounded from the data (Ambiguity & Change). The interview and the potential re-interview may bring some ideas to the participants, letting them to re-think their life events (Positive experience).
4.5.1. Semi-structured interview

There are many different types of interview, such as standardised interview, semi-standardised (semi-structured) interview and un-standardised and Berg (2004) explained that the major difference between these interviews was the degree of rigidity of the presentational structure (Berg 2004). Semi-structured interviews are located in the middle of the continuum of these different approaches and are defined as more or less structured which means that the questions and/or wording of questions is flexible (Berg 2004). The main advantage of semi-structured interviews are that they allow the conversation to flow where it needs to in order to deal with the participants ideas as they arise which is well suited to the ideas of Grounded Theory. The aim of Grounded Theory is to discover the participants’ complex behaviour without imposing ideas from the researcher that may limit the field of inquiry. In this way, a loose approach is suitable for this exploratory study. The interview questions need to be flexible but with a theoretical direction, particularly as the study progresses and themes begin to emerge. Thus, semi-structured interviews are the most suitable style to conduct the interview within a Grounded Theory study though it also has some disadvantages. It is generally agreed that this approach to data collection requires highly developed interviewing skills and careful preparation is also needed in order to avoid asking leading or prescriptive questions (Wengraf 2001).

With regards to this study, the interviews were designed to collect qualitative data regarding the cultural and social context of Chinese elders’ lives in the UK in relation to their health and help seeking behaviour. The questions about the key themes or concepts, such as health experiences and management of health problems, were asked of those involved. Furthermore, the kind and form of questions went through a process of development to ensure the topic and focus of the interview developed alongside the analytic process. Meanwhile, the interview topics and the time taken were flexible to ensure that exploration of new and emerging themes could occur simultaneously. In this way, deep and rich information might be obtained by the researcher. The questions became more focused and evolved as the analysis progressed and the categories emerged in this Grounded Theory study.

The interview guide initially contained topics which the extensive literature review had indicated as relevant to the study aims which were modified and developed by the
researcher in response to interim analysis and emergent findings. Moreover, the characteristics of “openness” meant that the participants were able to discuss areas which were important to them as opposed to the topic or direction that the researcher solely imposed upon them. In doing this, the researcher was able to ensure that the data remained grounded from the participants’ perspective.

4.5.2. The interview process

This can be thought of in four stages (Gillham 2005):

- The preparation phase, which begins before the interview takes place
- The orientation phase, which is used to explain the interview
- The substantive phase, the central core of interview
- The closure phase

4.5.2.1. Preparation phase

The preparation phase is important for improving the efficiency of the study; it aims to make sure that potential participants know what the study is about and understand what is required from them (Gillham 2005).

The preparation phase began with the initial contact and information giving at the beginning of the study. First, the ethics of informed consent and the information sheet were again highlighted to make sure that the elders knew they could withdraw at anytime without giving any reasons, and ensured that participants understood what was required of them in the research process. It is noted that allowing the participant to decide and control as much of the interview process as possible is very important for gaining good quality data (Denzin and Lincoln 1994). The suitability of the location was again checked and efforts were made to ensure that the setting was as comfortable and familiar as possible in order to put participants at ease. For example, if the interview was conducted in a community centre, the researcher asked the participant to suggest a place where she/he would like to be interviewed; usually an empty room of their choice was used.

For the researcher the preparation phase commenced before the day of the interview. Factors which might affect the interview were carefully considered, such as recording
equipment, including spare batteries and suitable refreshments (e.g. water). The researcher reminded herself of the main practical issues before conducting each interview. Furthermore, prior to the interview, the researcher checked the routes, leaving enough time to ensure a punctual arrival. A voice check on the digital recorder prior to the interview along with ensuring that all relevant documents, such as the consent form, was part of the preparation process. Though these issues seem relatively trivial, they are necessary to ensure that the interview is conducted without hindrance (Murphy et al. 1998) and give the interview a professional aspect (Gillham 2005).

Additionally, in the preparation phase, social elements were considered, such as the style of introducing the researcher (Gillham 2005). In this study, the participants were all older Chinese people. Showing respect for Chinese elders, particularly by younger people is essential in securing trust (Xie et al. 2007). In order to show respect to these elders, the researcher introduced herself again politely, dressed smartly in a way that would be expected and the introduction included much more detail such as personal biographical details and reasons for conducting the study (e.g. keeping a role of a student, emphasising there was no link with any health services). This meant that the interview began with some sharing of information.

4.5.2.2. Orientation phase: explaining the interview process

In this phase, the main task is explanation which does not only relate to the purpose of the interview but the whole research process. This includes recording of the interview, data analysis as well as the issues of confidentiality (Gillham 2005).

Before starting the main body of the interview, the researcher discussed the issue of the language to be used during the interview and the use of the digital recorder. All interviews were conducted in the participants preferred language (Mandarin or Cantonese) to offer a comfortable way to communicate. In fact, none of the participants chose English during the interview (despite the fact that some were bilingual) only interspersing a few simple English words to show their English level in their daily life. Thus, prior to the interview, if the participant had indicated that they spoke in Cantonese, she/he was asked whether an interpreter was needed or not. For the researcher, Mandarin is the first language but the researcher can understand Cantonese but not speak it fluently. As Mandarin is the Chinese official language, most elders who
spoke Cantonese could also understand Mandarin but could not speak it fluently. This is a peculiarity of the Chinese languages that both are understood but only one is the chosen form of communication (in fact, during the interviews with Cantonese elders, most of them alternated between both Cantonese and Mandarin languages when communicating with the researcher. Though the researcher repeated that elders could choose the dialect which would be more comfortable for them, these Cantonese elders still used some Mandarin to show their politeness to the researcher). Therefore, after being given a choice almost all interviews were conducted without the need for an interpreter. Only one interview needed an interpreter to translate as that elder spoke a rare dialect of the Chinese language.

In order to record the interview there are generally two methods suggested for interviews (Gubrium and Holstein 2001). The traditional method is the use of hand notes where the interviewer records responses during the interview. The biggest disadvantage is that the interviewer spends the majority of their time writing notes during the interview process and as a consequence may lose a lot of information from the interviewee in terms of body language and facial expressions which may have significant importance for the interpretation of data. The lack of eye contact with the interviewee may also cause a disjointed interview process and in the case of Chinese elders may communicate disrespect. Note taking also has a subjective element as it is impossible to record all responses fully and therefore there is an element of interpretation with this form of recording.

Audio-recording can be an ideal solution to provide a complete verbal record and free the researcher from note taking during the whole interview process. It allows the interviewer to use non verbal communication skills, such as eye contact, reassuring nods, some gestures, to enhance rapport during the interview process (Gubrium and Holstein 2001). It then helps the researcher explore issues in depth as cues can be taken from the participants’ non verbal language. The recorded interview also provides a permanent record of the interview which can be audited by other researchers and supervisors. However, some authors also point out disadvantages of using tape recordings (Patton 1987). The main drawbacks of recording interviews are that the tape recorder may make the interviewer and interviewee feel somewhat unnatural; but many commentators note that in reality the presence of the tape recorder is usually forgotten after few minutes (Witte et al. 2001).
In this present study, as a novice researcher with relatively little interview experience, all interviews were recorded using a digital recorder in order to avoid missing any important information. After inviting the participant to sit down, the researcher properly explained to the participants: “I would like to record what you say so I can understand what is said later and not miss any of it. If I take time to rely on my notes, I think I will miss something that you say or inadvertently change your words somehow. So if you do not mind, I will use it. If during the interview, you want to turn it off or whatever, you just tell me and I will switch it off.” This was a way of ensuring respect.

After this explanation, participants were always asked to indicate their comprehension. Then the researcher informed the participant that the recording would begin immediately to avoid losing any valuable information. However, there were still some issues to note, as mentioned in the field notes:

“Before each interview, I told the participant that during the interview, the tape recorder would be used and I explained the reason for using it, for the data analysis. After I emphasised the confidentiality – only I would listen to the recording and every participant agreed to be recorded during the interview. Though, I still could feel that not everyone was very happy with the recorder. During the processes of the interview, there were only a few participants glancing at it. Some other participants, while conscious of the recorder, did not seem intimidated by it; and as the interview went on, they totally forgot it. But for most participants, they were happy for the tape to be left on to show how true their talking was and their responsibility for what they had talked.”

(Field note – About the recording)

In this phase, participants could ask questions based on the information sheet and other related questions. This helped ensure ongoing consent for interviews for both researcher and participant (Gubrium and Holstein 2001). Before the researcher commenced any questions, participants were referred back to the interview letter. Most participants, interestingly, did not read the information sheet in advance before the interview. Some of them explained that they did not have the ability to read the information sheet because of their poor eyesight or illiteracy. All participants explained that the staff or their friends had introduced the general nature of the interview (e.g. content related to health issues) to them so there was no need for them to read the information sheet again.

In order to correct this, the researcher covered the contents of the information sheet at the beginning of the formal interview to ensure that the participants knew the interview research process. All participants indicated that they knew what was involved in the interview. In spite of this, the researcher repeated the information. The researcher took time to explain in plain language about the content for the interview, such as:
“I will ask something about your life and your experience in help seeking. Questions won’t be tricky, please just tell me your own feeling...... The research I am conducting is aimed to understand the help seeking situation of Chinese immigrants in the UK, and hopefully the results of the research can improve the service towards them.”

Additionally, after explanation of the interview, the researcher reinforced the issues of confidentiality, highlighting the consent form. Consent was not taken for granted at this stage and written consent was gained for all interviews. Meanwhile, it was also emphasised that the participants could terminate the interview at any point without any reasons. In this way participants’ autonomy was maximised (Denzin and Lincoln 1994).

4.5.2.3. Substantive phase

The interview guide
As stated by Glaser (2002), much interviewing in Grounded Theory study involves passive listening; then later certain narrower questions based on emergent categories during theoretical sampling are discussed in order to generate a theory explaining participants’ world (Glaser 2002). However, the interview guide is an important part of the interview which enables interviewers to become very familiar with the subject or problem area and it is critical for the interview to be conducted in a conversational, informal way (Gillham 2005). In this way, a very open interview guide with some key points is suitable and essential for a novice researcher to conduct a Grounded Theory interview, particular in the early stage.

The resultant interview guide included open-ended questions covering demographic information, migration experiences and living conditions in the UK. Questions related to help seeking behaviour included experiences and perceptions of accessing health care services. Several scenarios were included to assess participants’ knowledge about CHD when necessary (this was the area of interest at the early stage). The interview guide employed open-ended question to encourage extended responses. It provided topic or subject areas with which the researcher could explore, probe, and ask questions to elucidate and illuminate the subject area. However, as the interviews moved on, the researcher became more familiar with the points in the interview and became more actively involved in the process. The communication with the elders became much smoother; there were more and more natural conversational dialogues with the participants. As a Grounded Theory study, the simultaneous data collection and analysis process facilitated the researcher to pursue the new ideas in later interviews. The
interview guide at the early stage of the research and the modified one during the simultaneous data collection and analysis process are presented in Appendix 4-1. A short excerpt of a methodological memo is given here to show the continuous modifications of the interview topic guided by the theoretical direction:

“There seems some professional concern in advance, try to ask open and general questions, “How healthy are you?” “What is healthy to you?” or “how do you keep healthy?” and try not to use information guide or do some modification to make it more open (i.e. do not mention too much information about heart disease or CHD in advance). Being patient to wait for the emergence of links or some interrelations rather than being eager to find the links…” (Methodological memo, November 2008)

**Interview**

This was the main body and the core of the interview. Though it was conducted step by step guided by the flexible interview guide to cover a whole range of issue, careful listening was at the core of the interview process (Gillham 2005). Steps were taken to ensure that the questions followed the participants’ dialogue once the open questions had been asked. In this way, the guide prepared in advance was flexible but sometimes focused allowing for flexible interactions which motivated the participants, allowing for in depth exploration (Gillham 2005).

At the outset, many elders were anxious about whether they had the ability to answer the questions. For example, they were worried about the style of questioning and the difficulty level of the questions. In this way, the researcher generally began the interview proper with demographic questions, such questions as “Could you please tell me your age?”; “How long have you been living in the UK?” and “Can you tell me who you share your house with?” These questions were easy to answer and thus made participants relax at the beginning of the interview.

During the first few interviews, the broad questions such as “how about your health recently?”, “tell me about your health in general”, and “what sort of things do you worry about in relation to your wellbeing?” were discussed. This enabled the participants to realise that there were no right or wrong answers only their opinions and ideas. The help seeking behaviours were explored in-depth and focused on their individual experiences and social processes by using the theory of Symbolic Interactionism to provide the researcher a chance to find the participants’ perceptions about their own health in general.
Further on in the interview, when a rapport had begun to develop, participants were asked about their normal health seeking pathways “can you give me an example of a health problem you have had in the past and what did you do about this?” These questions elicited information about health seeking behaviour. From the responses the research followed the dialogue with questions about alternative health seeking behaviours. This aspect featured later on in the interview as these were often very personal reflections which involved personal beliefs, cultural influences and concerns (Glaser 1978). In this way, and taking a reflexive stance, certain key interview questions were justified after each interview:

“Thus, a topic list of the areas I want to discuss at the interview is generated prior to each interview. I add this extra topic, information to the interview guide, and this is adjusted over time to reflect areas which I feel I need to gain sufficient information and new areas of inquiry I wished to pursue later.” (Methodological memo – December 2008)

On a few occasions, during the process of the interview, there were sudden and unexpected pauses between the researcher and participants. In these situations, in order to keep the interaction going, the researcher would ask some direct questions which were mentally prepared well in advance of the interview, such as “Some other elders told me that they used TCM. Do you use some alternative health services as well?” Thus, a new topic which had close relationship with these Chinese elders made some reticent participants more talkative when they knew that others had raised this topic.

The first few interviews, because of the initial research proposal, were led by the researcher’s own professional concern. Thus, there were some specific questions about elders’ help seeking related to CHD in particular. If the participant mentioned their own heart problems, the researcher was able to ask direct questions based on the information presented. However, in most cases as the interviews progressed, the participants did not talk about heart issues proactively even though some had had heart related symptoms. General questions were asked to check whether the participants had any knowledge about heart issues or not, including “what do you know about diseases which affect the heart?” and then others such as “if you felt worried about your heart, what would you do about it?” Vignettes and scenarios were presented to participants at this point and helped in facilitating the interview (see Appendix 4-1-1). However, after conducting the first few interviews, the interview guides were modified into a more open format using Grounded Theory methods and were based on the simultaneous analysis and data collection and the use of the initial codes to guide the topics covered. For example, after
identifying that the main concern of Chinese elders was general health issues rather than heart related problems, questions specifically relating to heart disease were only discussed when the participants actively mentioned them. One of the modified topic guides used during the middle stage of the data collection is shown in Appendix 4-1-2. The interview guide was modified from one interview to another during the whole interview process. This changeable topic guide was usually based on two major influences: the previous data collection and analysis as well as the situation within the ongoing interview. For example, during theoretical sampling, the data already in hand led the direction of the subsequent interview topics in this Grounded Theory study which improved data saturation and theory generation. However, each interview tested out the emerging themes (and later the core categories) whilst remaining open to new ideas and perspectives. Thus the topics in the interview guide were continually modified. As the process of data collection proceeded, the topics in the interview guide narrowed down to certain themes in order to gain a rich and dense category and thus a solid theory. As an example, during the last stage of data collection, interviews focused on the fourth category, being cured. The topics here mainly included the role of WM professionals and the interaction with these professionals from participants’ perspective (see Appendix 4-1-3).

4.5.2.4. Closure phase

From an ethical point of view, leaving the field at the end of the study may be a problematic issue (Gubrium and Holstein 2001; Gillham 2005). In the conduct of a Grounded Theory study, a further contact is sometimes needed between the researcher and participant to explore issues further or to check out points of misunderstanding (Glaser 1978; Glaser 1998). These issues can be either researcher or participant led. In order to facilitate this the researcher generally said “thank you very much and you have been very patient… but do you think there is anything we have missed out or do you have any other comments about what we have discussed?”, At the end of the closure phase of the interview, contact details were again given to the participant in case they wanted to give some additional information or they wanted to receive further feedback. Then the researcher asked their permission for further contact, explaining the reasons, including that they may be able to help further in the research project if new themes arose or if further clarification of some ideas or information was needed.
The researcher offered to send participants a copy of their transcript if they wished to see it or to edit the information. The method of contact was agreed (personal, letter, telephone or email) which would best suit the participant. However, during data collection in this study, whether or not participants were re-interviewed largely depended upon the response of individual participants. Though many participants agreed to further contact, when the researcher contacted them again, most elders said there was no supplementary information to add, explaining that they believed that the researcher understood their meanings during the interview. Only three participants (participant 3, 4, and 5) were interviewed more than once (twice or three times). Among them, participant 3 was interviewed three times and she maintained contact for the whole duration of data collection (approximately ten months); this woman was the only participant who requested the transcript of the interview, although she made no changes. Because of the relatively longer relationship between the researcher and these three “key informants”, a greater degree of trust was established. In this way, some especially useful information (e.g. the issue “death” which was avoided by participants in other interviews) was provided by them (this will be discussed later in the findings chapter). This information extended the researcher's ability to gain an in-depth understanding of participants’ perceptions and to validate the emerging theory. The data collection period lasted for one year including the formal interviews, informal conversations and email follow-up. In total, there were thirty seven participants took part in the formal interviews. Among them, seventeen were recruited from an Elderly Luncheon Club, five from a Chinese Christian Church, and four from a Buddhist Temple. The other eleven participants were recruited on a referral-basis through the existing participants.

4.5.3. Transcribing the recordings

All interviews were recorded following consent from participants. After each interview, the researcher dealt with the data in two stages. Firstly, the researcher recorded what was not “on the tape”, including non verbal cues and the emotional content of the interviews. The researcher listened to the recording as soon as possible after the interview to ensure that everything was remembered in detail, particularly feelings. In addition, the researcher made notes indicating the reason she had selected the participant, what she felt about the participant and how she felt the interview was conducted. She noted non-verbal interactions, and how participants had reacted to being interviewed. Secondly, the transcription of each interview was written down, first in
Chinese then translated to English. The English version was then sent to a Masters Degree student to translate from English back to Chinese. The researcher then compared the two for accuracy and similarities.

**First stage**

The period after an interview is essential in ensuring rigour and validity in qualitative research (Patton 2002). Following the completion of each interview, the researcher endeavoured to reach home as soon as possible. This meant that field notes could be made when listening to the recording. It also enabled the researcher to recollect the dynamics of the whole interview. During the interview, there were some aspects of the context which could not be recorded on the recorder, such as facial expressions and gestures. It was very important to describe participants’ perceptions as well as researcher’s personal reflections of what happened in the setting in order to notice these salient factors which might enhance the quality of data collection (Bluff 2005). These notes included “becomes tearful again” “very shy and face turns red” and “voice rises to show her unhappiness”. Additionally, some other comments such as “Would be interesting to investigate what benefits they think they get in China compared to UK – is it the thoroughness? The lack of waiting time? The combination of TCM and WM? – perhaps this needs to be followed up!” “Important! What is happening here?” were placed in the research diary with the exact time to add to the transcripts later as reminders of important information for data analysis.

**Second stage**

After taking field notes, the researcher transcribed all 37 interviews herself. During the process of transcription, the interviews in Chinese were typed and the recordings were listened to at least three times for each one, to check the transcription and to familiarise the researcher herself with the data. Then the translation from the original Chinese version transcript to the English version was conducted. To improve the translation accuracy, back translation, which involved the translation of a text into the target language by one translator and then a translation back into the source language by an independent translator, was used in this study. It is most commonly used and recommended as a way to assess translation work (Harkness and Schoua-Glusberg 1998; Sperber 2004; Shigenobu 2007). After removing all the private information from the transcripts, the researcher sent them to a Chinese Masters student whose major was Public Health. This Masters student conducted the back translation from the English
version to Chinese version again and sent it back to the researcher. This process was completed in two or three days. After that, that Masters student was required to delete all the documents. The researcher completed the comparison between the back translation Chinese version and the original. In most cases, the distinctions between these two Chinese visions were just different in expression not meaning. If there was relatively major diversity, the researcher negotiated with the Masters student to revise it in a way which was acceptable to both. This ensured that the accuracy of the English version could be guaranteed. Subsequent to this, two hard copies of each transcript were printed onto paper. One copy was kept free from notes whilst the other was used for coding. The second one was coded line by line, adding some necessary notes and then photocopied (Glaser and Strauss 1967; Glaser 1992b).

4.5.4. Reactivity

Reactivity refers to the subjects of social research reacting to the fact of being studied, thus altering their behaviour from what it would have been normally; sometimes it can be seen as interference, or it can be seen as data (Chenitz and Swanson 1986). Although the settings and the elders themselves allowed the researcher to develop a great deal of trust and rapport, there were challenges related to reactivity (Vargas 2006). However, by utilizing in-depth interviewing rather than participant observation as the source of data, the direct involvement of the researcher in the phenomenon under investigation was reduced. This decreased the negative impact of reactivity on research validity (Parry 1998).

The role that the researcher adopted when undertaking the interview was that of a student. Though sharing a similar background as a native Chinese person with these elders, the researcher still struck the balance between having distance and insight. In many respects the researcher had different characteristics with the participants in terms of age, social role and professional background. During the process of interview, the researcher reminded herself of these differences. For example, sometimes, participants informed that “You know the elders always like this” or “You know Chinese people always have this difficulty”. When spoken in this way participants would generally stop and expect approval on their views. The researcher would generally nod in agreement but then usually followed up the salient point to explore further with exploratory questions such as, “could you tell me more about this as at that time I was still a very
“little kid?”, “this is so interesting and the situation is very different with my hometown… Hong Kong’s situation is very different with the mainland at that time…” or “I learnt WM in my University, I do not know much about TCM, could you explain it in detail, please?” In this way, the direct impact of the researcher in this study was reduced to the lowest degree and the scope from the insiders’ view was gained maximally. These strategies have been noted to be useful in clarifying and understanding participants’ ideas (Glaser 1978; Glaser 1992b; Vargas 2006).

4.6. Application of Grounded Theory analysis to study

Data analysis is like a dialogue which takes place when the data are broken down, conceptualised and put back together in new ways (Backman and Kynngas 1999). In Grounded theory, data collection and analysis occur concurrently with theoretical sensitivity being used to generate theory (Glaser and Strauss 1967). The foundations of a Grounded Theory approach offers qualitative researchers clear guidelines from which the step-by-step strategies are built to establish and maintain rigour in the investigation (Glaser and Strauss 1967). Like all qualitative methods, the essential concern for rigour in qualitative research emphasises density in the data which usually requires sufficient time in the field and explicit rich and thick description (Glaser and Strauss 1967). Thus, analysis of the data begins with full immersion in the data through the numerous readings of interview transcripts and reflective diaries and repeatedly sorting, coding and comparisons run through the whole analytic process (Charmaz 2006). In Grounded Theory study, researchers who want to achieve theoretical sensitivity must be able to maintain analytic distance, tolerate uncertainty and confusion, and trust in the notion that conceptual understanding will eventually occur (Glaser 1978; Glaser 1992a). It is natural for the researcher to become lost in the data (Glaser 1992b).

As Glaser (1992, p 16) suggested, Grounded Theory is “a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area” (Glaser 1992b). The strategies of the simultaneous collection and analysis of data include constant comparative methods, the two-step data coding process and memo writing, as well as theoretical saturation (Denzin and Lincoln 2003). The characteristics of Grounded Theory as they apply to this study are represented in detail here in order to explicate the systematic methodological procedure of the investigation.
Data analysis was initiated as soon as the first interview was completed; through carefully listening and reading of transcripts, field notes and the research diary, the researcher began the process of coding (details in the section on methodology). The researcher listened to the backup recordings as close to the time of interview as practically possible and prior to the following interview. A two-stage coding process was applied, starting with a substantive coding followed with theoretical coding. Throughout the process of data coding, the researcher strove to stay true to the data and carefully reviewed the transcripts in order to understand the patterns in the interview. The Grounded Theory concepts of constant comparison method and theoretical sensitivity were used during the whole study process to ensure that the developing codes and theories remained grounded in the data. Thus, the subsequent interview guides were modified and based on the analysis of previous interviews in order to expand the codes and theories in the setting. In the study reported here, it enabled the identification of consensus among other participants as well as disagreements or differences of opinion with the analysed data. This process also helped to ensure that the analysis process was grounded in the data and the interview schedule.

4.6.1. Data management: manual and computer analysis?

There are many different approaches to qualitative data analysis. Generally, qualitative data analysis is a difficult and complicated task, which includes reading a large amount of data, looking for similarities or differences, and subsequently identifying and developing categories (Denzin and Lincoln 1994; Silverman 2000; Holliday 2002). In order to assist qualitative researchers in this crucial process, qualitative data analysis software, such as NVivo, have been designed (Welsh 2002; Bazeley 2007).

However, the software is only a tool for managing qualitative data. After comparing both manual and computer approaches to dealing with qualitative data, Welsh (2002) pointed out that NVivo was less useful in handling the thematic ideas emerging during the data analysis process due to the fluid and creative way in which they emerged (Welsh 2002). Furthermore, NVivo is known to lack of power to identify the inter-relationships of these thematic ideas which is essential for gaining a deep understanding of the data (Welsh 2002).
Regarding to data analysis in Grounded Theory, Glaser (2003) insisted on manual approach rather than computer analysis, especially for the novice researcher (Glaser 2003). Grounded Theory methodology is full of the intricacies of data management which does not only focus on data but also includes systematic and rigorous procedures (Glaser 1978; Glaser 1998; Glaser 2003). Glaser (2003) also suggested that it was inappropriate to use computer analysis since it only concentrated on the type of data but ignored these essential linking strategies which connects data during the analysis process (Glaser 2003). For the novice, the computer approach can lead to a thin level of data analysis since these researchers have never experienced a theoretically complete Grounded Theory (Glaser 2003).

From the standpoint of Glaser, computer analysis has two major disadvantages when using it to conduct data analysis in a Grounded Theory study. First, the theoretical quest is crucial for culminating Grounded Theory generation and creativity and it is argued that computer sorting blocks this process (Glaser 2003). Analysis via software, tends to weaken meaning by simply reducing occurrences and re-occurrences of codes to numbers (Welsh 2002; Glaser 2003). Then the inter-relationships among concepts, themes, and categories are often lacking in their inter-connectedness Thus the theory can become full of preconceived conceptual descriptions as opposed to the abstract and solid conceptualisation which has relevance to the emerging ideas. Second, the computer does not allow the data analysis to begin anywhere, in order to let the theoretical codes emerge, and including the theoretical notes developed through memoing and sorting is difficult (Glaser 2003). As Glaser repeatedly emphasised, memos could be anything (usually conceptual ideas) which have emerged at any time or any stage of the analysis process, rather than at the actual time of coding (Glaser 1978; Glaser 1998; Glaser 2003). Incorporating these key ideas into the analysis using a computer package or software is difficult if not impossible when the data is fragmented in codes (or nodes) within the design of the software (Glaser 2003).

In this present study, the researcher used NVivo programme to conduct the first three interviews. It was founded that using this software led the researcher to expect and look for certain data rather than looking at the data as they were. It seemed promote a more descriptive qualitative research than a process of conceptualisation because it did not allow for any theoretical integration. The researcher believed that the real work was located in people’s mind and only people had the ability to find the connection and
integrate the theory. In this way, the researcher re-analysed the first three interviews manually and also the following interviews. It was therefore decided to continue the analysis using manual methods in this study.

4.6.2. Data coding

Coding is an essential strategy which is carried out by categorising segments of data, then conceptually grouping them together when appropriate and thus it is the pivotal link between collecting data and developing an emergent theory to explain these data (Charmaz 2006). Through coding, analysis begins with defining and categorizing the data. Coding that gains a new perspective and a detailed explanation on data usually directs further data gathering (Denzin and Lincoln 2003).

Different grounded theorists have their own procedures for coding. Strauss and Corbin (1998) lay down a structured method for coding data, open coding (the disaggregation of the data into units followed by axial coding (recognizing relationships between categories) and then selective coding (the integration of categories to produce a theory) (Strauss and Corbin 1998). Many other Grounded theorists question whether, or to what extent, axial coding helps or hinders the generation of Grounded Theory; they argue that axial coding provides a framework for researchers to apply to their data but caution that it may technically limit the data analysis (Robrecht 1995; Charmaz 2006).

In Glaser’s formulation, there are two stages of coding: substantive and theoretical (Glaser 1978). According to Glaser’s point, substantive coding and theoretical coding differ in the terms of the degree of conceptualization. Substantive codes conceptualize the empirical matter and theoretical codes conceptualize substantive codes and identify the relationships between substantive codes in order to integrate the analysed data into the theory (Glaser 1978). Glaser (1978, p 56) emphasised that “the two types of coding most often done simultaneously... but the analyst will focus relatively more on substantive coding when discovering codes within the data, and more on theoretical coding when theoretically sorting and integrating his memos” (Glaser 1978). The constant comparative method runs through the whole coding process, so that comparisons between data from different people, data from the same individual at a different time, and data within a category can be achieved (Gray 2004). In this way, it
may prompt the revision of earlier data or present a need to return to participants for clarification.

4.6.2.1. Substantive coding

Substantive coding is divided into two stages: open coding and selective coding. Through open coding, researchers conduct line-by-line data coding and all analysis are incidents not themes. During this process, the data are considered open in every way, keeping questions in mind: what is this data a study of? What category does this incident indicate? What is actually happening in the data? What is the main concern being faced by participants? What accounts for the continual resolving of this concern? The main goal in this stage is to code for concepts, not description (Glaser 1978; Glaser 1998).

Glaser (1978) advocated a relatively consistent standpoint and this was chosen by the researcher of this present study owing to its simplicity and proven ability to interpret participants’ perspectives and derive a robust theory (Glaser 1978). The researcher coded the transcripts systematically with simple words which reflected the perspectives of the participants. For example the code “normalising the symptom” was used to describe the way in which Chinese elders gave reasons to explain why they did not seek help when they had potential illness related symptoms. As the constant comparative analysis, the similarities and differences in this code were examined. These data showed a number of situations when elders experienced this “normalising” process to comfort themselves. In this example, some participants considered health problems as a disease related to old age, considering it as a very natural thing when getting older (e.g. some elders normalised chest pain as normal pain and attributed it to lack of rest; some elders even directly denied the related symptoms). As this example shows, the connections began to emerge and the condensing of codes were labelled to increase the conceptual degree to “normalising/minimising” (Glaser 1978).

Here it became clear that although this sounds like a straightforward and linear process, in reality many links were beginning to become clear with other codes attributed to the data. Cross connections were evident between the data. For example “normalising the symptom” in this case looked like it was a personal cognition or way of acting. It was clear from coding elsewhere that this process could be and was influenced by “family
influences”. Therefore connections between open codes and categories began to occur. This systematic and constant comparison of the data enhanced the level of coding as well as the theoretical sensitivity and familiarity with the data in this study.

The open coding process was a challenge for the researcher. This was the point that supervision was used most. Both supervisors were experienced researchers, in particular one of them was an expert in Grounded Theory. In this way, they guided the researcher and suggested how to name the codes and raise the conceptual level of analysis. This supervision experience increased the sensitivity to the data and enhanced the researcher’s ability to analyse the data in a deeper way. A further example of this coding process is shown in Appendix 4-2. Explaining the data analysis process repeatedly in supervision helped the researcher to establish connections between open codes and therefore led to the conceptual analysis and selective coding.

Selective coding is the coding only for the core and related categories. It delimits data collection and coding after potential key themes are emerging and the function is to verify and saturate the core category. It begins after connections have been made between the open codes, when the overall analysis around the several important concepts that have emerged from the data are well developed and the connections are more or less clear (Glaser 1978; Glaser 1998). By the time the major themes of this study were identified, the researcher scanned data and previous codes and interviews repeatedly to selectively seek cases which illustrated further the linked open codes. At this point the researcher also went through the research field notes, looking for differences in terms between the linked open codes. This led to the bringing together of groups of open codes and increased the conceptualisation level as connections became evident. Through the selective coding process, core themes and then core categories were developed. It was the process of choosing the core themes and then categories which were a storyline and the relationships between it and all other categories began to be clearer. In this study, after constantly comparing those emerged main themes which were identified in earlier coding (e.g. being healthy, self management, normalising/minimising, barriers to access health services and being cured), being healthy was identified as the core category because it drove the whole story of Chinese elders’ help seeking behaviours when facing any health related issues. After the core category was identified, the researcher selectively coded data. Thus the core category was explored with a denser content. At the same time, the researcher also purposively
sampled new data with this core category in mind, which was theoretical sampling, a deductive process in Grounded Theory (Glaser 1978; Glaser 1998).

4.6.2.2. Theoretical coding

During the theoretical sampling, the second type of coding, theoretical coding was applied to weave the previous fractured concepts into a theory which explained the main concern of the participants. It conceptualized the relationships among the substantive codes arrived at through open and then selective coding (Glaser 1978). It was very important for theory generation as the purpose of theoretical codes was to integrate the emerging theory. Glaser (1978) argued that there might be more than one theoretical code discovered, but researchers should choose the one that best fitted the relationship of the core category to other categories and properties (Glaser 1978). In this study, the relationship of all the other sub-themes to the core category was that in different phases Chinese elders met the various troubles and they ceaselessly resolved these problems in their own ways to achieve their goal of being healthy. This storyline and relationship among the core category and other sub categories will be discussed in detail in Chapter 6 “Presentation and discussion of theory of being healthy”.

4.6.3. Constant comparative analysis

Constant comparison is a fundamental element during the whole analytic process when the methodology is based on Grounded Theory (Glaser and Strauss 1967; Glaser 1978). Constant comparison begins with looking for key and recurrent events and each incident in the data is compared with other incidents. It emphasises the description of and accounting for all the incidents including their similarities and differences. This is the initial comparison between incidents to establish underlying connections and variance in the conditions leading to the development of concepts. Later, concepts are used to compare with other incidents for theoretical elaboration, saturation and densification of concepts. Finally, constant comparison is conducted between concepts and other concepts to establish the conceptual fit in the data set and raise the conceptualisation level. In this way, researchers can ascertain if the data support, and continue to support emerging categories. Moreover, data collection is alternated with coding and analysis to avoid “data overwhelm” (Glaser and Strauss 1967; Glaser 1978; Glaser 1998). In sum, the constant comparative method during the coding and categorisation of data facilitates
theoretical sampling and enhances the density of data which in turn advances the theory. This process of repeatedly looking back continues throughout the whole research journey and often involves a return to open coding, selective and theme generation. It is noted to be a circular process (Glaser 1978; Glaser 1992b; Glaser 1998).

Following the constant comparative analysis, during the process of data collection in this study, participants’ new perspectives prompted the researcher to reassess the data already collected. For example when analysing Interview 6 (ID 6) the researcher realised this man had certain heart problems. At the final phase of the interview, in order to gain information relating to his knowledge of heart issues, the researcher asked him to talk about heart conditions. Suddenly this participant became very serious and wished to avoid discussing heart conditions. From an ethical perspective, the researcher could not explore this point further as this participant was clearly unhappy to talk about this topic any further. However, this was a very important point. Similarly in Interview 3 (ID 3), the female participant also did not wish to discuss heart problems, and even she had been diagnosed with CHD. The researcher realised that this was an important issue and the incident led to awareness of this in future interviews and was key in theory generation. The main learning here was that Chinese elders avoided talking about actual or potential problems in order to maintain a state of peace and avoid anxiety, which later helped to conceptualise and establish an important theme “Creating a sense of normality”. This is a key feature of the Grounded Theory in this study.

On another occasion, as noted in the literature, family members were often reported as providing support to the elders when they faced health problems. However, the interaction between elders and their family members was not a simple unified story as mentioned above. In this study, many cases indicated that the family often hindered elders’ help seeking. For example, in Interview 3 (ID 3) and Interview 31 (ID 4), the female participants commented that family members helped them make decisions when facing illness. However, these women were lacking in knowledge of the disease and thought, for example, that there “would be no disease if without pain” and their families supported this misguided assumption. This led the researcher to re-examine the data for other incidents where family members both helped and hindered the help seeking process and once again the data were re-examined. This is a direct example of constant comparison in action within this study.
These are just two examples from many that the researcher can cite. These two examples were presented to show that constant comparison highlights not only similarities (the former example), but also the diversity (the latter one) within the data. The constant comparison and a thorough review of data were continuous until the final stages of data collection to review the emerging categories. The development of the structure of theory elements via concurrent analysis is presented in Appendix 4-3.

4.6.4. Theoretical memos and field notes

Memos are theoretical notes, conceptually connecting the category and its properties; and then beginning to integrate these connections with other categories to generate the theory (Glaser and Holton 2004). The writing of analytic and self-reflective memos is a crucial step which relates the data coding and the first draft of the completed analysis (Glaser 1978). Analytic memos consist of questions, musings, and speculations about the data and the writing of analytic memos is regarded as an important part of the process of developing and formulating theory (Glaser 1978). Self-reflective memos illustrate the researcher’s personal reactions to participants’ narratives. The details ensure that the researcher remains grounded in the research process and data (Denzin and Lincoln 2003). Therefore, they allow the researcher to explore processes and actions that are included under each category, look carefully at categories that are evolving, and examine how various categories may be inter-related (Charmaz 2006). The credibility of the qualitative study can be evaluated accurately only by both the adequacy of the research process and the appropriate research methods (Denzin and Lincoln 2003). The detail is the most significant element which should be carefully considered through the whole research process and the specifics of why and how the research is done should be cautiously explained.

Glaser argues that memoing is an essential and even crucial step in developing the theory (Glaser 1978). Memoing was a constant process in this study that began when first coding the data, and continued through reading previous memos and literature, sorting the themes and through the writing process to the completion of the research. In this way, “memo-writing continually captures the frontier of the analyst’s thinking as he goes through his data, codes, sorts or writes” (Glaser 1978, p 83).
In reality, writing theoretical memos occurred spontaneously, sometimes in the field and sometimes when the researcher did something else. These memos were made on bits of papers or notebooks which were convenient to write in at that time. After taking these recordings, the researcher arranged them in the research field diary, and some were sorted then coded, indexed and related to the relevant data. One example of a key theoretical memo is showed in Appendix 4-4.

As the setting and context of data collection in Grounded Theory are very important, field notes relating to these issues should be acknowledged in order to supplement the interview data (Glaser 1978). In this study, field notes mainly related to the interview setting and process which could not be digitally recorded and included notes on interruptions, non-verbal language, facial expressions, and the psychological states of both the participants and the researcher herself. They also included details of some informal conversations including discussions and additional comments. These field notes were presented or tagged onto the relevant data.

Both theoretical memos and field notes were used to explain aspects of the data as well as to increase the theoretical sensitivity of the researcher. Reviewing theoretical memos and field notes in the context of where they occurred was an essential step in linking the themes together and from where theory generation began.

**4.6.5. Themes and core category**

As the data and inter-related links emerge and are integrated, the main ideas are developed into themes (Glaser and Strauss 1967). This process involves a continuous examination and re-examination of all the codes as well as those field notes and memos which were related to the data. This enables the research to not only consider the data but also the context (Glaser 1978). These codes are sometimes complex and may often have different meanings when applied to different contexts within the data (Glaser 1998). In this study, it was at this point that the researcher felt analysis by hand was much more manoeuvrable than by computer. In doing this, it was possible for the researcher to view the codes, field notes, memos and the context of the data simultaneously, which facilitated exploration and further connections within and between the data in the early development of the core category. This process allowed the researcher to examine the data equally and to immerse in the data until the themes
emerged rather than applying preconceived connections between the codes and the themes which can often occur when computers are used to assist with analysis of data (Glaser 2003). In doing this, the researcher was able to identify key themes within the study. This added to the rigour of the analysis process in this study.

In Glaser’s opinion, the core category must be central to and reoccur frequently in the data and relate meaningfully and easily with other categories (Glaser 1992b). Examining the data in its entirety, the researcher was able to see the connections between the themes, how often these connections occurred and this led to the emergence of a core category which had the most connections with other categories and themes.

Following these principles, the core category and the major themes were identified and the detail of these interpretations will be presented in the findings chapter and the interactive relationships will be discussed in the theory chapter.

4.6.6. Emerging framework

The supervision meeting in March 2009 was very important for this study. At that time, 23 interviews had been conducted; Interview 21, Interview 22 and Interview 23 showed that the responses from these participants were very similar to previous interviews and no new ideas arose. In this way, the researcher was able to identify the core category and the four main themes in this study. At this point, there were sufficient data in hand to begin theoretical sampling.

The following is a summary of that supervision meeting from the research diary after discussing the issues related to saturation:

“Today is my birthday and there is also another big thing today – supervision meeting. Today’s supervision meeting is really very helpful for the next step in my study. At the beginning of the meeting, I reported what I had done in the past month. As 23 interviews had been conducted and data had been re-analysed, the core category (being a “healthy” person) and four main themes (self management, normalising, access health services, and cure model vs. manage model) had been identified. [Names of supervisors] showed their agreement with this point and advised me to test out these themes in the next round of interviews to add some depth to my work. Meanwhile, they emphasised theoretical sensitivity during the whole process of the study. Further, [name of supervisor] also emphasised that when I did theoretically sample in future interviews, perhaps I would concentrate (but not exclusively) on the themes whilst still allowing for some flexibility.”(Research diary, March, 2009)
4.6.7. Theoretical sampling

Grounded Theory is celebrated as “the discovery of theory from data systematically obtained from social research” (Glaser 1978, p 2). Thus the focus on theory generation adds an important dimension to sampling. In order to sample more data and to generate the theory in this study, theoretical sampling which used the codes as the direction to guide further data collection was applied at this point.

Theoretical sampling continues to explore the various properties of the themes and categories and their internal connections until the categories are saturated and the theory is practically developed (Glaser 1978). However, Glaser (1978) suggested that theoretical sampling has different forms and researchers have to be creative and let the data suggest which direction the data collection should go (Glaser 1978). Thus flexibility is again an important feature in theoretical sampling. To achieve depth and breadth in the developing categories, Glaser (1978, p 39) pointed out, “while in the field, the researcher continually asks questions as to fit, relevance and workability about the emerging categories and relationships between them”. Furthermore he suggested that “the discovery of grounded theory implicitly assumes that the analyst will be creative” (Glaser 1978, p 20). In this way, it seems that Glaser’s description of theoretical sampling encourages researchers to look at data rather than look for data in Strauss’s version (Coyne 1997).

Glaser (1992, p 102) stated that “in short, theoretical sampling in grounded theory is the process by which data collection is continually guided” (Glaser 1992b). Therefore, Coyne (1997) defined theoretical sampling using a more accurate term ‘analysis driven/governed purposeful sampling’ (Coyne 1997) in order to confirm the connections between the themes and the core categories and also to give depth and density to the data.

However, there is little guidance available for researchers on how to carry out this specific procedure (Draucker et al. 2007). Draucker and colleagues (2007) argued that authors often do not detail how the development of theoretical constructs were connected to a change in interview strategies or how the interview questions were actually modified according to data analysis (Draucker et al. 2007). In the following section, the researcher in this study will discuss how the activities were adhered to in
response to early findings and how the decisions shifted according to the theoretical developments being progressed at a particular stage, such as selection of participants and modification of the interview guide. In this way, the sampling decisions were facilitated and the audit trail was maintained to provide readers a full appreciation of how theoretical sampling was carried out in practice in this study (Draucker et al. 2007).

Following personal judgment which recognised which categories or codes had not been saturated yet, the researcher collected more data specifically on these categories or codes, until they were saturated. After reading Glaser’s texts related to theoretical sampling, especially “Chapter 3 – Theoretical Sampling” in the book “Theoretical Sensitivity”, the researcher thought that the most essential elements here were the interview questions, including the topic of the question as well as the manner in which the participants were asked, and the selection of the participants. During interviews at this stage, the researcher asked the participants to expand on these categories, including “being a healthy person”, “self management”, “normalising”, “access health services”, and “cure (symptoms) model vs. treat (root causes) model”, by for example asking “could you say more about XXX?” in an open-ended manner. This enabled the researcher to concentrate (but not exclusively) on the themes, whilst still allowing for some flexibility to theoretically expand, refine and enrich the emerging theory. The category “cure (symptoms) model vs. treat (root causes) model” was enriched most during this theoretical sampling phase and will be used as an example. When this category emerged, the researcher felt that it was lacking in density since elders did not explain or require more from doctors if they thought doctors did not provide what they wanted. Thus the directions of theoretical sampling were focused on “What do chronic diseases mean to the patients? /what do they know about these diseases?” and “Where does the information come from (if it does not come from doctors, why not)?” (excerpt from methodological memo – May 2009). After exploring these issues in-depth, this category was renamed “being cured” with dense properties and the internal connections, such as “ineffective culture related communication” and “avoiding bothering doctors unnecessarily”.

However, in relation to theoretical sampling in this study, difficulties were encountered determining which elders to select. The researcher was not able to know in advance the background of the elders, their experiences and their thoughts. Further, if it was suspected that particular elders could inform the researcher on the required topic, it was
considered potentially unethical and could jeopardise the findings and, to some extent, force the data. The researcher attempted to solve this dilemma by theoretically sampling a wide range and number of participants to check the validity and enhance the trustworthiness of the theory (Glaser 1978). Further, the researcher decided to ask elders to refer other elders who might share their concerns. This might be a form of snowball sampling or chain referral sampling, but it made sense here to gain saturation and integrate the theory during the theoretical sampling.

4.6.8. Data saturation

In order to maximise the depth of enquiry, sampling which works towards saturation is employed in Grounded Theory studies. This refers to the point at which interim analysis indicates that no further properties or theoretical insights relating to the Grounded Theory occur in data collection (Glaser and Strauss 1967; Green 1998). Codes and categories are sorted, compared, and contrasted until they are saturated. The point at which this is reached remains a source of much debate amongst grounded theorists and it must be able to accommodate emerging perspectives.

Actually, in Strauss & Corbin’s (1998) book, two versions of data saturation, category saturation and theoretical saturation were mentioned. In the Axial Coding chapter of Strauss & Corbin’s book (1998), the authors stated that “a category is considered saturated when no new information seems to emerge during coding” (p 136) when doing substantive coding, in particular in axial coding (Strauss and Corbin 1998). They explained category saturation and emphasised that the relationships among categories were established and validated in terms of properties, dimensions, and variations (Strauss and Corbin 1998). Then in the Theoretical Sampling chapter, theoretical saturation was defined as “(a) no new or relevant data seem to emerge regarding a category, (b) the category is well developed in terms of its properties and dimensions demonstrating variation, and (c) the relationships among categories are well established and validated” (Strauss and Corbin 1998, p 212).

4.6.8.1. Theoretical saturation in this study

In Glaserian Grounded Theory, there is just one type of saturation, which is theoretical saturation of categories. This happens when a decision is made to collect further data
(this process known as theoretical sampling) and then the researcher discovers that the new data do not provide fresh insights for categories and the same properties continually emerge through the full extent of the data (Glaser 1978). In other words, the categories in question are saturated. In this case, theoretical sampling is stopped for these already saturated categories. This is the most obviously positivist influence in a Grounded Theory study as this process narrows down the focus of the interview and reduces the data already in hand to encourage and search for diversity within the properties of categories. It is notable that the importance of theoretical saturation means all categories are saturated; otherwise the theory is then unevenly developed and lacking density and precision (Glaser and Strauss 1967; Glaser 1978). It was the aim of this study to continue until all categories were saturated using Glaser’s approach.

From the researcher’s experiences and understanding in this study, saturation was the point at which no new information emerged. This process involved a judgement about the new data. Saturation of some codes was very obvious to see. In an example involving communication, the issues of communication mainly related to two aspects. Firstly, it was mentioned by almost all of the participants, that there were language barriers. These included barriers to understanding and speaking English with health professionals and barriers in reading the printed materials from health care services, such as letters or posters in clinics. Secondly, the communication barrier was also reflected at the cultural background level, such as different ways of describing symptoms or the interpretation of disease and conditions.

For other codes, saturation was not easy to identify; for example the codes related to the roles of family. There were a huge range of unique family situations and the complexity of the relationships between the participants and their family members made analysis difficult. The researcher found it was very difficult to identify unified stories or absolute consensus to define a dense category. Data collection about the family role continued until the very end stage of the interviews, both in a substantive level and in a procedural level. However, not all the elders wanted to talk about their families’ impact on their health related issues. The dilemma with this aspect of theoretical saturation was whether the researcher should ask about their family’s role in their lives and how this related directly to health although this may have led to a forcing of the data when it could simply be that family members sometimes do not get involved with the health care needs of the elders. This issue was written in the field dairy:
“These days the participants are all some elderly ladies, they live alone. They all mentioned that their husbands are dead and seem very lonely now. They seldom talk about their children (but they have children), I do not know whether I am polite or not to ask them about this. This is related to filial piety in Chinese culture. I have tried to talk about their interactions with their children further, however they change the conversation topics, seeming not to want to discuss this anymore. Is theoretical saturation seeking for a unified story but sometimes they simply don’t want to talk about it, which makes getting saturation difficult?” (Research diary – April 2009)

Another challenge in deciding to stop data collection was whether or not to continue with interviews already booked; this was due to a combination of practical contingencies and ethical problems. From the standpoint of ethics, the researcher thought it was very unethical to cancel pre-booked appointments, giving the reason that the elders were not needed as no new information would be added by talking to them. This was very impolite because the potential participants gave their valuable time to the interview and helped the conduct of this study. The researcher carried out pre-booked interviews beyond the point of saturation when saturation could be described as having occurred. After conducting these interviews, the researcher also found some useful outcomes which were provided by these two interviews beyond saturation point which included enhancing the depth of the data as well as maximising the diversity of the dimensions and properties of the categories. In addition, these interviews also provided an opportunity to test the emerging framework.

4.6.9. Theoretical sensitivity

Theoretical sensitivity refers to the awareness of the subtleties of meaning of data and the aim of developing it is to ensure that all are grounded in the current data rather that being imported from the preceding perspectives of the researcher (Glaser 1978). In order to keep an awareness of the subtleties of meaning in the data, theoretical sensitivity plays an important role in grounded theory; this significant feature refers to a personal quality of the researcher and relates to understanding the meaning and subtlety of data. It is described as an essential requirement to gaining insight in order to discover substantive categories to develop a grounded theory. Furthermore, Glaser (1978) pointed out the implications of theoretical sensitivity as the core ability in conducting a Grounded Theory study, such as creating or giving meaning to data and separating out inauthentic information (Glaser 1978). In this way, a conceptually dense theory is able to be formulated through the theoretical sensitivity of the researcher.
Theoretical sensitivity stems from a number of sources. Glaser (1987) outlined the two main principles related to enhancing researchers’ theoretical sensitivity. First, entering the research field with few predetermined ideas enhances the researchers’ sensitivity to the study. Second, being versed in the literature, not just limited to the single area of interest, but extensive and comprehensive knowledge related to the study area is another way to increase the theoretical sensitivity (Glaser 1978). Glaser advocated that researchers should attempt to widen their reading to include material from related or even unrelated disciplines. In doing this, he suggested that this would ensure that the researcher could develop theoretical sensitivity in the emerging theory (Glaser 1978).

Additionally, the analytical process itself, which can provide insights into the meaning of the data, also allows this sensitivity to occur. This is achieved by the researcher immersing themselves in the data and seeking to understand what the participants views are and which of these views are of importance and significance (Glaser 1978). Concurrent analysis of data in the light of a comprehensive review of corresponding literature and reflexivity play the central role in this process as it is essential to acknowledge the potential impact that the researcher’s subjectivity can have on the research process. An objective stance is enhanced by the critical thinking of the researcher in order to stimulate thought and increase ability to recognise properties emerging from the data itself. Multiple view points are sought on interpretations, with this being facilitated by regular meetings with research supervisors. Through these approaches, analysis can actually reflect data (Glaser 1978).

In this study, the enhancing of theoretical sensitivity dated back to the writing of the research proposal in 2007. As the area of interest was centred on Chinese immigrants, the researcher read much documentation related to Chinese immigrants’ history, living (economic situation), education, and psychological status. These associative domains provided some general knowledge about overseas Chinese people’s world and helped the researcher to keep many thoughts and ideas in mind when approaching the analysis process.

In the data collection and analysis process, constant comparison was used through the whole analytic process to prompt theoretical sensitivity, continuously reflecting codes back against the actual data, looking for interactions and relationships between data and
different sources of information, to make sure they were not from the researcher’s pre-existing knowledge. Thus, the researcher kept stepping back periodically and asking what was going on here and what fit the codes, themes and categories had with each other and the developing theory. The researcher was mindful that some aspects of her prior knowledge may influence the data collection and analysis process. This is an inevitable part of any qualitative or social research process (Denzin and Lincoln 1994; Glaser and Holton 2004).

Another method for the back-check and the development of theoretical sensitivity was a re-examination of the early drafts of the chapters during writing-up of this thesis. In this way, it was hoped to ensure that the researcher remained faithful to the data and that over abstractions could and would be avoided. In early drafts of those various chapters, the researcher kept the original sense of the data and, thus, a balance could be achieved among these different kinds of data, such as interesting data or important data which the researcher thought useful to this study. This process allowed the researcher to re-examine conflicting data which might have been overlooked after the themes emerged. Correspondingly, these drafts provided a full view to maintain a clearheaded appraisal of the original data and help to prevent deviating too far from original ideas. Additionally, the researcher’s unique experience as a native Chinese person also aided sensitivity by providing a familiar base to develop an understanding according to the explanations of those with a personal background and knowledge of the participants. In this way, it allowed events to be more clearly explored, understood and interpreted.

4.6.10. Theory development

Glaser (1978, p 93) asserted that “the goal of Grounded Theory is to generate a theory that accounts for a pattern of behaviour which is relevant and problematic for those involved” (Glaser 1978). “Theory as process” produces a concept that Grounded Theory gives a feeling of ever developing and a non perfect product (Glaser and Strauss 1967). The “discussional” form as opposed to propositional form is chosen to formulate theory which is grounded in data (Glaser and Strauss 1967).
4.6.10.1. Types of theory

The notion of theory as a developing process does not restrict researchers to a particular type of theory. Rather, Glaser and Strauss (1967) stated that comparative analysis could be used to generate either substantive or formal theory. Glaser and Strauss (1967) outlined that the distinction between substantive and formal theories was the level of generality. A substantive theory focuses on an empirical phenomenon and is defined particularly in terms of a certain specific time and space, such as patient care, education and race relations. In contrast, formal theory is developed for a conceptual area of sociological inquiry which is less bound by space and time, for example, the process of socialization (Glaser and Strauss 1967; Glaser 1978; Dey 1999). A comparative analysis between or among groups within the same substantive area can be used to generate a substantive theory. In contrast, the formal theory can be achieved by an analysis among different kinds of substantive cases which fall within the formal area (Glaser and Strauss 1967). It is worthy to note that both substantive and formal theories must demonstrate their ability to explain the data. Further, Glaser and Strauss (1967) suggested that the analyst should focus clearly on the substantive theory or formal theory they wished to develop because the choice would impact on the strategies of data collection and data analysis (Glaser and Strauss 1967).

In relation to this study which focused on both Chinese elders’ help seeking behaviour (individual experience) and interactions, context of spatial and temporal settings played an important role during the help seeking process. It was appropriate to develop a substantive rather than formal theory with the focus on this substantive area. Moreover, substantive theory usually requires fewer participants and much narrower settings to inform an empirical area; thus making this research workable according to the practical issues associated with this study.

4.6.10.2. Procedures for analysis and theory development

The central importance in generating theory is the code since coding fractures the empirical data and then conceptually groups the codes to explain what is happening in the data (Glaser 1978). Following the standpoints of Glaser (1978), substantive coding is deliberated by beginning with open coding and then selective coding; then, theoretical coding is detailed in order to show how conceptual coding develops to theory. For many
Grounded Theory analysts, line-by-line coding is the initial step (Glaser 1978; Charmaz 2006). During the first process, three questions must be kept in mind and constantly asked from the start: “What is this data a study of?” “What category does this incident indicate?” and “What is actually happening in the data?” It works particularly well with detailed data from the empirical world. Likewise, it allows the researcher to see the patterns of data and the direction of the study (Glaser 1978). Additionally, during this phase, Glaser (1978) showed how coding with verbal nouns can help researchers detect processes and stick to the data (Glaser 1978). The point of using verbal nouns encourages the researcher to analyse data from the participants’ perspectives; further, a strong sense of action and sequence can be gained by this simple and precise verbal noun (Charmaz 2006). For example, the verbal noun “being” or “becoming” does not only describe a certain situation, but also presents a basic social process which explains a considerable portion of action in an area and relates to most categories (Glaser 1978).

During the process of open coding mentioned above, the core conceptual category often forms (Glaser 1978). Once the core category is identified, selective coding replaces open coding. Selective coding is the second step in this first stage of substantive coding. These codes are more directed and conceptual than line-by-line coding (Glaser 1978). It uses the most significant and frequent prior codes to synthesize and explain large amounts of data (Charmaz 2006). The goal of this step is to verify the initial codes and make analytic sense to categorize the data incisively and completely (Charmaz 2006). In this way, it becomes a guide to further data collection and theoretical sampling.

Although Glaser (1978) addressed theoretical coding separately, it was integral and implicit in the process of substantive coding. When coding comes to the theoretical element, it becomes a sophisticated process and it conceptualises the codes and categories related to each other to be integrated into a theory (Glaser 1978; Charmaz 2006). Theoretical coding discovers relationships between categories emerging from substantive coding and helps the analyst raise the level of conceptual abstraction (Glaser 1978). Thus, the substantive and theoretical codes are conceptualized as well as integrated to an analytic and theoretical story (Glaser 1978; Charmaz 2006).

Once the theoretical saturation of this theory is achieved with the support of memos and field notes, the researcher proceeds to sorting, putting fractured data back surrounding the core variable. The sort starts occurring by emergent theoretical codes (Glaser 1978)
and becomes guided by emergent analytic rules (Glaser 1998). It is an essential stage for conceptual build-up which ends with sorting memos (Glaser 2003). This process guides and tracks the emergent latent pattern as well as makes the generated theory rich, multi-relational, and multivariate (Glaser and Holton 2004). Furthermore, this theoretical sorting at the conceptual level is the preparation for the writing stage, and without sorting, the writing up of theory lacks direction (Glaser 1978). Via memo sorting, the data and ideas are theoretically ordered and richly integrated within the dense connections between categories and properties in the cumulative development of the theory (Glaser 1978).

4.6.10.3. Generating substantive theory in this study

From the very beginning of this study, it was not a straightforward process to generate a Grounded Theory as the researcher had to move back and forth from data to theory for a long time. During these emerging “trips”, the researcher followed Glaser’s (1978) suggestions of the three main inductive approaches with the main principles of theory development mentioned above in mind. First, after simply reading the data, a common sense impression was gained in theoretical language which was unsystematic. Second, the researcher systematically developed a few major categories then proceeded to describe them analytically at length within the data. At this time, there might be some exciting findings as no further conceptualization of data seemed necessary. Third, by systematically analyzing data, a detailed theory was generated and the focus in this third phase was organizing the emerging ideas (Glaser 1978). In this way, the analytic process was governed by and the theory was developed in a structured and methodologically consistent way which helped to maintain rigour in the process. The result of the theory development is presented in the findings and theory chapters.

4.7. Comparative literature review in this study

In the book “The Discovery of Grounded Theory”, Glaser and Strauss (1967, p 163) discussed the merits and drawbacks of using existent literature; they did not say that a literature review should be purely rejected but “using various qualitative sources, alone and in combination, to generate theory effectively through comparative analysis” (Glaser and Strauss 1967). The literature should instead be read in the sorting stage, being treated as more data to code, and compared with what has already been coded and
generated. This comparative literature review makes it possible to integrate substantive concepts emerging from the fieldwork with their counterparts in the relevant literature into the theory and make the scholarly contribution (Glaser 1998). Meanwhile, comparison of the emergent theory against the existing literature is one important approach to judge the fit of the substantive theory which is a criterion for assessment of a Grounded Theory (Glaser 1978; Glaser 1992b).

Literature is considered as another source of data after completion of conceptual analysis of the data, useful for integrating into the constant comparative process (Glaser and Holton 2004). However, Glaser (1978) also realised that when Grounded Theory moved beyond description, there was a danger that it might produce isolated islands of knowledge (Glaser 1978) with the emerging theory remaining separated from the general body of knowledge frame or knowledge hierarchy. In this way, from a methodological point of view, the utilisation of literature during this procedure aims to compare how and where the study fits in with the literature or to establish where in the literature the generated theory is situated (Charmaz 1995). By so doing, the theoretical codes and the substantive core category can extend beyond the present study and then link diverse studies in the relevant areas (Glaser 2005).

In the case of this study, for practical reasons related to the requirements of the PhD programme, such as the need for ethical approval, a pre-field work literature review was conducted. However, as no papers were identified as being directly relevant to Chinese elders’ help seeking in the UK, the impacts from the literature were few and its premature influence on the study were avoided. In this way, only a general question was identified before entering the field. Therefore, Glaser’s position was adopted in this study.

The post-fieldwork literature review set out to conceptually compare and integrate substantive concepts emerging from the fieldwork with the literature after data analysis was completed (Glaser 1978; Glaser 1992b). As suggested, the experience of inductive analysis during the present study may influence the literature review (Heath 2006). Since the emergent theory in this study illustrated that Chinese elders’ general health behaviours and help seeking behaviour were mainly shaped by certain unique Chinese characteristics rather than externally practical factors, two main bodies of the literature were used as a basis of comparison, the concept of the core category of Chinese being
healthy and the process of Chinese people’s help seeking overseas. Meanwhile, the names of categories and analytic elements were used as search terms to guide this post-fieldwork literature review using electronic databases.

It was not intended to produce a systematic review in the sense of a comparative literature review in this Grounded Theory study (Glaser 1992b). As a substantive theory of being healthy was generated, corresponding empirical literature were searched. The intention was to carry out a preliminary scoping of the potentially relevant literature so as to assess and ascertain the nature and distribution of relevant studies for breadth and depth. The search strategies included a search of all health and social science related electronic databases. The inclusion criteria were empirical studies (both qualitative and quantitative research), relating to Chinese people overseas, and health related behaviours. The search of electronic databases covered all the dates from 1951 to 2010. The details are presented in Appendix 4-5: Comparative literature review search in electronic databases. Additionally, citations and abstracts were used to identify all relevant papers. From a total of 200 abstracts, 13 empirical studies which explored the help seeking behaviour among Chinese people abroad were identified. Full text of the papers were read and compared with the emergent theory in this study on the basis of their potential to display representative features of corresponding elements of the theory. The results of the comparative literature review are presented in the chapter that discusses the theory of being healthy.

4.8. Data presentation

“Analysts have an obligation to monitor and report their own analytical procedures and processes as fully and truthfully as possible (Patton 2002, p 434).”

Adequacy of the description of qualitative findings through the whole research process is needed so that researchers can demonstrate how they reach their particular interpretation of the social world under study and therefore allow the reader to follow an audit trail (auditability) in the data presentation process (Ashworth 1987). Denzin (2001) used the term “thick description” to emphasise the rich, detailed, and concrete descriptions (Denzin 2001), which form the bedrock of qualitative study (Patton 2002). The presentation of data in Grounded Theory is a crucial part of the whole study process. In Grounded Theory study, following the development of theoretical coding, the data
are reduced and grouped in categories and finally themes (Glaser 1978). This process effectively compresses the large amount of data to a readable story, thereby reducing the complexities encountered in the field into a clear and readable representation. Therefore, some key elements were considered in presenting the data in this study.

First, the balance between description and interpretation is a significant issue in presenting data (Patton 2002). Sufficient description includes some appropriate quotations which will allow the reader to have a clear understanding of this study. However, the presentation of data needs to be adequately supported by representative quotations (either typical or atypical) so that the reader can understand the interpretive process. It was hoped that these data were presented to give the reader some feel for where the ideas and theory came from. Notwithstanding this difficulty, extracts from both the research dairy and interview transcripts were italicised to illustrate the data presented. The researcher distinguished those quotes from different sources at different times by using different tags at the end. Further, square brackets were used to enclose any supplementary data which aided understanding of the extracts presented.

Second, although qualitative analysis does not present tests of statistical significance, some numerical data will be presented in the findings to add emphasis to the numbers of participants who made a particular comment. For example, expressions such as ‘most’ and ‘few’ will be used to indicate the emphasis and importance given to certain findings (Patton 2002). In this study, the various shades of the findings were presented to allow the reader to make their own decisions about the evidence provided by the researcher.

Finally, it is argued that qualitative researchers may fall into the trap of making their data fit existing theories (forcing the data) (Thorne 1991; Denzin and Lincoln 1994). In order to prevent this from occurring in this study when presenting the findings, the researcher undertook a number of steps to achieve academic rigour to keep as true as was practically possible to the participants’ own accounts of the events. The researcher wrote and presented the findings chapters first in draft form and then moved onto the comparative literature review at a later stage to avoid contaminating the data presented in the findings section.

The findings of the study, based on the process of data collection and analysis outlined in previous sections, are presented in the findings chapter. Some direct quotations, both
long and short from the interviews, along with theoretical memos and field notes which often explain the context of the data and are used to illustrate the findings. This will allow the reader to assess the trustworthiness of the data (Denzin and Lincoln 1994).

4.9. Ethical consideration and researcher safety

“Interviews are interventions.” (Patton 2002, p 405)

Healthy volunteers were researched in this study, so the research proposal for ethical approval was delivered to the research ethics committee of the University of Manchester, as seen in Appendix 4-6 (including the information sheet with response letter, consent form, Ethical approval). Ethical approval was gained in July 2008. For the purpose of this study, in this section the researcher discusses ethical issues under five headings: harm, autonomy, informed consent, confidentiality and relationality. Further, issues related to safety as a lone researcher are mentioned.

4.9.1. Freedom from harm

The central ethical issue surrounding data collection through interviews is that participants should not be harmed or damaged in any way by the research (Gray 2004). Some researchers often seem to ignore that active participation in a research project, even on a purely verbal level, may arouse feelings, or stir memories. If the participant becomes anxious or upset during the course of an interview, the researcher should remedy the situation or the session should be abandoned (Gray 2004).

In this study, the researcher followed these guidelines when conducting the interviews. For example, when talking about illness history such as gynaecological issues, some elders’ emotional expression of hesitance or/and a red face showed their shyness and embarrassment. At this point, the researcher decided to stop exploring this topic or changed the conversation if appropriate. In addition, when narrating a serious illness history of participants’ family members, they usually became quite emotional and some burst into tears. When this happened, besides comforting them, the researcher changed the topic to shift their attention. By doing so, anxiety and difficult emotions were avoided to a large extent and elders were protected from potential harm. This is important in Chinese culture as the direct expression of emotion is generally avoided. As the interview progressed, the researcher generally came back to sensitive subjects from a different perspective and explored the issues using a softer manner of asking
questions. This was essential in securing both depth and understanding of difficult issues amongst the elders.

There was another point relating to harm in this study. During some interviews, various elders talked about very difficult situations where they were obviously at risk, either through a lack of information or through not taking tablets (the interview content will be discussed in detail in the finding chapter). The researcher did realise that these misunderstandings would bring dangers to the elders. Though the researcher did not have any right to tell them what they should do because of her identity as a research student, the researcher considered this issue seriously. When this happened at the end of the interview or during informal talks, no matter if elders asked the researcher’ opinion about their own situation or not, the researcher usually took the opportunity to talk with these elders, encouraging them to see a doctor as soon as possible. If the elder’s behaviour was obviously wrong, the researcher usually had a longer conversation with him/her in order to attract their attention to their health problem. The researcher talked about some others’ stories (scenarios) in order to encourage them to seek help and to some extent to change their incorrect understanding about illness. For example, if an elder did not take hypertension tablets anymore and thought he/she did not need them, the researcher told him that "there was another elder almost the same age with you; he told me he had some symptoms before which seemed quite similar with yours. But after follow-ups, he had good consultations from his GP and now he told me he was much better than before. Maybe I think you can see your doctor and tell him/her your problem." By doing so, it was hoped that elders who were at risk could have an appropriate way to resolve their health problems as soon as possible.

4.9.2. Autonomy – freedom of choice

Participants had complex emotions such as anxiety and sometimes distressing feelings and the researcher wanted to avoid participants feeling under pressure to take part in the research. Hence, fully informed consent was an important part of the research process in this study. All of the participants had the right not to answer individual questions during the interview or to terminate the interview before its completion without providing any reason. Ongoing and process consent (Grbich 1999) whereby the researcher asked questions like “is it OK to continue?” “if this it too difficult for you we can stop” and other such reassurances ensured that no participants was under any pressure to
participate and they knew that they could withdraw at any point before, during or even after the interview and research process was completed.

4.9.3. Informed consent – respect for the participant

It is very important that all participants are warned of any risks of involvement before participation. Informed consent may be given through a verbal agreement, but a written statement is best (Gray 2004). In this research, all the potential participants were given a written research information sheet in Chinese, explaining the purpose of the research and the reason why they were invited to participate. Time was allowed for all participants to read the information sheet and any questions about the potential interview were asked during this period. A few days or weeks later (as decided by participants), the participants who wanted to be interviewed approached the researcher or the organization staff to give their decisions about when they were willing to be interviewed. Therefore, all of the participants had at least two days (often longer) between receiving the research information and the interview.

4.9.4. Confidentiality

Confidentiality was the main ethical consideration in this study. Confidentiality as a concept firstly related to anonymity; and secondly, it emphasised the importance of the security of the data. The names of the participants were removed from all material to make sure the participants were not identifiable in the transcription sheets. The recordings for interview were stored anonymously on computer disks; the transcriptions were stored in different safe place and were locked, and only the researcher could access them. Participants were identified by a number allocated by the researcher. Apart from the researcher, nobody was able to link individuals to their numbers.

In almost every study site, there were some elders who asked about the issues of confidentiality. The researcher assured them that no others could identify them directly and explained that though the final thesis might involve some direct quotes from interviews, those data would be anonymised. A serial number was used for the participant and only participants would be able to recognize what they had said from transcripts. In order to avoid the serial number being identified by the managers or staff at the study sites, the researcher ordered all the numbers from the different sites.
consecutively, without an identifier to the study site. This is how the data are presented in this study.

4.9.5. Relationality

In undertaking this study, the researcher clearly introduced herself as a PhD student and stated her own interest in the subject area along with the requirements of the study leading to the personal award of a PhD degree. The researcher never hid this fact from participants and when asked replied honestly that the study was for personal interest and professional development as well as increasing our knowledge of the subject area. In doing so, confidence was gained from the elders and a good rapport was developed. In this way, data collection was not just mechanistic. It obviously facilitated the findings of the study. This point was discussed previously in the section of “Gaining Trust and Rapport”. More importantly, in Chinese culture a lot of status is afforded to education and professional development and Chinese people respect learning. However, the researcher also hoped that there was some utility for the participants. Actually, most participants were interested in the topic and often re-examined their health problems to a greater or lesser extent. Therefore, it was believed that this study was conducted in an ethical way with consideration of the participants involved. Above all, it gave the participants a rare opportunity to talk about their health and concerns.

4.9.6. Researcher Safety

As the researcher was working alone during the period of data collection, matters of safety for lone workers were considered. The researcher ensured that her husband was aware of the timing and location of each interview; and phone calls were made with her husband before and after every interview to ensure safe arrival and completion of each visit. This included issues that the researcher was safely positioned near to the destination when the interviews took place in participants’ homes and that a mobile phone was carried in the unlikely event that emergency contact might be needed.
4.10. Academic rigour

“The debate surrounding the methodological rigour of qualitative research is
confounded by its diversity and lack of consensus about the rules to which it
ought to conform and whether it is comparable to quantitative research”
(Sandelowski 1986, p 29)

According to different epistemological and ontological underpinnings, rigour in
qualitative research is not amenable to a simple unified standard or approach and has
been hotly debated for many years (Silverman 2000). This debate mainly focuses on
whether the quality of qualitative research can legitimately be judged, and if so, how to
judge it (Mays and Pope 2000). This debate itself is a complicated epistemological
question and it seems a mystery to many health care researchers.

4.10.1. Rigour in qualitative study

Despite the lack of overall solutions which are accepted by researchers to assess quality
in qualitative study, it is perhaps fair to say that many qualitative researchers believe it
is necessary to judge the quality of qualitative study and express the rigour, a view of
which the researcher would concur with in this study. Between these two extreme
perspectives, a balance between creativity and rigour is required (Sandelowski 1986);
whilst rigour within qualitative research is necessary, the creative element is essential
for the production of a high quality study, that is, researchers need to aim for “rigour”
rather than acquiring “rigor mortis” (Sandelowski 1993). In this way, the adoption of
criteria for quantitative studies which fail to reflect the assumptions underpinning
qualitative inquiry are insufficient (Murphy et al. 1998). As mentioned, many
researchers provide guidelines and criteria for qualitative inquiry; see for example
However, many of them are intended to be generic whilst some are paradigm specific,
for example Altheide and Johnson (1994). Further, from the view of specific
terminology, there is a large range of vocabulary relating to rigour from the terms
Reliability and Validity in quantitative paradigms. But as Murphy and Dingwall (1998)
argued, these various labels used by different researchers to express similar ideas and
most of them have their genesis in the earlier writings of Lincoln and Guba (Murphy et
al. 1998). The terms, in qualitative inquiry, Credibility, Neutrality or Confirmability,
Consistency or Dependability, Applicability or Transferability, and Auditability are
considered essential criteria for quality (Lincoln and Guba 1985). In most cases, the concepts, credibility, transferability, dependability and confirmability, which were modified later by Denzin and Lincoln (1994), are accepted as good enough criteria for rigour in qualitative research by nursing researchers (Kincheloe and McLaren 1994; Murphy et al. 1998).

4.10.2. Evaluation of quality of evidence, analysis and interpretation

Following these generally accepted measures which were conceptualised by Lincoln and Guba (1985), and modified later by Denzin and Lincoln (1994), credibility, transferability, dependability and confirmability were taken to ensure the rigour of this qualitative research. The following sections do not seek to specify the origin of the terms but to convey their meanings and usage in this study.

4.10.2.1. Credibility

Credibility is defined as the extent to which the researcher’s conclusions are endorsed by the participants (Murphy et al. 1998). Participant validation or member-checking through the process of feedback is the main technique for assessing credibility of the data and interpretation (Sandelowski 1993; Guba and Lincoln 1994). Participant validation with concurrent data analysis and back-check with participants was adopted during this study, which was a fundamental component of the Grounded Theory method (Glaser and Strauss 1967; Glaser 1992b).

Though the interviews, especially the first few purposive interviews, the interview guide was the main tool to guide the conversation. However, some ideas or topics emerging from the previous interviews were added to the subsequent interviews to gain validation among later participants. Additionally, preliminary findings were shared with participants during second interviews that took place later in the research process. In the theoretical sampling, summaries of the current findings, including themes, were presented to participants for comments and evaluations of credibility. Furthermore, semi-structured interviews, informal conversations and some email responses were used to adjudicate between different accounts in the data and to check understanding. Credibility was also established by checking data and their interpretation with participants (Koch 2006); supervision during this process made a great difference. The
important aspects were shared with supervisors in follow up meetings to discuss the findings throughout the data gathering, analysis, and writing of the research account. This approach helped prevent the researcher from identifying too closely with Chinese people’s perspectives and losing sight of other perspectives. In addition, field notes and memos were available for scrutiny.

This level of debriefing is known to increase the credibility of the analysis (Denzin and Lincoln 1994) and clarified the interpretation process of the data. Practically this meant keeping a consideration of how the researcher’s assumptions impacted on data collection and analysis, and also any processes that might shape the findings. This process enhanced theoretical sensitivity, guarded against selective inattention and facilitated a reflexive approach to the data and consequently contributed towards the rigour of this study.

When reporting the findings, the researcher attempted to make the whole research process transparent. This included how the data were collected and analysed, how the researcher’s characteristics and assumptions might have shaped the research process and results. In this way, the full and thick descriptions of the research findings were given based on the participants’ context and their perceptions thus, readers can assess whether the presentation reflects participants’ experiences and to what extent the result can transfer to other contexts. Therefore, via these techniques, the credibility of the findings added to the rigour of this study.

4.10.2.2. Transferability

Providing a rich and detailed description of the context of the study is the essence for achieving transferability which is defined as the extent to which the data can resonate with other groups in a similar context (Lincoln and Guba 1985; Denzin and Lincoln 1994).

In the case of this study, in order to achieve this, the researcher gave a thick description of the data as well as the context and the interactions between the participants and the researcher in these settings. Detailed quotes and often more than one exemplar were offered in the findings section so that readers could make their own assumptions from the data.
The data were also compared with the relevant literature and, there were some aspects which clearly resonated with overseas Chinese immigrants in other localities across the world. This provided some confirmation that the findings were potentially transferable to the real life of Chinese immigrants living in other societies.

Murphy and his colleagues (1998) also stressed membership checking as another way to achieve transferability (Murphy et al. 1998). The researcher encouraged discussion and debate among participants from different backgrounds in order to identify the contradictions and consistencies within the data. There were various responses reflecting varied life experiences; some findings resonated for some elders now and again, others had a high degree of resonance, still other ideas only partially resonated with participants. Glaser (2004) indicated that in Grounded Theory, seeking negative cases was not a useful or necessary procedure and was one kind of “forcing data” (Glaser and Holton 2004). In this study, the careful and methodical approach to analysis and simultaneous data collection meant that membership checking was a constant and ongoing process. The decision to move from purposive to theoretical sampling was also based on the feedback during interviews with participants and was influenced by their agreement with the emerging themes.

4.10.2.3. Confirmability

Confirmability is an assessment of the quality of the integrated processes of data collection, data analysis, and theory generation to measure how well the inquiry’s findings are supported by the data collected (Lincoln and Guba 1985). As the researcher collected data independently, the assistance of two supervisors in auditing the research methods was valuable. The supervisors examined the audit trail consisting of original transcripts and data analysis documents whilst the researcher thoroughly examined all the research recordings, such as the transcripts, field diary, comments from the member checking, and the drafts of the various chapters (as outlined above). Thus, the confirmability of the project, as well as the completeness and availability of auditable documents were assessed. The researcher made the pre-existing conceptions and potential biases explicit. In this way, in the presentation of the findings, plentiful data and interpretations with clear explanations were provided to readers for judging whether the findings are adequately supported by the data; thus convincing the readers of the
relevance of the theory. Above all, the detailed presentation of the working methods offered in this chapter will allow the reader to judge the quality of the study and the methods used. A clear and open audit trail is available here.

4.10.2.4. Dependability

Dependability is defined as a clear description of ever-changing research procedure, with sufficient detail of the research strategy provided to allow the method and rigour of the approach to be evaluated (Lincoln and Guba 1985; Johnson et al. 2001; Robson 2002). In this study, the concept of dependability was operationalised through the use of a research dairy, which included detailed notes and memos. These files recorded the sampling and analytical decisions or audit trail, where appropriate showing the theoretical or personal justification for these decisions, made throughout the study process. The various stages of the whole study procedures were explained as clearly as possible to exhibit a view for readers of this text to assess the value, trustworthiness and relevance of the findings of this thesis. Great pains were taken to ensure consistency between ontology, epistemology and methodology (see chapter 3 Methodology) which for many qualitative authors is the true method of judging the dependability of the research process (Altheide and Johnson 1994; Denzin and Lincoln 1994; Mays and Pope 2000; Cohen and Crabtree 2008).

4.10.3. Evaluation criteria in Grounded Theory

Whilst the previous section attends to the criteria for judging the rigour of qualitative studies in general, this section examines the criteria suggested from within Grounded Theory for assessing the rigour or quality of the theory generated in this study. As it was the aim of this study to systematically generate a theory from research data mainly based on Glaser’s methodology the academic rigour for assessing the theory is specifically illustrated here. Glaser (1992) and Strauss and Corbin (1990) had conflicting views on the criteria for evaluating rigour of the theory generated in Grounded Theory studies. Glaser (1978, 1992) offers a list of general criteria which can be used to evaluate the quality of the theory in Grounded Theory studies: fit, work, relevant and modifiability, considering them as the pertinent indicators to evaluate the theoretical rigour of the theory (Glaser 1978; Glaser 1992b). On the other hand, Strauss and Corbin (1990) though acknowledging the criteria proposed by Glaser, added
reproducibility and generalisability to judge the rigour of Grounded Theory study (Strauss and Corbin 1990). Glaser (1992) strongly disputed these two criteria and considered them as quantitative concepts (Glaser 1992b).

Glaser’s (1992) criteria appear relatively suitable for qualitative study to evaluate rigour because the criteria address both the scientific and creative aspects of doing qualitative research as well as giving more flexible and applicable space for exploring research. In this way, it was adopted in this study as the criteria to enhance theoretical rigour. Moreover, the criteria used to evaluate this Grounded Theory study should take consideration of the Glaserian approach (Smith and Biley 1997). A rigorous theory must have fit and relevance and it must work and be readily modifiable (Glaser 1978). This will be discussed in the section of “Theoretical assessment of theory” in the theory Chapter 6.

4.11. Reflexivity and Grounded Theory

The central focus of Classic Grounded Theory remains developing a systematic and conceptual hypothesis via abstract conceptualisation (Glaser 1978; Glaser 1998). Glaser (1998) claims that if the researcher follows the Grounded Theory approach strictly then any misconceptions on the part of the researcher are corrected by this systematic and rigorous research method, including constant comparison and theoretical sampling. Though Grounded Theory builds its methods for verifying emerging categories and theory, leaving an audit trail can make the process more transparent (Sandelowski 1986; Koch 2006). This is because researchers are still people and they must rely on their own sense and process when expressing all information (Denzin and Lincoln 1994). In presenting the decision making process and how the interpretations have been reached others can judge the quality of the theory. The reader can also determine whether, or to what extent, the researchers’ perspective has influenced the conclusions (Chambliss and Schutt 2006). The complex nature of the social world is acknowledged and attempts are therefore made to convey this complexity, rather than ignore it. Therefore there is an emphasis on processes, not simply on outputs.

Reflexive practice in qualitative study acknowledges that the interaction between the researcher and the research process affects the whole research (Denzin and Lincoln 1994; Silverman 2000). Reflexivity enables researchers to make personal and
theoretical biases explicit and also potentially enhance the credibility of the findings (Murphy et al. 1998). Murphy et al. (1998) consider reflexivity as sensitivity to the ways in which the presence of the researcher influences the data collection and how preliminary assumptions contribute to the data analysis. This point echoes to theoretical sensitivity in Grounded Theory. Glaser and Strauss (1967) and later Glaser (1978) emphasise the impact of the researcher during the study process through their concept of theoretical sensitivity.

In this section, the themes of the personal position as a researcher are shown to indicate the relations with the participants in the complex research settings. In this study, reflexivity included the critically continuous examination of the researcher herself, such as the researcher’s beliefs and ideas as well as methodological and theoretical decision-making and also constant scrutiny of the interactions and interpretations between researcher and the participants in the research setting. Issues of reflexivity were clearly tracked in order to explicate the researcher’s views and indicate the data analysis process. For example, completing a field diary about the decisions regarding data collection and analysis and their impacts on this process was one part of this process. This allows the reader to evaluate, or even audit, the flow of the research process, including seeing the researcher’s subjectivity and bias. Where appropriate, excerpts from the research diary and memo written in the analysis process are presented alongside excerpts from the data.

4.11.1. Personal effect on the study

Glaser (1978 & 2002) often counselled researchers with similar experience as their participants to make field notes about themselves in order to prevent researchers’ forcing their own reading of the data. Critical self-examination was one of the most important points among the reflexive practices in this study. During the interviews, it was noticed that both the participants and the researcher shared similar backgrounds and they could understand each other, although there were also diversities including age and immigration experience. During the initial phase of data collection, the researcher felt that this was a hindrance as there was the potential to miss important information because of the assumption of shared understanding. After discussion of the initial interviews with supervisors, the consciousness of this “seeing me as an insider” by both the researcher and participants was recognised and amended accordingly and gradually.
The researcher tried to keep asking the participants to explain everything and not assume that she knew about what they might consider to be obvious or common sense. In this way, critical self-consideration was crucial and helped her to explore further the participants’ standpoint in this study. This self-examination gave an effective way for discovering potential barriers when Chinese elders faced the health problems in this new social context, which was discussed earlier in the section of Reactivity.

The following are examples from an early research diary after discussion with supervisors and a field note critiquing the researcher’s own experience on the data:

“Here, this is an interesting point about her expectation that her family do the care (the interpretation); and shows a difference between her expectation and what the hospital thinks it should provide. At the moment, I just thought that I agreed with this lady that the UK government provide a good service compared with the pay fee service system in Chinese hospital. I think, here, I lack of follow up and should continue further – Are you happy about having your daughter do the translation? Why?” (Research diary, July, 2008)

“This is the second time elders mentioned about big hospital and said they trust it more than the GP. Last time I did not notice it was an important issue because I took it for granted (in China “big hospital” means professional). I ignored this issue in the context of the UK and did not follow up. This time I sensitively recognised this point and explore it further by asking the elders – why? This is Glaser counsel – researchers’ life cycle interest forces the read on the data.” (Field note – August 2008)

4.11.2. Reflection on recruitment of participants

On reflection, the researcher was concerned about the possibility that her personal position might impact on the recruitment of participants. As initial introduction of the study and the distribution of the information sheets were sometimes via the senior staff in these Chinese communities, this could lead to a perception that the researcher was associated with, or allied to the senior people or even their GPs. This might have been viewed as some kind of pressure to these elders and reduce their trust and confidence in this study. To avoid these negative perceptions from these elders, the researcher initially identified herself as an independent researcher, emphasised the role as a PhD student, and stressed that there was no official relationship with any other health care services. Further, the researcher used School of Nursing, Midwifery and Social Work, the University of Manchester as the reference and contact point to show her independence. Indeed, after undertaking the ethical duty of informing participants of their autonomy,
the elders who took part in this study appeared to be very open and honest, showing their trust and that these concerns were not evidenced.

4.11.3. Reflection on data analysis and interpretation

Reflection on data analysis and interpretation in this study focused on one main point, whether there were preconceived themes or pre-existing explanations in data analysis and if there was, to what extent they impacted on the final data interpretation.

Prior to the commencement of the interview, the initial literature review explicated the existing perceptions of Chinese immigrants’ help seeking behaviour in different social contexts. However, the researcher reminded herself to suspend these ideas and focus on the actual data in the setting of the UK when managing coding, analysis and interpretation. Further, the key features of constant comparison and theoretical sensitivity were used via the whole process of data analysis and interpretation to reflect all emerging themes and theoretical explanations which were grounded in the data. This process included checking themes back with the participants, comparing what participant’s perspectives were common or rare with other participants and assessing different shades or levels of the same concept among different participants. Although differing in social background and genders, Chinese elders in this study shared a major degree of conformity with each other, and disagreements tended to be slight. The following are some sentences from the research dairy in the early stages, showing how the researcher kept the sensitivity in data analysis and interpretation:

“Codes have to be from data!!!” (Research diary, July 2008)
“Is this my own ideas? Am I identifying this from the interview?” (Research diary, July 2008)
“Make sure all is data. Do not expect them to tell me anything I want!!!” (Research diary, September 2008)

4.11.4. Reflection on methods and application

Before this study, the researcher had not conducted any research independently or individually. The most challenging aspect at the beginning was the selection of a method which was congruous with the philosophical position. Grounded Theory was found to match the researcher’s philosophy to the highest extent. To counter the uncertainty of beliefs and thoughts on the whole research approach, including data collection, analysis and interpretation, Grounded Theory was chosen as the
methodology to guide this study. On the one hand, it was congruent with the purpose of this study; that was to describe and explain elders help seeking behaviour when facing health problems and emphasise the concept of this study based on the social context. On the other hand, as the key techniques of constant comparison and theoretical sensitivity are central to the Grounded Theory approach this facilitated the identification of themes from the data and also promoted rigour and reduced potential bias. Thus, in this study, the researcher principally adhered to the key elements in classic Grounded Theory as well as considering the pragmatic issues to suit the context and resource constraints, such as time and money of this particular PhD degree study.

4.12. Summary

The present study was undertaken to provide an understanding of Chinese elders’ central concerns of their health related events and problems as well as the pattern that how they managed these issues during their daily life. Classic Grounded Theory was selected as the most appropriate research methodology to conduct this study, as its core idea is to explore the basic social process and thus develop theory.

Data collection included 37 formal interviews and also some informal conversations. A variety of texts, including field notes and memos, were also used to enhance data analysis. Data collection and analysis were conducted simultaneously guided by the main principles of constant comparison and theoretical sampling in the Grounded Theory approach.
Chapter 5 Findings

Introduction to demographic data presentation
Data from the demographic questions are summarily presented using descriptive statistics; results of this analysis are presented in this chapter.

5.1. Characteristics of elderly Chinese participants

This chapter commences with the presentation of data relating to the context of the study sites. This is followed by a presentation of the characteristics of the elderly participants.

5.1.1. Introduction to study sites and elderly Chinese participants

Glaser (1978) emphasised that descriptions of the places and people who participated in the study are necessary in grounded theory analyses. This information should be provided to orientate the reader to the nature of the sample and the context where the study occurred (Glaser 1978). The Chinese elders who participated in this study were selected using purposive sampling to begin and then theoretical sampling, in which the themes from the developing theory were used to guide the sampling of subsequent participants. This point had been previously described in the Chapter on Working Methods.

5.1.2. The context of study sites

Manchester’s Chinatown is the second largest Chinatown in the UK and the third largest in Europe (Christiansen 2003). The first study site was selected on the basis of criteria relating to the type of Chinese community, type of population served, as well as location. An Elderly Luncheon Club which was especially for Chinese elders was chosen as it represented a demographically large Chinese community and was easy to access in terms of transportation. As a major centre for Chinese elders in Manchester, approximately one third of the participants were recruited from this study site. A significant feature of this site was that, historically, almost all the staff and elders spoke in Cantonese. Furthermore, some activities, such as health lectures were conducted in Cantonese. Thus, very few Mandarin speakers came to join this club. In order to gain
more information from participants with diverse backgrounds, other Chinese communities in Manchester, such as two Chinese churches, were also contacted to gain access to participants in order to maximise the number of Mandarin speakers. These study sites were not dedicated for Chinese elders but were intended for the general Chinese population. These study sites were recommended by elders as well as some facility providers in Chinese communities. After contacting them, some interviews were conducted in these centres while some were conducted in the participants’ home. In this study, participants were geographically dispersed across Greater Manchester.

5.1.3. Chinese elder: biographical characteristics of study participants

This section presents a summary of the data relating to the characteristics of the elderly Chinese participants in this study. Generally, they were heterogeneous in terms of birth places and dialects spoken. Chinese elders participating in this study varied in the number of years they had lived in the UK, their first language, their educational level as well as their marital status and family structure. Differences in age and gender were noted. Details of each participant’s personal details are presented in Appendix 5-1 Demographic information.

A total of 33 Chinese elders took part in this study from July 2008 to June 2009. Of the 33 elders who participated 10 (30.3%) were male, the remaining 23 were female. The first language of the majority of participants was Cantonese, only seven (21.2%) were Mandarin speakers and only one (3%) was Hakka (another dialect) speaker. Among the 25 (75.8%) Cantonese speakers, most were also able to understand Mandarin, but only four were able to speak Mandarin fluently. The data in this study were reflective of the reality at the study sites at the time the study was conducted. As a qualitative study, the aim was not to recruit a representative sample, rather one that reflected the diversity of the population as much as possible informed by the emerging themes.

5.1.3.1. Age

The Chinese elders who participated in this study were predominantly in the 60 – 69 years (n= 12, 36.4%) and 70 – 79 years (n= 18, 54.5%) age groups. Only 3 (9.1%) were aged more than 80 years. The range of Chinese elders’ ages was from 60 to 84 years and mean age was 71 (Figure 5-1).
5.1.3.2. Years living in the UK

Chinese elders who participated in this study showed wide variability in the number of years they had lived in the UK: from 19 months to 54 years with a mean duration of 25 years. The majority of elders had lived in the UK between 10 to 19 years (n=9) and between 40 to 49 years (n=9). Seven Chinese elders had been living in the UK for less than 10 years and among them, only one had lived here for less than five years. It should be highlighted that of the seven Chinese elders who lived in the UK for less than 10 years, five were Mandarin speakers who came from Mainland China. Demographic data showed that a high proportion of Cantonese speakers emigrated to the UK for work whilst most Mandarin speaking elders came to the UK to be reunited with their adult children.
5.1.3.3. Education level

Chinese elders’ educational level ranged from none to university level. The majority of participants’ education level (n= 16) was elementary school. However, many of the elders emphasised the hard experiences in the old days which led to their non completion at school. Six participants did not have any educational qualifications whilst only three held an advanced academic degree from a university. In general, this data was representative of Chinese immigrants in the UK; the number of Chinese immigrants who had no qualifications was relatively higher than White British people (Office for National Statistics 2004b).
5.1.3.4. Marital status and family structure

Fourteen (42.4%) of the 33 Chinese elders who participated in this study were currently married and the remaining 19 (57.6%) were widowed at the time of interview. Among the 14 married Chinese elders, 10 of them lived only with their spouses. Among the 19 widowed elders, 11 of them lived alone. The remaining 12 Chinese elders lived with their children and/or children’s family, and their spouses. It is notable that 15 of the 19 widowed elders were females and only 4 were males, echoing the tendency that the average life expectancy among females was higher than for males both in China and the UK.

5.1.4. Summary: Chinese elders’ characteristics

Although the Chinese elders who participated in this study were not randomly sampled, they did constitute a reasonably mixed group of elderly Chinese people living in the UK. The participants represented a range of ages, years lived in the UK, gender, and different educational levels. However, males and Mandarin speakers were slightly under-represented, in comparison to the number on the UK Census.
Introduction to qualitative data presentation

In this and subsequent sections (5.2 & 5.3), findings from the analysis of the interview data are presented within a framework of categories and thematic codes. Supplementary data from analysis of participant feedback as well as comments recorded in field notes after feedback/validation discussions are also presented at the appropriate stage in the data presentation chapters.

Data analysis resulted in the identification of one core category with four interrelated key categories, containing concepts and themes which embodied the fundamental elements that Chinese elders in this study used to represent their perceptions of help seeking. Although the categories are presented as separate elements, they are not conceived of in isolation or as accruing uni-dimensionality, but are envisioned collectively, functioning as a dynamic, integrated and interrelating collection of themes.

Grounded Theory produces a substantive theory that aggregates and synthesises the perceptions and understandings of the participants. In this study, the substantive theory describes and explains Chinese elders’ perceptions of help seeking. In order to illustrate the theoretical concepts that are used to construct the theory, narratives have been selected as typical or representative of the collective or majority of Chinese elders’ perspectives of help seeking. Meanwhile, variations are specifically identified, if necessary and when appropriate. As many comprehensive illustrative quotations as possible are selected from all elderly Chinese participants and presented in italics and indented. At the end of each quote the text enclosed in brackets indicates two types of information: the sequence of interviews (consecutive numbering) and the individual identification number of each participant taking part of the study. Some participants were interviewed twice or more and while the identification number remains constant for each individual, the interview number will vary.

Being healthy as a pervasive goal with its four constituent key categories is presented diagrammatically in Figure 5-4. The important themes are represented under each category.
Figure 5-4: Categories of Being Healthy

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self management</td>
<td>Normalising/minimising to be healthy</td>
<td>Access health service</td>
<td>Being cured</td>
</tr>
<tr>
<td>Self-reliance</td>
<td>Creating a sense of normality</td>
<td>Roles of family</td>
<td>A dual character of Western medicine</td>
</tr>
<tr>
<td>Personalised self</td>
<td>Knowledge about health issues</td>
<td>Controversial health care service in the UK</td>
<td>Variation in appraisal towards practitioners</td>
</tr>
<tr>
<td>care and self treatment</td>
<td>Old age and accepting Emotional stoicism and fatalism</td>
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5.2. Core category: the context and meaning of being healthy as a pervasive goal

5.2.1. Introduction – the philosophy of Chinese health care

Cultural beliefs shaped the perceptions of participants and thus affected their understanding of health and illness; health seeking behaviours were influenced by health beliefs. This study revealed the nature of Chinese elders’ help seeking behaviour in relation to being healthy, coupled with a host of social and environmental factors, including both their personal living situation and the UK health care service system. These factors contributed to a very particular experience of how being healthy was constructed and challenged within their Chinese traditional notions.

Exploring Chinese elders’ perceptions of help seeking behaviour proved to be a both fascinating and challenging process for a number of reasons, many of which were consistent with the literature. The first and most immediate challenge related to difficulty with the description and explanation of the key study construct: the context of being healthy among Chinese elders. Chinese health beliefs were found to be a set of principles and practices associated with nature, based on a holistic view, including physical, psychological as well as external factors which contribute to health. Reflecting on the interview conversations, this notion directly or indirectly influenced health beliefs among Chinese elders participating in this study. Beliefs surrounding a healing approach and their relationship with life style and the way of nature were typically summarised as:

“I am very happy every day. Now I feel I am very healthy, without any disease. Thus I am very happy. I take a leisurely life every day. Well, I let nature take its course. Doing what comes naturally. I do not think about disease...Just let nature take its course.”

(Interview 35, ID 31)

Elders’ accounts of the philosophy of Chinese health care incorporated both an art and a science of living alongside nature, which echoed beliefs among the general Chinese population. Specifically, the Chinese healing approach was about cultivating a healthy and balanced lifestyle, which included the physical, psychological, dietary and environmental levels of health.

Analysis of the interview data relating to the ideal healthy lifestyle, which was discussed by participants, revealed a unique awareness and definition of health. Elders believed that being healthy was a philosophy of living and that healing came from within. They proposed that the health of human beings was independent of external
interference. In this way, elders were concerned with the complexity and richness of living on both the mind and body, including healthy approaches to diet, rest, sleep, exercise and mental health. Elders reported that there would not be any health problems if they actively engaged in these healthy routines. Meanwhile, they also acknowledged that ailments, to a large extent, were not easily avoided as they were part of the natural process, particularly the degenerative diseases of old age.

Besides the influence of traditional culture, elders’ knowledge also influenced their awareness of health problems. Elders tried to explain their ailments in terms of their incorrect living style, which they then attempted to adjust in order to regain their health. This was fundamental to the elders’ understanding of health issues which they believed were under their own control.

Participants’ ideal lifestyle sought to address issues related to being healthy; this included maintenance of health, prevention of disease and the treatment of disease. These perceptions of health related events strongly influenced elders’ help seeking behaviour; they maintained that help from professionals and medical services should be used only when these life style adaptations failed to provide a cure.

In addition, participants expressed their preference for remaining independent in handling their health related events. This concept of promoting self care was a significant factor for elders in this study. This philosophy could be tracked back to Chinese traditions which state that self improvement was the mainstay of a strong character although this can also be mediated by practical issues such as the lack of sufficient government institutions for health care, social welfare and the availability of health care service resources, in China, which has shaped Chinese people’s views of health seeking behaviour. The elders emphasised that they were not medical professionals but in pursuit of being healthy they could manage their own lifestyle and therefore remain healthy. One female participant summarised this:

“What we can do is concerning the food, eat fresh or natural food. Another thing is rest, have good rest as well as good sleep... We should keep balance, keep peace. Getting older, diseases are always there. There seems no method to stop it...I am not sure about other things (medical related issues). I do not have a lot of knowledge about it.”

(Interview 31, ID 4)

For most participants, perceptions of being healthy were similar, or at least common ground was apparent. However, there were also occasions when elderly Chinese
participants expressed different perspectives about specific health related issues. In the following sections, the daily healthy routines including diet, sleep and rest, exercise, as well as the physical and mental discipline, and external factors which influenced health are presented in detail, grounded in the participants’ perspectives.

5.2.2. Healthy diet for wellness

Analysis of the data revealed the important view that food was the best medicine and was closely integrated with health. It was unanimously reported that if people ate a healthy diet they would remain healthy. Some participants summarised these viewpoints in a concise way:

“That (keeping health) is to take care of my food.” (Interview 12, ID 11)

“I concern my food a lot... Eating is important for health.” (Interview 26, ID 24)

In order to avoid health problems, participants considered that a healthy diet meant that their bodies could and would function and behave properly. The data suggested that elderly Chinese individuals held their own theory of “healthy” dietary principles, which were used to explain the principles of health promotion, illness prevention and disease elimination. Elders’ views of a healthy diet were characterised by the coexistence of numerous Chinese medical traditions alongside the notions from western medicine (WM), traditional Chinese medicine (TCM) played a major role in maintaining health. The coexistence of these two medical worlds represents a particularly unique response to their conceptions of diet and healthy eating. Elders reported their individual dietary rules and categorised the nature of foods according to their own perceptions and understanding. They stated their ideal dietary style which would promote health. When health problems existed, such as degenerative diseases, elders paid much more attention to dietary issues. Similarly, based on their knowledge of physical ailments as well as diet, elders would choose or avoid certain foods to target particular health problems.

5.2.2.1. Important foods

Discussion about healthy diet was a prominent topic and elders spontaneously mentioned their diet when talking about their health. A lack of consensus on the definition of healthy foods became apparent early on in this study. In general, most elderly Chinese participants favoured a typical Chinese diet, which included wide
varieties of vegetables and fish but only small quantities of meat. Diets including too much fat or oil were avoided by the majority of participants.

The basic rule of elders’ dietary healing principles was the diversity of categories of foods. Elders thought the human body needed a number of different nutrients which were contained in abundance of foods types.

“I also concern my food. I eat both meat and vegetables. I think mix and match food can make me healthy.” (Interview 14, ID 13)

“... Every dinner, make sure there are fish or meat, and some vegetables. I eat a lot of vegetables, different kinds of them.” (Interview 30, ID 28)

Elders believed that a diversity of foods was necessary to provide all the nutrients and meet the demands of healing. The traditional diet of rice, different kinds of meat and many kinds of vegetables and fruits produced a balanced diet to meet nutritional requirements. Although elders considered vegetables as very healthy foods, they emphasised the importance of meat also and indicated that healthy foods contained both vegetables and meat. Meat or fish was defined as the source of nutrition which provided protein and was vital for human health.

“In this way enough nutrition is important... everyday and eat fish, chicken or pork…” (Interview 10, ID 10)

Some elders still emphasised the importance of meat consumption as a source of necessary nutrition although religious beliefs led them to selectively eat certain kinds of meat. One Buddhist believer did not refrain from eating meat, apart from beef and lamb. She believed that meat was irreplaceable and a vital component in promoting a healthy physical condition.

“(I pay special attention to) my normal life. I eat everything, meat, vegetables, but I don’t eat beef or lamb. I believe in Buddhism, and don’t eat beef or lamb. (But) I eat everything else...” (Interview 13, ID 12)

However, in most cases, elders optionally chose certain types of meat based on their understanding of food energies in terms of Chinese cultural traditions. As mentioned in the Background Chapter, two basic principles of “Yin” and “Yang” form the Chinese world and these two interacted universal opposites are a dichotomy. According to the universal polarities principles in TCM, foods are also divided into two main categories: “Re” (hot and warm) and “Liang” (cold). Warm and hot foods, which possess the characteristics of “Yang”, make the body warm and stimulate the circulation of blood and energy and this was defined as “Zao” (irritating) (according to TCM, too much of
this kind of foods will make human body “dry”, causing pain or inflammation to people). This view was also expressed by elders in this study. They believed that it was essential to keep a balance between these two polarities and gain moderation when achieving the goal of being healthy. In this way, elders avoided some types of meat, such as beef or lamb because of their definition of them as “Zao” which were considered as being linked to the development of some illnesses. Meanwhile, their age and a self identity as having a weak physical status led them to believe their body could not tolerate too many warm and hot foods.

“...I drink soup everyday and eat fish, chicken or pork. I won’t eat those which “Zao Re” (TCM glossary, means “rise heat in the inner body”), such as lamb/mutton and chilli. It will lead to some diseases.” (Interview 10, ID 10)

Fish was often chosen as the preferred type of “meat”. Fish could offer high quality nutrition and did not have an irritating effect because fish live in water so the characteristic of them was “Liang” (cooling). Elders talked about fish separately to emphasise its particular energy when compared to other types of meat.

“Now I seldom eat meat…but fish is not the same as other meat, my main dish is fish.” (Interview 31, ID 4)

Water and other forms of drink were defined as soothing (Run) and as an indispensable component in elders’ lives. Elders reported the significance of water in order to maintain their health and help healing.

“Now, I concern the food a lot. I drink plenty of water, drink tea...” (Interview 29, ID 27)

Besides water, juice and tea (particularly Chinese green tea) were considered as having beneficial therapeutic functions. Elders reported regular tea consumption as part of daily life and a healthy lifestyle as well as an effective approach to illness prevention.

“I only drink water and some apple juice...” (Interview 24, ID 3)

“I think this life style is very good for my health. I always drink Chinese green tea with no sugar or milk. It is good for me to keep healthy...” (Interview 25, ID 23)

Although TCM principles deeply impacted elders’ healthy dietary habits, these data also suggested that elders’ perceptions of foods were also influenced by WM, such as their perceptions of high fat foods. In most instances the concept of high fat was similarly defined as one of the most fearful and terrible factors in the western diet. When referring to fatty foods, elders used the terms oil, oily, or fat rich, reporting that foods with fat or oil were full of cholesterol. They perceived that large quantities of
cholesterol in fatty meat or fried foods led to cardiovascular diseases and several types of cancers.

“I don’t eat things with high cholesterol level...” (Interview 2, ID 2)

“Just consider the food. I consider eating a lot. Do not eat fried foods. Other things do not worry... I consider food a lot. I do not eat fried food... I am too old so I can’t eat too many oil foods. In the UK, I never eat fried food. I think (fried) fish and chips are not healthy.” (Interview 20, ID 19)

Cholesterol was frequently mentioned during interviews but most elders did not have a comprehensive and accurate knowledge of cholesterol. However, they did have a general understanding, considering it to be an unhealthy dietary factor and reporting that they avoided it in their diets. A significant finding was that very few elders could provide clarification about why they defined cholesterol as dangerous to health. A few of the elders could describe cholesterol as something from a fatty meal that was stored in the human body, accumulating in the artery walls. Thus it narrowed the blood vessels and led to hypertension and heart diseases.

5.2.2.2. Manner of eating

Many of the elders were concerned with what they ate and also paid attention to how they ate. Eating patterns were very important for healing, including the manner in which food was consumed and how much should be eaten.

One of the traditional Chinese principles regarding dietary conventions is the belief that foods should be consumed in their fresh form and not frozen. Raw foods were considered as especially rich in nourishing ingredients. Natural foods did not include food additives which were considered artificial and unhealthy.

“I also like fresh food. I do not like the frozen food. Those foods are not healthy, not good for my health.” (Interview 30, ID28)

One female participant mentioned her rejection of dietary supplements, such as vitamin tablets, which also supported this viewpoint. Elders believed that raw and fresh forms of foods provided optimum effects for their health as opposed to artificial products:

“I take much notice on my food. I care about it a lot and I think food should be taken good care of...I don’t eat tonic either. I am eating fresh vegetables a lot now...” (Interview 2, ID 2)

Elders also kept a close eye on how much food they consumed. Traditional Chinese beliefs dictate that overeating is considered damaging for people’s digestive system as
well as having bad consequences for the whole body. Many elderly participants
described this healthy eating pattern in their daily life:

“Anyways I take care of my food. You (everyone) have to be careful about your eating…
That’s eating less but having more meals…I have to take care in normal life, not eating
that much sweet and eat less in more meals; not eating too much, only about 70% or
80% percent full.” (Interview 15, ID 14)

“During the daily life, I think about my food a lot. I always consume eight out ten (80
percent of satiety). I do not like eating too much. Elders cannot eat too full. That is not
good for health and the stomach cannot bear it too.” (Interview 30, ID 28)

Many elders followed the Chinese proverb “70 to 80 percent full makes people healthy
and long lived”, considering it as a healing principle regarding the quantity of food
consumed. Further, they also supported eating smaller and more frequent meals.

In summary, elders demonstrated their beliefs in natural diets which were varied in the
types of food groups and were healthier than eating processed foods. It was widely
accepted that dietary materials which were in an unrefined state had the capacity for not
only maintaining health but preventing illness and following this rule meant the
supplements were not necessary. Adequate amounts of fluid were felt to be essential and
in order to manage the digestion of food in old age they also emphasised the moderate
consumption of foods therefore preventing overburdening the digestive system and
other parts of the body.

5.2.2.3. Diet as a cure

Elders paid special attention to their foods when they faced certain common health
problems. They modified their eating style and hoped to cure themselves by managing
their diet. One female elder pointed out that appropriate foods and eating habits
efficiently ameliorated the diseases associated with ageing and improved her health
status.

“For the things related food, I think about them a lot and I do self manage them…
Those fruit, I only eat one kind of pear and banana. Elders always have problems with
teeth, so I cannot eat some sour taste fruit such as orange. I am very concerned about
the constipation problem. Elders always have this kind of problems. I have four meals
every day, breakfast, lunch, supper and a midnight snack, to keep my intestinal tract
healthy.” (Interview 24, ID 3)

Eating “light” foods (not containing much salt or fat) was helpful in improving health
and this was particularly true of those elders who had some form of degenerative
disease. Salt was considered to be a major contributing factor to these diseases and a
dangerous ingredient in their diet.

“I have high blood pressure, diabetes. I also have the high cholesterol problem… I
know they are all chronic diseases but I also know they cannot be cured. Just like that…
I think I know some information about them. I think the most important thing is food. I
need to concern food a lot… Light food is good. Bland diet…Now if I cook at home
myself, I won’t use salt anymore. I always eat light foods. Even I make soup at home; I
do not use any salt. It will be OK if the food is light. Controlling diet will make it OK…”
(Interview 33, ID 29)

Elders believed that the ideal way of curing their degenerative diseases and keeping
healthy was not taking medicine but rather adjusting eating habits. This again indicated
that the concept of “into the mouth come diseases” ran deep in Chinese consciousness
and controlling certain foods was the best medicine. Furthermore, adjusting dietary
habits was not only a natural approach to curing without side effects but also a
fundamental solution which cured the root of the disease not just the symptoms.

Incorrect eating habits were perceived to lead to an unhealthy status and also cause
diseases. Bland diets would ensure people remained healthy and would directly protect
the digestive system and promote a cure for related ailments. One male participant tried
to identify the cause for his gastric ulcer, referring to irritating foods (those foods that
make the human body dry and hot) and unhealthy eating styles. Further, he hoped to
cure his illness by adjusting his diet. In this way, it was believed that the disease could
be controlled.

“My gastric ulcer problem, I think it is mainly about the diet…the stimulated(“Zao” –
irritating) foods are not good so I prefer the light diet than them… I tell you, in the past I
liked spicy food a lot…I also like it very much. But now I think about my diet a lot. I do
not eat any chilli. Just a little spicy will make my stomach painful. Spicy ones, icy ones,
I cannot eat. Now I have that disease, so the stomach is the most important thing. The
stomach is the most protection thing. Everything should adapt for it. If I do not concern
the food… it will make me very painful. I should suffer the bad result.” (Interview 34,
ID 30)

In this situation, appropriate diet was judged to be more beneficial than drug treatment
as it helped to achieve good health without any side effects. However, it is clear that the
problem has not been eradicated and he still shows the signs of an ulcer. It seems to be
controlled rather than cured by his dietary habits although he clearly believes his own
self management cures the problem. Many elders believed that they could adjust their
eating habits to a healthy style in order to fight against diseases and restore health
without seeking help from others.
5.2.3. Healthy approach to sleep and rest

Chinese traditions dictate that relaxation means freedom from activity and worry; particularly emphasising peace of the mind and soul (Lin 2001). Relaxation in the Chinese language takes many forms, including sleep as well as rest. Elders in this study believed that a balance between work and relaxation was one of the main ways that the human body stays healthy. They reported that both sleep and rest were considered as natural human activities for healing as well as a natural therapy for many diseases.

“Some diseases, such as cold or cough or headache, just... having a rest, the symptoms will be better.” (Interview 24, ID 3)

Elders considered sleep and rest as one of the most vital healing principles in their health care approach and believed that sufficient sleep and rest were necessary for their energy levels and the replenishment of the spirit for the relief of many symptoms. On the contrary, poor sleep or rest could be harmful for health, resulting in a breakdown of the human body, both physically and psychologically. Elders outlined their awareness of paying attention to these crucial issues during their daily life.

“I have a friend in Beijing, and we send e-mail to each other regularly. She is of the same age as me. We often talk about how an elder can keep healthy...tips about eating and sleeping.” (Interview 11, ID 3)

5.2.3.1. Sleep

Sleep was considered an indispensable component of a healthy life. The quality of sleep itself was an essential barometer of health. From elders’ perception, it was an important and consistent criterion to evaluate their well being and health status. Elders strongly believed that the ability to sleep well was associated with good health. Conversely, the inability to fall asleep, or superficial sleep, was considered a prophetic sign of some health problem:

“I feel that I am now very healthy. There is nothing wrong with my heart. Good heart, good body, also I can eat, and sleep, also I can walk around, so I am fine, very healthy...At present, now I can walk, can move, can eat, also can sleep; there is no problem to go anywhere, can do anything. Therefore all are good.” (Interview 13, ID 12)

“But if I am sick, it will be painful. During that time, I can’t fall asleep and I can’t eat either.” (Interview 20, ID 19)

Elders reported many issues related to sleep, such as when and how to sleep. They believed these factors had real effects on health and illness and might result in direct
positive or negative consequences. These subtleties are detailed in the following sections in order to reveal participants’ perceptions of sleep issues.

**Amount of sleep**
It was a generally acknowledged truth in Chinese traditions that approximately one third of the lifetime of human beings was spent asleep and nothing else could take the place of sleep. The correct and proper amount of sleep time was one essential component used to evaluate sleep. Following the “golden mean” that is moderation in all things as one of the best of rules in China, elders in this study believed that either insufficient or excessive sleep was not good for human health. Individuals varied, but everyone approved of eight hours as a universal truth, which was expressed in a proverb by these elderly Chinese participants – “too much is as bad as too little”. One female participant felt worried about her drowsiness and claimed it was not good for her health to sleep too much. This participant reported that she suffered from hypertension but did not associate feeling tired with her condition.

“I am not sure. I do not know. I just feel dizzy; the whole day… I feel like sleeping the whole day, but I know it is not good to sleep too much…” (Interview 31, ID 4)

Shortage of sleep was thought to lead to lower energy and a low spirit as well as a breakdown of the whole body eventually. However, elderly Chinese participants emphasised that too much sleep without proper physical exercise might also lead to weariness in the body and mind, and even to problems such as backache or dullness of the mind. This point is discussed later in the section on exercise.

**Manner of sleep**
Variations existed among individuals when talking about the manner of sleep, such as when, and how often, to sleep. Under a regimen of sleep, Chinese people believed that early to bed and early to rise was a general rule in their healing system. In this study participants did not give an accurate definition of the timing for sleep, but did indicate that they were concerned about the issue of timing for sleep in relation to a healthy lifestyle. The internal clock was another issue which was referred to by elders as it directed both sleep and waking activity. Erratic sleep patterns conflicted with the natural rule of the healing process:

“Nowadays, I am getting interested in surfing the internet and sit there for a long time without movement; further, (because of it,) my sleeping time is not scheduled. I think these things are not good for my healthy but you know, sometimes (things are like that)…” (Interview 24, ID 3)
It was clear that the healing process which emphasised a habitual and conventional lifestyle was considered to be an essential element in keeping healthy in elders’ minds.

**Quality of sleep**

Elders were also concerned about the quality of sleep. Participants were concerned with the process of getting to sleep as well as the depth of sleep to assess their quality of sleep. It was perceived as preferable to fall asleep in a short time soon after being in bed. The depth of sleep was another important indicator of quality. The deeper the sleep was, the better the quality of rest and correspondingly this afforded more benefits to health. Likewise, if people continually suffered from poor sleep, the eventual results were physical and mental health problems. Some elderly participants acknowledged that poor quality of sleep, such as insomnia, did not simply mean inability to drop off to sleep but was also related to some diseases, explaining that symptoms could be induced by poor sleep:

“I think the bad quality of sleep influences the blood pressure, maybe. Sometimes I cannot fall asleep after 12am, during the midnight, until 1am, 2am, I am still awake. I think this is not good for my blood pressure…I think the bad sleep influence my blood pressure and make it higher… it is not good.” (Interview 31, ID 4)

In this situation, elders believed that poor sleep was an indicator of actual or impending health problems. They saw it as influencing blood pressure rather than the other way around. In this way, they often refused or did not feel the need to seek help which has obvious consequences for their health.

5.2.3.2. Rest as a cure

Rest was the word usually used to emphasise a peaceful situation without real activity. It did not mean sleeping in bed but rather closure of the eyes in a meditative fashion. In this study, elders were used to having frequent rest during their normal activities, particularly when they had ongoing health problems. Interestingly, many Chinese elders believed that rest could bring back certain energies and spirit to them and consequentially their physical constitution was enhanced. In this way, as replenishment strengthened the ability to “self repair”, and they felt that they were able to ease symptoms such as pain and discomfort as well as successfully conquering the disease:

“It’s not necessary (to see doctor). It is just slight pain and after a rest it always becomes normal. Keep the whole person quiet and then the body recovers and is full of energy. I can manage myself.” (Interview 8, ID 8)
However, the data indicated that this group of elderly people experienced a variety of degenerative diseases besides locomotor problems. In most cases, they seemed likely to ignore the disease itself but focus on how to ease the symptoms. Again, in context, this was a potentially dangerous situation as the relief of the symptoms mask the deterioration in the disease or condition and the often insidious deterioration in their health. Though this could be potentially harmful, elders maintained their rest approach as an efficient cure for their symptoms; therefore from their perception, they can maintain their health. Some elders simply attributed their fatigue and even the disease to lack of proper rest:

“Sometimes I get out of breath when I am doing the exercises, for example, when I am walking in the park. Thus I always have a rest for a while, like having a seat on the bench...If I feel I cannot breathe, I will have a rest and then it will be OK. I know how to control it and I know my own body, it is all right...Then I thought that it was not necessary to go hospital. I thought that I could have a rest at home, had something to drink, and then become normal again.” (Interview 5, ID 5)

“I just thought that I might not rest well, and felt that it could turn well if I rest more.” (Interview 7, ID 7)

The implication in the latter quotes is that a lack of rest was the cause of the problem not the consequence of it. They did not have sufficient professional information or knowledge about their health status. However, on the other hand, based on their own experiences, they sought the root cause of the ailments, such as a lack of rest. In this way, they proposed that after a good rest, they would be healthy because “rest is important thing for health” (Interview 16, ID 15) at their age. This view was frequently expressed among elders with some cardiac conditions who were more likely to emphasise how they eased the symptoms and how they recovered after rest, therefore demonstrating they were healthy and there was no need to seek help:

“If in some situations I can’t breathe, I will take a rest and do some exercise (a slow meditation type exercise). In this way I feel much better. I just walk around in the room, and it will get better.” (Interview 2, ID 2)

It was clear from these quotations that elders did not want to dwell on their diseases and further, it may also indicate that they did not want to seek help for their problems. They see health as merely the absence or rather the control of symptoms. Elders who discussed rest as a factor in their healing approach usually mentioned issues related to exercise, indicating a relationship between rest and exercise. In the following section, Chinese elders’ perceptions of a healthy approach to exercise are discussed, as well as its interaction with other healing components, such as sleep and rest, when appropriate.
5.2.4. Exercise for promoting health

Exercise was reported as an important component in the Chinese healing approach. Exercise was considered as one of the major tools for promoting health and disease prevention among this elderly group of people. In the Chinese health care system, there is a widespread understanding of the importance of exercise and a central belief in Chinese culture that “life lies in movement”. In this study, the majority of elders discussed their perceptions of physical exercise as a way to maintain health and treat diseases. Elders proposed that daily exercise would avoid stiffness, for example and the process of exercise itself verified elders’ belief that if they can (and still) do exercise then they will maintain health. Many elders generally put a high premium on exercise as a healing approach, using the phrases “a lot” or “mainly” to describe the degree of concern about exercise and highlight the importance of it:

“In sum, my health mainly depends on my exercises. I think about exercise a lot… Because when people get to this age, older and older, the natural resistance of the body is weaker and weaker. It is because the physical quality is not as good as it in the youth. Now I keep doing exercise is for enhance my physical quality” (Interview 35, ID 31)

Taking into account their personal and specific health situation as well as their external surroundings, such as the natural environment, elders in this study reported specific features related to exercise. In this section, participants’ perceptions of the healing effects of exercise were elaborated from different angles, following elders’ awareness of the functions, types and intensity of exercises as well as the time and place for exercise.

5.2.4.1. Functions of exercise

Key functions of exercise reported by elders included benefits for both physical and psychological health. These functions are presented in three short sections: health as an index, anti-aging and invigoration, as well as promoting recovery.

5.2.4.1.1. Health as an index

Many elders reported that the ability to undertake physical exercise itself was an important measure of their health status. For elders who exercised regularly it was not only to promote health, but to verify how healthy they were. Elders’ views about vulnerable groups made them believe that being agile through movement meant being
healthy; ease of movement was a characteristic of youth and was a strong indicator of being healthy.

“Everything is fine. I can... doing exercises, though it was not as many as in the past when I was young, I still can do some and some other work – no problem. Now I do exercises well...” (Interview 32, ID 5)

5.2.4.1.2. Anti-aging and invigoration

Elders acknowledged that aging was an inevitable process. However, they still wanted to slow down this process and show their capability to handle it.

“I often do exercise so I am in good condition. The other elders can't crouch down because they are too rigid. However, I can do that since I do exercise all day such as jumping with one leg, jogging or swing my arms in sequence.” (Interview 2, ID 2)

It was clear that elders were willing to modify or change their lifestyle to the fullest extent possible to ensure they were more active. In this way, they hoped to reverse the aging process to some extent. If exercise indicated wellness, they could compare their own health situation to their sedentary or less active peers. Again, this is a crude measure of health which also plays a part in the lack of help seeking.

Physical exercise was also reported to have a direct effect on mental health. Elders reported that exercise enhanced their mood and spirit. It provided a fresh feeling to their body and mind, gaining a clearer, more active and healthier consciousness. As one male elder summarised:

“It makes me very happy and my mood is very nice. That's good, good for my health. After exercise, I feel my body is in a good condition. I feel comfortable...Self management and self promotion, such as I am now doing exercise and think about this a lot... every day I do exercise and after it I feel very comfortable.” (Interview 35, ID 31)

5.2.4.1.3. Promoting recovery

From elders’ perceptions, regular exercise and some particular activities could not only prevent many forms of degenerative diseases but may also relieve some symptoms or health related problems. The elders felt that exercise was important in promoting recovery from a wide range of problems such as heart disease, asthma, joint and bone problems, as well as some minor problems, such as colds and general illness. Some elders avoided a sedentary lifestyle even when experiencing health problems. They believed that physical exercise made their body more active therefore speeded up their recovery process.
“Even during that period of time (when I was sick), I still insisted on doing exercise. My son asked me to have good rest at that time, but I still continue my exercise. I am very lively.” (Interview 25, ID 23)

Here again, it is clear to see how their self management could potentially be dangerous to their health. However, the perceptions of many of the participants were that physical exercise helped participants maintain agility. In this way, when suffering bone or joints problems, elders did regular or particular activities to strengthen the bones, joints and muscles to gain recovery. One female elder who experienced ailments around her shoulder (she said she did not know the exact problem but thought it maybe arthritis or frozen shoulder) trusted that exercise would have a positive impact on symptoms and aid recovery.

“Take the time of peri-shoulder-joint inflammation as an example, after the checks, the doctor also taught me some knowledge, such as how to recover better with proper exercise.” (Interview 3, ID 3)

An important feature of the latter quote is that although the doctor gave specific advice about exercise in this situation, this woman took the information to mean exercise was useful in the recovery from all problems. Later, during the second interview with the previous participant, she again emphasised the importance of exercise as a useful therapy:

“I have been in (big hospitals) twice, one for a lasting cough and the other, for a common illness among elders, peri-arthritis of shoulder. I feel that the big hospitals here are not bad. Hospital even helped me do recovery exercise for my shoulder, for around two months. That’s good. I think it’s good this way.” (Interview 11, ID 3)

Some other elders also reported their conviction that exercise was an effective approach for their musculoskeletal problems.

“When I came here, I had frozen shoulder…I went home to do exercise. I insist on doing exercise and it is much better now.” (Interview 28, ID 26)

“Sometimes I was unsteady on my feet and when I wanted to stand up and then I felt a bit wonky. Now I think about doing exercise a lot. Maybe exercise helps me to handle this problem. Making it better… Now it only depends on doing exercise.” (Interview 33, ID 29)

From these quotations, it was clear that elders believed that physical exercise could prevent bones and joints from deteriorating and could also stimulate internal organs and bring benefits to the whole body, lowering blood pressure and improving blood circulation. They believed that exercises strengthened the heart muscle, protecting it and making it more powerful and that it also helped with breathlessness.
“I do some exercises. Clap my hands and clap my foot… In this way, the blood circulation will go much more smoothly.” (Interview 14, ID 13)

However, although exercise was reported as improving elders’ ailments, it sometimes played a very risky role and hindered elders’ help seeking behaviour. Relying on their own interpretations of health and related problems, for example cardiac illness, it could arguably be dangerous if they self managed their problems based on the belief that exercise could cure it. One female elder reported she had certain heart related symptoms; however, she said:

“There is nothing wrong with my heart, so I didn’t take it (pill). All because that I did exercise, and my body got better gradually. I do every kind of exercise. I do a lot of exercise.” (Interview 13, ID 12)

In this situation, the general belief that a lot of exercise is beneficial may bring potential dangers and act as a barrier hindering the help seeking process.

Additionally, exercise was also considered as an efficient strategy which could boost the immune system and increase the metabolic rate. Thus, it was perceived as increasing blood and oxygen circulation to the whole body and helped recovery from some minor diseases, such as the common cold:

“It’s just a small problem (cold), and will recover after some exercise. Now there is nothing wrong.” (Interview 32, ID 5)

“When I was in Hong Kong, I had known one famous Qigong expert practitioner…He also told me more exercises motivated the metabolism and made me healthy.” (Interview 35, ID 31)

Generally, most elders only emphasised the advantages of exercise. They did not report any potential dangers or problems with engaging in a self managed exercise programme. They did not report any potential risks and this may impact on help seeking behaviours.

5.2.4.2. Intensity and types of exercise

Elders described comprehensively their ideas about exercise and referred to the intensity as well as the types of exercise and sometimes even the importance of the rhythmic flow of doing exercise and activity. The reasons why elders in this study chose the certain physical activities are presented in the following sections.
Intensity

All exercises shared some universal characteristics and brought some common benefits for the body. The majority of the elderly participants referred to traditional Chinese healing exercises most of the time when talking about exercise. Elders expressed or described this traditional Chinese healing exercise as softness, fitness, mildness and slow in tempo, in contrast with the intensive or competitive sports undertaken by younger people. Exercise was characterised as having a slow and harmonious rhythm thus it was more suitable for the elders’ physique and time of life as the participants considered themselves as a physically weak group. Many elders were not able to undertake intensive sports and they preferred doing traditional Chinese fitness exercises with the purpose of improving health and healing.

“It lasts for half an hour every time, swing hands, standing on one leg sequentially. But the exercise shouldn’t be too fierce…” (Interview 2, ID 2)

“I think I cannot do intensive exercise. In the past, I like sport. I played football frequently. There was none of these problems in the past. But suddenly I felt I have many problems. Age, old age… it is like this because of the old age and everything is not good…Ideal healthy… that is the situation when I was a teenager, in my youth. Now I am not strong. The older age and weaker health…I feel I am weaker than before. Years make me older and older. Health should be kept when you are a child. It should be kept in a good condition, a good level. If you get old, you only can do some minor exercise to keep your healthy. But you can’t do it intensively.” (Interview 19, ID 18)

It was clear that appropriate and moderate exercise was perceived as good for health promotion, whilst too much exertion was something most elders carefully avoided. This was again the golden rule of moderation. Only one elder reported that he actively engaged in very intensive exercise in his daily life; this kind of exercise, from his perspective, functioned as a criteria or particular way to evaluate his own health status, particular for his heart condition. This elderly participant’s behaviour might also be explained as a health index or anti-aging which was mentioned before in the section on the function of exercise. Though this participant may be considered a deviant case, his relatively younger age might account for his particular views as he had just turned sixty at the time of the interview.

“I do some intense exercises on purpose. After that I will feel the function of my heart to check whether I can bear it or not. If after doing the exercise, I feel there is no uncomfortable feeling then I think my heart function is good. If there is uncomfortable feeling after only slight exercises, such as some walking and feel tired, then there must be some problems with heart. This is very useful for checking the body function…My friend told me that. I think that my heart is very good as there is nothing after I do that intense exercise. So sometimes I play table tennis or boxing, I will do it intensely to check whether there is problem with my heart or not, to check its function.” (Interview 18, ID 17)
Though this male participant claimed insistently that he did not have any heart problems, his comments indicated that he did worry about the health of his heart. According to the perceptions he had about health, this male elder carried out a crude assessment to establish if his heart was functioning properly. This way of self management did not only hinder help seeking behaviour, but could also arguably be detrimental to his health.

Another interesting point noticed here was that, whilst describing and discussing levels of intensity of elders’ exercise, some elderly participants expressed concern about the gradual process of exercise in a proper sequence. In other words, going slowly and getting prepared before relatively intensive activity as well as taking time to cool down or tapering off after the exercise were considered as the ideal way to do exercise. Light walking was considered as moderate exercise and was the preferred exercise for the elders in this study:

“I jog every day, and take a walk after jogging. Body gets well naturally after exercise. This is the most important.” (Interview 32, ID 5)

It was clear that this quotation that elders followed the golden rule of moderation. From elders’ perceptions, a short period of warming-up time or cool down time helped the human body to gradually adapt to the situation, a kind of mental and physical preparation for both the beginning and end of activities.

**Types of exercise**

Chinese elders in this study talked about many kinds of exercises, such as Tai-chi, walking, jogging, stretch and setting-up exercises, dancing, Ping-Pong, boxing. Among them, Tai Chi, walking, as well as stretch and Chinese setting-up exercises (a free-hand exercise which was a popular national fitness exercise among the public in China) were mostly discussed as the best optional activities which were utilised by the majority of elders in their daily life for healing and natural health.

Primarily, walking was discussed among elders as it was considered as one of the simplest forms of exercise and could be conducted anywhere. It was known as an efficient way to reduce some risk factors for degenerative diseases, such as hypertension and high cholesterol levels. Furthermore, it was perceived as immediately effective in increasing joint mobility and relieving arthritis. In addition, it refreshed elders’ minds and eased depression. One elderly female who experienced cardiovascular problems as
well as musculoskeletal ailments demonstrated the significant effect of walking for being healthy:

“… Elders should have some exercise every day. The easiest exercise is 30 minutes’ walking every day.” (Interview 11, ID 3)

Another major type of traditional Chinese exercise mentioned by elderly participants was Tai Chi. Tai Chi is a traditional form of natural exercise and requires a slow rhythm in perfect harmony with the mind and body. It involves coordinating the breath tempo with the bodily movements; through this gentle exercise, the energy is regenerated and depression is relieved. However, Tai Chi has various exercise styles and is difficult to teach and much more difficult to learn. The data suggested that elders who joined Chinese communities preferred this exercise as there were Tai Chi teachers to guide them. Although Tai Chi was challenging to learn, these elders trusted in Tai Chi exercise, considering it as an effective healing approach and did it following the teachers’ guidance on a daily basis:

“I come to take part in Tai Chi every week and I have done (learned) this for nearly two months. Tai Chi is very good, good for my health.” (Interview 19, ID 18)

Another traditional activity, Chinese setting-up exercise, is popular among Chinese people, as it is a hand-free exercise using no mechanical equipment. There are many components associated with it, with different physical movements for arms and legs as well as the trunk, such as twisting, jumping and stretching. While discussing or explaining their daily exercise, many elders in this study expressed their views about Chinese setting-up exercise. Though there was no consensus on the accurate manner to carry out these exercises or the specific names for the components, a number of common characterising constructs influenced by Chinese setting-up exercises were identified. It indicated elders’ main concern of the function of exercise for their healing: enhancing elasticity and mobility.

“The setting-up exercises is very helpful. It is very good for my health. I insist on doing that exercise.” (Interview 28, ID 26)

“Another thing is exercise. I do exercise every morning after I get up. Just some stretching exercises… I invented these actions myself…” (Interview 30, ID 28)

Elders also reported other activities such as cycling, dancing, swimming, and badminton although these were much less frequent. However, as mentioned previously the golden rule of moderation was adopted by the elders when conducting these physical movements in order to promote their health. The perceptions of many elders who
expressed their preferences for exercise in a variety of forms were illustrated by the following selected quotations:

“Do some exercises, such as boxing, dancing, table tennis, etc.” (Interview 18, ID 17)

“I concern exercise a lot, such as Tai-chi, Ping-Pong, and dance. I like dancing very much.” (Interview 35, ID 31)

In addition, some female elders also regarded housework as a form of physical exercise, emphasising that it was the physical activity itself rather than the form of exercise that was important. The following representative quotations illustrated female elders’ paying attention to physical activity rather than the specific type of exercise.

“I keep doing exercises at home. I will do housework… I do some exercises and moves at home every day. I clean house every day, wipe windows, brush houses…” (Interview 9, ID 9)

“Usually I am staying at home. You see, this house is so big, and I do exercise at home, or do walking around this house. I also do the housework every day.” (Interview 31, ID 4)

Exercise played a prominent role among elders’ views on the healing process and it echoed the popular Chinese proverb mentioned at the beginning – life lies in movements.

5.2.4.3. Time (timing and frequency) and place for exercise

The time and place for exercise were two further important considerations when conducting physical activities. These beliefs might to some extent be influenced by traditional Chinese exercise physiology. Elders believed that by following these principles they would gain health. The following sections detail these components from Chinese elders’ perceptions in this study.

**Time**

The timing and frequency of carrying out physical activities were considered essential elements when referring to exercise as a healing approach. From the perceptions of participants, exercise should be carried out on daily basis and the ideal timing for it was during the early morning after getting up but before breakfast. In this way, a better and greater healing effect was gained by adopting this optimal way of conducting exercise. The perceptions of many Chinese elders who emphasised the importance of timing and daily activities were illustrated by the subsequent selected quotations:
“I wake up at 6 every morning and then I do exercise…I think it last one hour every morning.” (Interview 20, ID 19)

“I insist on doing exercise every morning after I get up. This is the main thing to keep me healthy… The health issue is the most important thing now. I get up at 6am every day. Then I go outside to do exercise for one hour. After that I have my breakfast. I go out have a walk again after my breakfast. Every day I insist on doing exercise like this. The regular life style is very good for health.” (Interview 25, ID 23)

Elders who did not follow such strict rules believed that a lack of exercise was not good for health promotion and they were aware that they were not gaining the integral benefits of certain exercises:

“I am still not satisfied with my own self-management work. I think I have not done it very well because I am to some extent lazy. I sometimes do the setting-up exercises but do not make sure to do it every day. I do not make sure that I walk every day…I think these things are not good for my health but you know, sometimes, I am lazy to do exercises strictly.” (Interview 24, ID 3)

With reference to the timing of exercise, traditional Chinese healing rules also warned against doing exercise immediately after a meal as the digestion process might be affected. However, light movement was suggested as an aid to help digestion after a meal. As one male elder summarised:

“Body health relies on exercise. There is an old speak in China, which is -Take a walk after meals, and live up to 99 years old.” (Interview 32, ID 5)

**Place for exercise**

When elders commented on the place for exercise they did not refer to a gym or sports hall. In this study, Chinese elders always mentioned two categories of places for exercise: indoor and outdoor, depending on whether it was in their own home or not.

The ancient Chinese recommended exercising in a natural environment. Breathing fresh air whilst doing physical exercise could maximise the effects of exercise in promoting health and healing. Whilst describing and discussing exercise environments, many elders reported that they enjoyed the beauty of nature and the fresh air when exercising outdoors. Although there were also other forms of exercise undertaken indoors, elders emphasised the benefits when conducting exercise outdoors as they were integrated into the harmony of nature. Some Chinese elders summarised the general experience when doing activities outdoors:

“The air is good! … We walk and ride. We have good air quality here.” (Interview 4, ID 4)
“In the UK, even when the weather is very cold during winter, I still do exercise outside. I will wear warm clothes and insist on walking in the snow for one hour.” (Interview 25, ID 23)

Although elders emphasised the benefits of outdoor exercise, there were some practical difficulties for them in carrying out movements at will. In this way, elders in this study also discussed indoor exercises for health promotion.

“I sometimes… walk around or dance when I am at home. It is quite convenient.” (Interview 10, ID 10)

“But they are not the formal ones, just some movements. I do exercise at home to stretch my arms and legs… whenever I want.” (Interview 21, ID 20)

When conducting exercise indoors, elders thought that it was easy to get into a regular routine based on their individual lifestyle and did not need to rely on external factors, such as the time of day or the weather outside.

Besides the healing rules of such physical activities, elders also mentioned the mental discipline which is discussed in the following section.

5.2.5. Impact of the mind on physical health

Exploring Chinese elders’ perceptions of a natural health system and healing approach was key to understanding their health related behaviours. A prominent factor was the holism of human mental and physical issues. From a traditional Chinese natural healing system, people believed that a holistic view of the whole person, including consideration of both the mind and body, made it possible to govern health status, therefore to a large extent promoting health. Elders believed that when they experienced ailments, they may not relate purely to physical problems; mental issues were also considered to be causative factors. Only by linking together the mind and body could they hope to gain a full understanding of their health problems and then improve them.

A traditional Chinese healing system emphasised the close interconnection, interdependence and interaction between the mind and body. These two elements interacted through a cause and effect relationship for healing to take place. A healthy mind was necessary for the proper functioning of the body; a good physical condition was essential for a healthy mind. On the other hand, a mental disorder might lead to physical discomfort and a physical disease could result in mental health problems.
Awareness of health among elders was deeply influenced by the concept of holism and integration of the mind and body. Elders perceived that to achieve the goal of health they needed to keep their mind in good health. Elders avoided being influenced by anything which might bring them negative emotions. A positive approach to mental health was perceived as beneficial and preventative against health problems and physical illness. When elders experienced illness, they emphasised that keeping a positive mental state was the key component to rid them of illness and elders confirmed that it was a prerequisite to recovery and regaining their health.

5.2.5.1. Mental state shapes health

Chinese elders did not appear to have a clear definition of mental health. Elders identified those sensations which were non-physical or intangible or immeasurable as mental health related issues. Elders believed that the feelings inside their mind or head, although influenced by external factors could only be regulated by themselves. While describing and discussing the essence of the healing approach, many elders expressed concern about the importance of psychological issues:

“The most important thing for a man is being happy anyways. Don’t think too much, be in good mood, and body will be healthy itself. Hence I feel that I am fine, very healthy. So I really take things easy.” (Interview 15, ID 14)

“Now I am old, and the most important thing is the mood. If I am happy, then everything is OK and my health is fine.” (Interview 31, ID 4)

It was clear from these quotations that elders highlighted the significance of emotional factors beyond the physical aspects as the leading component which affected their health status. In their view, mental health was thought to be essential for all of their life matters, including their physical health.

5.2.5.2. Keeping a peaceful mentality

Elders expressed the importance of keeping a peaceful mentality. Being in harmony with the rest of the world was the ideal psychological state elders wanted to achieve in their daily life. They described some effective methods of keeping this optimum state of mental health which often meant appearing aloof or distancing themselves from the world. This also included being content and not seeking perfection in every aspect of
life; as well as avoiding listening to unhappy news or learning to forget negative news. One elder described how she managed to control her mental health and well-being:

“I am happy enough as they are living well, and isn’t worrying. I am in good mood, so I am getting healthier as well.” (Interview 8, ID 8)

In addition, “grasping the present” was another important effective pathway for these elders to adjust their psychological states. Their self identity as older people played a key role in this area, believing that grasping the present was much more productive in maintaining their mental wellbeing than looking forward to the uncontrollable future.

“I do not worry about it after the surgery. There is nothing to worry about. About the future, I don’t know and I don’t want to think about those things... Yea, just don’t think about those. I am already this old, and there is no use to worry. It will make me anxious and unhappy. So I don’t care.” (Interview 7, ID 7)

From this typical excerpt, it was clear that from elders’ perceptions, they now experienced the relatively later stages of their life; the present was the most tangible part which could be monitored to achieve their goal of well-being. Elders explained this specifically in relation to emotional fluctuations of over thinking about the future which is discussed in the following section.

5.2.5.3. Avoiding emotional fluctuations

Elders believed that unsettled emotion had a negative impact on health as these emotions were usually the roots of physical diseases. Emotions were perceived as directly connected with health. Emotional activities, such as worry, fear, over stimulation, anger and even excessive joy were the most commonly discussed emotions that were mentioned by the elders, defining them as the accelerators to make people more vulnerable to the development of illnesses or defenceless against health problems.

“Nothing, nothing to worry about, avoiding thinking too much, it is not right, not good to laugh or cry (when facing anything)... there is nothing for me to worry about... I should be optimistic with my life.” (Interview 16, ID 15)

Specifically, negative emotional activities, including over thinking, worry, anger, and fear, were avoided by elders. They categorised these emotions as the internal causes of emotional fluctuations, therefore leading to health problems. On the contrary, keeping a healthy mental state was the foundation of physical well-being. One elderly participant summarised how the health situation was influenced by the emotional factors, weighing the pros and cons:

“I began to know that mood affects health a lot, and is really a big problem. I was in my 60s at that time, and got new idea in my health problem. I felt that I have to avoid being
angry or listening to bad things. If anyone is saying something bad (to me), I shall just walk away and not hear it. I shall not watch unhappy things or listen to bad things. In this way I get healthier… Now I am very good, have no problem. I do not want to think too many bad things and get worried. It is not good for my health, I do not want to know; it does not matter with me.” (Interview 8, ID 8)

“Over thinking” was one of the most talked about emotional activities by the elderly participants and they believed it is the root which brought them other negative emotions, such as worry, sorrow or fear. Their self identity as older people made them deliberately avoid thinking about their mortality:

“Now I worry about nothing, and think about nothing. No thinking about that thing (death)... The more you worry, the more illness you have.” (Interview 15, ID 14)

It was clear that most elders emphasised that the mind influenced health status; however, elders did not clarify the fundamental evidence for making the link between mental health issues and physical diseases. Only one elder discussed the traditional healing theory related to emotional activities as following:

“When I was in Hong Kong, I had known one famous Qigong expert practitioner. He told me that “do not think, do not think your body is unhealthy, and do not think you have any problem. Just keep happy. In this way, your Regular Channels in your body are smooth”… He told me that I should avoid thinking the bad things, not thinking about the diseases everywhere. It was very bad for health.” (Interview 35, ID 31)

It is relevant at this point to mention a field note made in relation to this discussion, showing the interdependence and interaction between mind and body in elders’ minds:

“Qi – internal energy, circulated in the internal body. From ancient china, people believe emotions have a negative impact on health because it drains Qi energy from the human body.” (Field note – interview 35)

Moreover, emotional fluctuations were linked to, and thought to be responsible for, many degenerative diseases. Elders tried to keep a peaceful mentality, free from stress or emotion. In this way, although there were obvious potential dangers arising from their diseases, elders proposed that they had controlled the disease-causing issues and thereby achieved the goal of being healthy.

“I will avoid knowing or hearing something stimulating on purpose, in order not to excite my heart. Because of all this my body gets better naturally.” (Interview 2, ID 2)

“When I was not happy, my blood pressure went higher and made me very uncomfortable…” (Interview 28, ID 26)

The following is an example where one elder directly refused to discuss his heart related problems and presumed that if the conversation continued, it would cause insomnia or nightmares, or even a heart attack:
“I don’t want to say anything about this. I don’t like this topic (problems related to heart). The reason is, you know, I am quite old, of very old age. I don’t want to think too much about these problems. I know the heart is important, but I have to avoid these problems which will make me anxious. I don’t want to think about it since I can’t sleep well when I think too much. This is in fact bad for my health. I am so old now and just want to live for as long as I can. Even I won’t know when I will be like that (dead). I am already this old, so I don’t want to talk about this. I am fine as what I am now.” (Interview 6, ID 6)

A field note made in relation to this strong emotional reaction from the discussion with this participant indicated how sensitive people needed to be when talking about these issues; furthermore, it showed that emotional activities were perceived as causing physical diseases:

“This is a very important point – like the elder in interview 3 – they seem to want to avoid talking about heart related problems even when they have them diagnosed.” (Field note – interview 6)

5.2.6. Environmental concern

Environmental problems were highlighted as part of every person’s life. In this study, elders reported their concerns about environmental issues which had a great impact on their health.

The study participants had experienced two main environments, the UK and their hometown in China. Whilst describing and discussing the influence of environments, in most cases, elders compared living in the UK and China, reporting their satisfaction of environmental factors in the UK compared to China. Polluted water, poor quality food and noise pollution, which elders had experienced in the past, were all mentioned when talking about environmental concerns. Contaminated air, which was seen as degrading the quality of life and causing many health problems was emphasised by these elders.

“Here the climate is good and the environment is nice. Just a little humid... The air quality is good too. Less pollution... this is much better than China.” (Interview 34, ID 30)

Elders were aware of environmental hygiene as an essential factor in their overall health; the cleaner the environment, the healthier and longer life would be. Air pollution alone was reported as a serious environmental concern. Whilst discussing environmental issues, to a large extent, elders equated it to the concept of air quality. Elders emphasised the direct relationship between air and their internal organs, including their
lung and heart. Although the lungs had ways to get rid of the impurities, excessive intake of polluted air still threatened their health conditions.

“Air quality is good, which is good for health. Yes, air quality is very important for your health, good air quality and smaller population. These are very good for health, and make you resist many diseases. This place is much better than Hong Kong. Hong Kong was better in the past. Nowadays, when I go back to Hong Kong, I see cars, people and skyscrapers everywhere. Air quality is quite bad, not good for health, so is not suitable for elders. Therefore I always stay very short time in Hong Kong – about 2 to 3 weeks. I go back to the UK after visiting some relatives and friends each time.” (Interview 8, ID 8)

Elders believed that a cleaner air supply benefited their blood circulation as well as their internal energy (Qi) circulation. Furthermore, fresh air was a motivator for the recovery from many kinds of diseases. The elders argued that plenty of clean air was a key factor in hindering the spread of viruses or germs which caused most sicknesses. They attributed this environmental problem to the number of people in a certain area. The following selected quotations detailed elders’ main concerns about environmental issues related to air quality which was believed to be the cause or the cure of health problems, comparing their own health situations between China and the UK:

“Good. It is very nice living here... It’s good to stay here, especially for us older people. There are fewer people, and better air quality. I never caught a cold here... Yes it makes me be far off catching cold, of course. The good environment makes good health... We have good air quality here, and it’s good for our older people’s health. You see my husband? He was diagnosed heart disease and cerebral thrombosis, and doctors said he cannot be cured – they sentenced him to death. However, look at him, when he came here, he became healthy. So we like here, and don’t want to move. We don’t want to go back to China (to live)... I haven’t really caught a cold after moving here – only recently I had a little bit of a cold. But it’s not serious. The air is good! In addition we always do exercise, so there is no serious illness... We have good air quality here, and there aren’t many people around. Avoiding contact with crowd will prevent us from infectious diseases. In this way we are healthy.” (Interview 4, ID 4)

“I think it is very nice for us living here in the UK... There are a lot of people in China, you know, there is too many people... Population of 1.3 billion is really the biggest problem in China. In contrast, here in the UK... the quality of air is very good. Thus, it is good for people’s health.” (Interview 5, ID 5)

The above quotations were from elders who had been in the UK less than ten years. Although elderly Chinese immigrants mentioned these environmental factors which had an impact on their health conditions, the diverse living surroundings of their hometowns constituted a sharp contrast to the UK’s environment for the relatively fresh immigrants and made them more aware of the interrelationship between their health and the environment.
5.2.7. Beliefs about illness and help seeking

The traditional Chinese health system defined health and illness issues based mainly on the notion of balance and harmony. In the Chinese language, disease is a phrase combined by two single words – “Ji” (疾) and “Bing” (病). In ancient Chinese characters, “Ji” describes the symptom of pain in any part of the human body and “Bing” means being in bed and having physical mobility limitations. These two words in English both mean ailment or illness. However, in English, ‘disease’ is an abnormal condition of an organism that impairs bodily functions, associated with specific symptoms. In a broader sense, these symptoms included both mental and physical problems, such as pain, dysfunction, distress and disorder. This western awareness is to some extent different with the representation of illness from the elders in this study. Analysis of interview data revealed that elders’ representations of illness were influenced by both TCM and WM but mostly the former. Although the consciousness of illness was an individual matter, clarifying the representations of illness from elders’ perceptions as well as their general illness concern made it possible to understand the interrelationship with their help seeking process in the context of the Chinese community in the North West of England.

5.2.7.1. Traditional representation of illness mixed with Western Medicine and help seeking

All elders used their own judgement as the criterion to identify differing levels of symptom severity and what to do in response to differing levels of severity:

“I just think that my feeling is very important. If I feel that I am tired, not fresh, I know there may be something wrong with my body and may see doctor. If I feel pain on my body, I will see doctor. By and large, (the index is) just my own feeling.” (Interview 6, ID 6)

Based on the symptoms, elders divided health problems into two main categories; minor or normal illness and acute or serious disease. In terms of acute or serious disease, elders defined it in the strict sense, as a true illness which needed urgent assistance. Again, they made judgements based on subjective feelings which usually included differing levels of discomfort or serious pain.

“Normally the pain won’t be too piercing, and I will just bear it. If it is too painful, I already have got some medicine prescribed by the doctor… I only see doctor when I feel uncomfortable.” (Interview 2, ID 2)
It was noteworthy that participants would not seek help unless they were experiencing severe pain. However, by this time their condition may already have progressed to a serious level. It could be argued that elders experienced potential dangers to their health without perceiving the need for help seeking behaviour. The following was a typical example showing that elders’ views changed from regarding a condition as “minor or normal illness” to “acute or serious disease” depending on the severity of pain experienced:

“It was not very painful in the beginning, and I didn’t know why. Therefore I didn’t take it seriously. After a period of time, especially in the night, it became severe. I couldn’t bear it anymore so I went to doctors... Then there was severe pain, and it happened every midnight. Therefore I thought I should go to doctors immediately.” (Interview 7, ID 7)

Elders, perhaps not surprisingly, reported self diagnosing and self management for the “minor or normal illness”:

“It’s not necessary (to see doctor). It is just slight pain and after a rest it always becomes normal. I can manage myself.” (Interview 8, ID 8)

“Cold or snot, these kinds of problems I won’t see doctor. It is no need to (see doctor)...” (Interview 20, ID 19)

Although the majority of minor health problems could be self managed from their perspective, some of these problems lasted a long time and recovery seemed unpredictable. In this case the duration of disease was another important criterion for judging the severity of ailments by elders; it was also reported as another motivator for their help seeking behaviour.

“Now if I have minor cold, or minor cough, I will buy some Traditional Chinese medicine patent prescription (TCMPP) myself... When the situation is very severe – sometimes if I cough very badly, I mean for too long, I feel I cannot bear it. Then I will go to see my GP.” (Interview 27, ID 25)

Lack of clarity surrounding the definition and description of the criterion of duration of disease became apparent; this vague concept was again judged and based on subjective feelings by elders. Very few elders spontaneously acknowledged uncertainty about the duration of a disease which required help seeking from a professional. One typical example was selected:

“For example, if I have a fever of higher than 38 °C near 39 °C, I will be anxious; considering (the time problem), if the fever lasts for one or two days it’s not too bad, if it lasts for more than three days and still continues, I will be very anxious. I know if you have a fever for more than three days, that will hurt your body and I will feel worried. Am I right?” (Interview 3, ID 3)
It was clear from the data presented in this section that elders used the degree of severity and the duration of the symptom as the criteria to judge whether the health problem was the “acute or serious disease” and whether they needed to seek help. However, these criteria were all based on elders’ subjective feelings. This inappropriate help seeking behaviour brought many potential dangers to these elders.

5.2.7.2. General illness concern

As the target population in this study were elders, their understanding as a group of people vulnerable to illness made them calmly accept their weak health status. Therefore, from their perceptions, the normal diseases, such as cold, cough, headache, insomnia, and fatigue, were considered as common experiences. When they talked about health problems, they referred to ailments which threatened and impacted on their daily life, such as pain or limited mobility as well as continual and serious symptoms.

In this section, two main types of illnesses that elders expressed concern about are discussed in detail.

5.2.7.2.1. Chronic diseases (Heart disease, Hypertension, Diabetes)

Diseases of the cardiovascular system were mentioned and discussed by many elders in this study. Elders had a vague knowledge of the functions of the heart as well as the blood vessels. They explained that the heart played an important role in the human body and it was the organ pumping fresh blood as well as oxygen to the various parts of the whole body; in the absence of blood, tissues died thereby causing life-threatening problems. Elders also reported that there were some internal relationships associated with problems in parts of the heart and blood vessels. However, there was lack of accurate or detailed understanding of how these factors interacted with each other. Moreover, they did not have accurate information about signs or causes of the diseases even if the elders were experiencing them at the time of the interview.

In terms of heart problems, the elders did not have explicit knowledge about the different types of heart related disease. Some had second hand or incomplete knowledge about certain specific heart diseases, such as Coronary Heart Disease (CHD), because of the experiences of themselves or their friends.
“Of course I know (heart diseases), I read books. I have heard of CHD, it’s just myocardial infarction (MI), I know it. I think it’s impossible for me to have MI, since both my blood pressure and cholesterol level are not high.” (Interview 2, ID 2)

Informative field notes were made in relation to the issue of elders’ illness concerns about heart related problems, such as MI, and a memo was made to ask participants about their views.

“Again, there is another participant mentioned MI and directly considered it as heart disease. Though participants talked about it, it does not mean they know the meaning of this term. In China, most people know the professional term MI. A lot of publicity via media, such as the advertisements of medicines on TV or newspapers, may explain why elders have this misunderstanding. People know MI as very serious heart-attack symptom, but they have no knowledge about the detailed information about it, for example, the cause, the result or the prevention.” (Field note – interview 18)

“Explore – where does this knowledge come from?” (Memo – interview 18)

According to the perceptions of elders, symptoms of the cardiovascular system, which meant problems related to the heart and blood vessels, such as hypertension, high cholesterol level and diabetes, were all defined as chronic degenerative diseases. These health problems were common among the group of elders and certainly discussed frequently during the interviews. In most cases, elders’ self identity as being at an elderly stage of life made them accept the worsening body conditions resulting from these chronic diseases. On the one hand, elders helplessly or apathetically faced these problems on account of their age. This powerlessness aggravated the indifference towards the diseases among elders:

“I have a lot of problems: high blood pressure, diabetes, high cholesterol level. I also have blood vessel problem. My blood flow is not good, and my blood vessels are blocked... Maybe (the doctor told me some information about them). I cannot remember very clearly... It doesn’t matter. I have already had these problems.” (Interview 6, ID 6)

On the other hand, in some elders’ minds, what disappointed them was the lack of a radical cure for the chronic diseases.

“I have history of illness – I had Coronary artery bypass surgery before ... I won’t be always fine even after this surgery. It turns bad slowly. The longer after the surgery, the worse the effect is. I don’t know when it will recur. Anyway, it will definitely recur. *How long it will recur, nobody knows. Now, sometimes I still feel uncomfortable, not as serious as before. But time goes, and it will be much worse. (Answered in English)* This is for sure, and the situation will get worse and worse.” (Interview 7, ID 7)

“The (blood pressure controlling) medicine should be taken every day. The medicine is able to control my symptoms, but the high blood pressure illness cannot be cured.” (Interview 17, ID 16)
From the above quotations, it was clear that many elders experienced frustration from not achieving their ideal goal of being totally healthy or of being cured of the root cause of their illness. In addition, a lack of accurate position of chronic symptoms led elders to show helplessness as well as some extent indifference to chronic disease. As one female elder said:

“(So under what kind of situation you went to GP?) I have cholesterol... I woke up and felt headache. I went to doctor, they said that I had high blood pressure and gave me some medicine to lower blood pressure; and then they diagnosed that I have high cholesterol level. I am taking aspirin all the time...Early last year, should be... Last year, for a period of time, I felt severe headache when I woke up, and it didn’t turn better after massage (for the head). Therefore I went to GP. I began to take aspirin from March last year. I had taken that for one and a half year already. But not too much help...no use...” (Interview 9, ID 9)

In this situation, help seeking behaviour was inevitably hindered, thereby speeding up the possibility of exacerbation of the condition. This interview conversation was very interesting and a field note was made in relation to the issue of this participant’s concern about chronic diseases and a memo was made to ask subsequent participants their views about this point.

“This is important as I have asked her three times about health problems and she has only just told me this (only three words – I have cholesterol). This is very important.” (Field note – interview 9)

“The important part of this section is that she does not consider these ailments a problem. Also, again she is saying and experiencing surprise at the fact that there is no cure. She seems to expect a radical cure. This point should be noticed and checked again later when appropriate.” (Memo – interview 9)

5.2.7.2.2. Arthritis

Elders in this study only had a vague knowledge of arthritis. In most cases, elders simply considered inflammation of any joint or aches of bones and joint as arthritis. From their perceptions as older people, the joints inevitably became stiff and painful. This triggered a vicious cycle of a more severe process of stiffness. The disease of arthritis was stressed by many elders not only because it brought about the joint or bone pain and stiffness, muscle aches, as well as fatigue, but it also made the elders less mobile and affected the day to day life of the sufferer.

“There is nothing to worry about for chest pain, just find some medicine to control it, and just take some pills to control it. What I fear most is that my body cannot move again.” (Interview 1, ID 1)
Rheumatoid arthritis was a joint disease discussed by some elderly participants in this study. Elders did not have any information about the illness being related to autoimmune system diseases. From elders’ perceptions, rheumatism was caused by exposure to “wet” or “cold” in the afflicted part and the symptoms were chronic pain which usually intensified during cloudy or rainy weather.

“Just pay attention to avoid water… when weather is not good, sometimes I still not feeling well in my feet. Hard to tell. Just not being so agile, a bit deadlocked.” (Interview 17, ID 16)

Because of the unbearable pain and the threat for elders’ mobility, rheumatoid arthritis was noted by the sufferers as a major health problem related to their daily life. One elderly sufferer summarised the problems associated with this mobility-limiting disease:

“Now I have a lot of diseases. It is very troublesome to have so many diseases. I have high blood pressure, diabetes. I also have the high cholesterol problem. Further more, now I have the serious rheumatism, and it is very bad. My hand is painful, the joints are very painful. There are spurs (pointing the feet)... a lot of problems... they are very troublesome. It brings a lot of discomforts to me, to my life... En... Now I feel I am very hard, I mean the life for is very hard... if I want to go out, it makes me exhausted. Because it is not very easy for me to stand up, I feel tired. Further, only 5 minutes walking makes my feet very painful... In short, walking is very hard for me and it makes me very uncomfortable... When it was painful, I could not make any movement... Now I feel very hard about my life. If I want to go some place to have some activities, it seems impossible. It is so troublesome. It makes my mood so bad. I feel very hard now.” (Interview 33, ID 29)

The integration of data presented in this section into the criteria of judging illness, again showed that subjective feelings were the major indicator for elders’ help seeking. It might suggest that this inappropriate behaviour delayed the right time for treatment and brought potential dangers to these elders.

5.2.8. Summary: Core category: the context and meaning of being healthy

Being healthy as a pervasive goal, the core category of the study of help seeking behaviour among Chinese elders living in the UK, exemplified how Chinese elders experienced the process of being healthy on a daily basis. The context and meaning of being healthy was identified in several areas: the approaches of diet, sleep, rest, and exercise, mental discipline, as well as environmental impacts. Elders’ beliefs about illness and their main concerns about diseases were also presented because of the crucial position; they were directly affecting help seeking among Chinese elders.
These perceptions relating to health and illness issues in elders’ minds directly influenced their help seeking behaviour. How elders managed their health related problems and their concerns about the practical process of seeking help are discussed in the next chapters of key categories.
5.3. Four main themes

The data analysis from this study resulted in the identification of the core category – “being healthy” with four interrelated sub-categories, containing themes and concepts which embodied the fundamental elements that Chinese elders used to represent their perceptions of help seeking issues. The data are presented around these general themes which emerged from the interviews and are explained in terms of the process associated with their unique help seeking behaviours. Although these four sub-categories are presented below in separate sections and their properties are portrayed as separate elements, they should be envisioned collectively, functioning as a dynamic, integrated and interrelating collection of themes.

In what follows, the process of being healthy and help seeking in the context of the Chinese community in the North West of England in this study is discussed in more detail.
5.3.1. Category 1: Self management

5.3.1.1. Introduction

The core category of being healthy has been identified and described in the previous chapter. This section aims to outline the first category of being healthy. Self management was the first category and represented one of the major healing processes when elders faced health related problems, via illness prevention, health promotion and the treatment of ailments. Furthermore, elders believed that regularly self-managed healing was one the most essential ways to achieve the goal of being healthy to which they mostly aspired. The elders in this study reported that they self managed their condition both before and after contact with health care professionals.

Self management is presented in two sections: first, self-reliance (which focused on elders’ mental status) and second, personalised self care and self treatment (which described elders’ practical actions). Although these self management behaviours were presented in different subcategories, Chinese elders reported a continuous process of self management. Key concepts contained within this category were trusting ability, private affair, attempting to control, protection, self judgement, mental adjustment, peaceful life, self reliance, as well as TCM. Field notes relating to elders’ descriptions of how they performed self management activities helped to identify the theme and name of this category. A preliminary working title of this category: “Health is private issue and one’s own affair”, indicated its main element of self management.

5.3.1.2. Self-reliance and keeping peace

Virtually all the Chinese elders in this study reported being experienced in self management in the various aspects of their daily life. However, elders emphasised different points and frequencies of concerns. A high proportion of elders reported that they actively engaged in self management regularly on a daily basis; whilst the minority spoke of relatively rare or infrequent episodes of concern only when there were some health problems. Many of the elders’ suggested that health was “their own affair” and described as essential the concept of self management or self government. The thought patterns, which were significantly impacted by traditional Chinese culture and the corresponding behaviours of elders when they faced health issues in the UK are discussed firstly in this section.
5.3.1.2.1. Self-reliance

When describing and discussing health care management in daily life, all Chinese elders expressed concerns about self management on a daily basis.

“I think it (getting healthy) depends on my own promotion. Self promotion is very important.” (Interview 33, ID 29)

Self reliance was regarded as the main principle when elders faced health problems. Although there were only a few elders who mentioned this fundamental underpinning of their self management behaviours, a number of common characterising constructs were identified according to their Chinese background. To a large extent, self reliance could be interpreted as “God helps those who help themselves” in the western world; or conversely, it was comprehended to be self-sufficiency or independence which was regarded as important in Chinese morality. This point might, from one important standpoint, explain the elders answer “health is my own affair” naturally when they were asked the reason why they self managed their health problems. The elders indicated that they considered self management as their own business. The following is an example from a field note made in relation to self management as a private affair from a discussion with one elder with whom the researcher had established a long term relationship and had regular email communication; furthermore, during the association with this elder, the non-verbal behaviours which were revealed from the description of her daily life reinforced what she was saying.

“Discussed with this lady again, notably, she naturally believed that health was her private affair, and it was of course to take care of her own health problems herself and no one other should be responsible for her health, including professionals. This point is so interesting and should be discussed deeper with subsequent elders, particular the point – not the responsibility of professionals.” (Field note – participant 3)

This field note helped to identify the theme of this category, self reliance or non-professional dependence. In this way, to get a deeper understanding of this important perception from elders the question “why not seek help from professionals?” emerged as an important area for exploration. There was consensus in the data that Chinese participants favoured independence rather than professional dependence when facing certain health problems which they perceived as not serious. Data showed that they recognized that medical help from professionals was useful to some extent; however, elders still consistently highlighted the importance of self sufficiency in getting or remaining healthy.
“Only the conditions but the external causes are the core issue. Doctors are the external cause, just help us... the main core is to promote and prevent health oneself.” (Interview 34, ID 30)

“Oh, it of course depends on me. Doctor?! How can I depend on doctor? Health is mainly about promotion. Self management and self promotion...” (Interview 35, ID 31)

It was clear that the majority of Chinese elders in this study agreed upon the importance of self reliance and did not rely on professionals. There might be many factors which impact on their thought patterns as well as their help seeking behaviours. However, when being asked why they preferred self management, there was consensus on their ability to be self aware and to manage their health status. Elders believed that self-awareness of the body was the foundation for getting and keeping healthy. They emphasised that no one else but elders themselves had the ability to achieve the goal of self awareness.

“I think I am very familiar with my own body, and I understand it a lot. So I think health should depend on me... But promotion of health needs to continue and it depends on me. It helps to recover the health to a good condition. When getting older, people should understand the importance of health promotion. Only in this way, the health condition will get better and better. Everyone knows his/her own body better than anyone else. So it is necessary to keep health by self promotion.” (Interview 30, ID 28)

What these quotes indicated was that most elders identified self reliance based on their own awareness of health situations as a key care process for getting and keeping healthy in their daily lives. Attempting to take control of their own health problems was considered to be the foundation of achieving the goal of being healthy via the main care process, self management. However, there was no consensus on the effectiveness of self management during their care process. On the one hand, a high proportion of elders trusted their own capability to get healthy via self management which for many was so ingrained that they felt it did not need an explanation. One elder summarised these views:

“This is certainly very important. My body is mine so I have to know how to protect myself well.” (Interview 10, ID 10)

On the other hand, because of a gradual decline in health status, a few elders doubted whether their practical actions could provide adequate maintenance to gain the ideal of being healthy:

“Yes, self management during everyday life is the most important way to keep healthy. It is the most important thing, I think. However, I am still not satisfied with my own self-management work.” (Interview 24, ID 3)
Furthermore, during informal conversations that often followed interviews, some elders also expressed questions about whether they operated correct or effective self management for their health. This indicated that some were lacking in confidence and certainty of their knowledge and practical pathways for controlling health problems though they believed that they themselves were the most familiar with their own health status. Furthermore, it was notable that even when these elders recognised that they were lacking in ability to handle their health problems, they were still trying to determine the causes of their own failings in self management rather than seeking help from professionals. This raises obvious concerns for help seeking.

5.3.1.2.2. Keeping a mentally undisturbed peace

Chinese elders preferred self management and only sought help from a medical professional when an ailment progressed to a serious level. The mental attitude of keeping an undisturbed peace was one of the main factors which affected this aspect of help seeking. Undisturbed peace was described as a state which was achieved by avoiding any negative influence upon their “ideal” daily life. Here, the term ideal was taken from the elders’ emic perspective. This situation of daily life mentioned by elders was, to a large extent, a spiritual idea in their mind. According to their holistic thinking, health was integrated with both the mind and the body and elders then tried to hold a peaceful mental state in order to gain the goal of being healthy. From the elders’ understanding, it was an effective method of self-preservation and a way to resist illness. As a consequence of this, the elders believed that keeping an undisturbed peace was very important for them to make themselves healthy.

Elders emphasised that the primary essential approach to achieve the goal of undisturbed peace was mainly related to an optimistic psychological state rather than pursuing a physically symptom free status. It would seem that the main aim was to avoid seeing a doctor so as to conceal one’s illness thereby avoiding fear and worry. Most elders in this study showed their avoidance of seeing a doctor in most cases during their daily life, particularly at the early stage. Elders explained that they would rather avoid, or not be likely to seek help, as seeking help might disturb the peace of life and may cause worry and therefore be harmful to their health. This was a consistent and reoccurring theme in the data. This assumption is made based on the understanding of Chinese culture and the sub-meanings/emotions reflected in interviews.
The majority of elders in this study identified two viewpoints regarding the concealment of illness for fear of worry, including both aspects of their thought patterns as well as their practical behaviours:

- Predominantly secular but religious faith was regarded as a support – bad deeds, as well as good, may rebound upon the doer (to acknowledge illness might mean admitting bad deeds)
- Seeking help brought troublesome concerns to one’s self and others, including family, neighbour, and doctor, but particularly oneself at psychological level

A more detailed explanation from elders’ perceptions of these viewpoints to achieve their undisturbed peace is now presented.

**Do well and have well**

As discussed previously in the section on mental discipline and physical health, the close interrelation and inevitable interaction between mental status and physical situation were valued highly. In this way, the elders’ unwillingness to confront their ailments which might worsen their health status was another way to gain the goal of being healthy. Related to health issues, some elders supposed that not doing evil acts during their life time, would lead to their lives ending well without suffering from the aches and pains of various ailments. The following is a typical example, with a male elder emphasising that he had never done wrong and repeating the assertion that he was a “virtuous person” during the interview.

“Furthermore, I think during my whole life, I never do anything bad on purpose; I treated people surroundings kindly, so I feel good now. My mood is good. You know, do well and have well, it is always like this. No need to worry a lot (about the health problems)... I will be good...” (Interview 35, ID31)

Though there were only a few participants who directly praised themselves as a good person in the formal interview conversation (traditional Chinese modesty might explain this behaviour), it could still be seen that this cognition in elders’ was evident in a few isolated words and phrases after some of the interviews. Field notes in the research diary recorded an informal conversation with one participant after the interview; it demonstrated that the idea of punitive justice was regarded as an important element for elders when explaining why they did not seek help:

“Today after the interview I was invited to have lunch in their club. I sat next to the participant and continued talking with him. He mentioned do well and have well to indicate that he had a peaceful and wonderful life time during this end stage of his life. This is the second time I heard elders talk about this philosophy of their time. This time
I got more sensitive about this important point and noticed that it influenced elders’ help seeking behaviour. I do not know whether this viewpoint is unique in Chinese groups, because of the traditional cultural factors associated with China?” (Field notes – interview 7)

In this way, it was clear that many elders believed strongly that they would end well in their life. Meanwhile, they did not want to attribute their illness to the consequence of being punished for being evil; they were likely to believe that the diseases would go away and frequently suggested that they would get well at the end of their life when the proverb (do well and have well) would come true.

Further, the majority of elders reported being secular (without religion) but they believed in traditional Chinese religious faiths and regarded them as a form of mental support. Among them, retribution from the Buddhist perspective was one main principle of faith that guided Chinese people’s thoughts and behaviours. People believed that there was retributive justice in the unseen world. There was one Chinese proverb, “do well and have well whereas do evil will have evil”, which expressed the core idea of the Causal Theory of Buddhism. This philosophy of interdependence or co-dependence emphasised that the wellness would be the reward for doing well in your life. It was a moral and ethical teaching which was largely accepted by the elders in this study and which correspondingly affected the identification of physical illness and the help seeking process by hindering active help seeking behaviours as all will be well at the end.

Avoiding being confused in the mind

When explaining the reason for not seeking help, many elders used the word “troublesome” to describe help seeking behaviours. Of course, it might be understandable that there were many practical troubles; seeking help brought problems for themselves and others, including family members, neighbours, as well as doctors. These practical difficulties will be discussed in Category 3: Accessing health services. However, here, it was often emphasised that sometimes elders described practical troubles, confusion and worry which aggravated their illness. Elders explained that if their health problems had the ability to be self cured or healed, they could remain optimistic and seek to promote recovery without getting medical help thereby avoiding many inconveniences. From their perception, elders did consider this to be a positive mental attitude. On the contrary, after seeing the doctor, elders became worried and upset, feeling fearful about their diseases. Some elders argued that after seeing the
doctor, “the disease appeared” (as diseases were identified). If they avoided seeking medical help they suggested that there would be no problems. Most elders expressed their behaviours or attitudes to avoiding seeking help in an implicit way:

“If there is no matter do not need to go (to see doctor), not necessary… I do not like to go there (GP/hospitals) frequently… no need.” (Interview 16, ID 15)

One male participant directly argued that it was not good to see a doctor frequently as it might make him anxious therefore leading to worse health problems:

“I do not think about those bad things. I do not like to see doctor. I do not like have checks. If after the checks, I am reported some problems here and there, such as some minor problems in liver, lung or intestine…What I mean is if there are some minor problems, for example, if there is a polyps in my intestine, without checking, there might be no problem. Just keep healthy mood, it may get OK later. Such as this kind of minor problem, it will be very troublesome if having it checked. Why? If after the checks, the small problem will be identified and the doctor will ask me to have a surgery to cut it. If the surgery is successful, then I will recover very soon and this is good. However, if the surgery is not very smooth, it may bring troubles to my whole body. It will influence my whole health. In this way, I think these minor things are not as important as… or I do not need to care these things… how to describe? I think the most important thing is to keep a healthy mood, keep happy. In this way, there won’t be disease.” (Interview 35, ID 31)

It was clear that this elder wanted to avoid receiving a definite diagnosis so that he could avoid being worried. This phenomenon was common among many elders; they were trusting that psychological issues played an important role in physical health and they believed that keeping optimistic was conducive to health and healing for their problems. In this way, in most cases when elders self judged their health problems as normal or minor they preferred keeping an undisturbed or calm approach to life rather than seeking medical help from professionals.

Analysis of the interview data relating to follow up after regular health checks or treatments from professionals also revealed that elders showed passive attitudes and actions. They typically underplayed physical symptoms and relied on health professional to be pro-active in making contact which indicated that elders purposively avoided negative information thereby they also avoided feeling worried and confused and maintained balance. From their perceptions, no news was good news and no communication with professionals was equivalent to no problem. This also could be constructed as another form of “avoiding seeing doctor so as to conceal one’s illness for fear of worry”. One elder expresses this well:
“Nothing (wrong)... I have not received any letters from the hospital. They did not post me any letters. It means nothing is wrong. No letters means no problem.” (Interview 31, ID 4)

The following was the field note made in relation to this noticeable interview data:

“No communication = no problem; satisfied that no news is good news; very passive help seeking behaviour.” (Field note – interview 31)

5.3.1.3. Personalised self care and self treatment

Chinese elders in this study reported regularly experiencing a range of diseases as they aged. Many described common health problems and chronic degenerative diseases as well as self management of these problems. Variations existed among individuals as to exactly how elders performed self management activities for their respective health problems. Personalised self care and self treatment were merged to conceptualise elders’ self management when facing health problems. Among them TCM was mentioned repeatedly by the majority of elders in this study when discussing self management of their health problems.

Generally, this section will focus on the dimension of elders’ practical actions when they faced health problems. Key concepts in this section included personalised, unsupervised, self dosage, as well as a preference for minor and gradual treatment.

5.3.1.3.1. Beliefs of TCM in Chinese elders’ mind

Although WM was well accepted in the mainstream of the medical care system among elders, TCM was still considered to be useful for specific ailments and also as a supplementary or even an alternative medicinal system in the medical world. From elders’ perceptions, TCM was the term which was extensively associated with many practices, including herbal medicine, acupuncture and massage. Qigong and Tai chi also had close relationships with the theoretical underpinning of TCM.

**Characteristics of TCM**

A high proportion of Chinese elders reported trust in the utilisation of TCM and related practises in their daily life. There were many characteristics of TCM which facilitated its usage from the elders’ perceptions. Firstly, TCM paid particular attention to individualised therapies. There was no universal agreement on which materials or
treatment pathways were definitely better than others. In this way, elders had the confidence to be involved in the utilization of TCM as the main approach to self management. Secondly, elders believed TCM medicines were made from natural materials, such as herbs or animals which grew naturally. Thus, they could consume these materials to gain treatment without side effects. Furthermore, there was no regulation of the dose of TCM. Hence, they could modify the dose depending on their needs. In sum, elders believed that since the TCM materials were all natural remedies, a specific dose of TCM was not necessary to achieve accurate or appropriate treatment. They knew that overdoing the treatment was potentially harmful for their health, but elders still felt free to try the therapy in various dosages.

“I prepare TCM myself in normal time, and I will buy a lot of TCM herbs back whenever I travel to China. Also my daughter will bring me a lot of TCM herbs from the US. I will prepare TCM myself to take. I really believe it… I feel that there is nothing bad to take TCM, and there is no side effect. Sometimes I feel feet pain, I will drink some TCM for bone optimizing, and that’s good. Different TCM optimizes different part of body, and is hence very effective, very good.” (Interview 17, ID 16)

Furthermore, because of the undemanding and flexible usage of TCM, some elders reported taking their favourites on a daily basis in order to promote body constitution and improve their health condition. Some elders summarised the peaceful healing approach of TCM for health promotion during daily life:

“When I was in Guangzhou (a city in China), I had a relative who is a TCM doctor. He was very good at TCM and very experienced. He often prescribed some TCM for me. I felt those TCM were really very good and efficient. TCM helped me to keep my body at a good condition and made me feel very comfortable after taking these TCM. It’s nice…” (Interview 16, ID 15)

It was clear that the natural feature of TCM materials played a very important role in the utilization of TCM as opposed to WM. Elders believed TCM provided a natural recuperation for the human body. Elders argued that too many WM medicines were harmful and disturbed the internal natural system. Some elders described their previous personal experiences as well as the experiences of their friends or relatives to articulate that too many WM drugs were not good for the physical constitution. One female elder clearly illustrated her attitude towards the medicines of WM and refused to continuously take them for her chronic symptoms in the long term as she associated taking tablets with getting cancer:

“If I am not dizzy I won’t take pills anymore. Why continue having pills even if I am fine? I always think it is not good to have too many pills. It is not healthy. I heard that it is not good for stomach. I tell you, my mother was an example. I remembered at that time, she was very sick and took a lot of tablets. At the end, she had the stomach cancer. So now I am very scared of having too many tablets. Drugs are not always good things. Chinese
people always say “medication will be one third of toxicant forever” (As a medicine, it is somewhat toxic). I feel that when having too many pills in the stomach, it is not good. When there is disease, of course we need medicine. But in the daily life, we cannot take them every day. If so, when one day we really need them, it will be inoperative. They are not good for stomach. I remember my mother was like that. She also had the high blood pressure, more than 200. Every day she took a lot of tablets and then she got the stomach cancer. In this way, I think... If we have disease, then we take pills. But do not have medicines everyday for a long time. When recovered, when getting better, we should stop having pills.” (Interview 31, ID 4)

The integration of this quote with the previous ones showed that there was a clear consensus among elders that TCM was useful and safe. Furthermore, elders also reported its efficiency in treating certain specific illnesses. Elders believed that such TCM therapies were more effective and better for their minor and chronic conditions which they self diagnosed than WM tablets or treatments. From elders’ perceptions, it was readily understandable why they chose TCM for their self treatment of minor ailments. They explained it as “no need” to seek help from professionals; and the focus of TCM was at the root, strengthening the body’s constitution and health condition therefore helping to prevent and cure the ailments gradually.

“These small problems do not need to see doctor. Moreover, for these diseases I never use WM, I never eat pills. I only use TCM. I deal it by myself. Do you know the herbal tea which is very popular among us Cantonese people? This kind of tea is very efficient for cold or fever. If I feel uncomfortable I will boil some herbal tea to drink. This herbal tea is one of traditional Chinese medicinal materials.” (Interview 21, ID 20)

For chronic symptoms or intractable illnesses, elders articulated that TCM was the so-called cure for the root cause of chronic ailments. This was philosophically opposed to WM which was perceived to focus on symptom control and relief. Additionally, elders believed that a good TCM therapy was not only related to the TCM materials but also the experience of the TCM practitioners. Well-known veteran doctors of TCM played an essential role in ensuring the effectiveness of TCM treatment in older age.

“I used TCM. I saw an old TCM doctor, who is very experienced. I always saw him, never change doctor. I trusted him.” (Interview 10, ID 10)

However, the perceived lack of expertise in practitioners in the UK meant that TCM had a poor reputation which affected the elders’ confidence of it:

“Do you know the Shanghai acupuncture in the China town? I have gone there once to have a try. The TCM doctor is a very young man, and he did not take my body's pulse, just have a look at me... The doctor gave me 5 small bags of traditional drugs, for the problems of constipation. There was no effect and then I never use TCM in the UK.” (Interview 16, ID 15)
Field notes relating to this elder’s attitude about experienced TCM practitioners helped identify the characteristics of TCM practitioners, showing the important role they acted in treatment from elders’ perspectives.

“Again, today’s interview, the elder mentioned about the importance of TCM practitioner. This time, it made me think more about it – why elders emphasise on the judgement of TCM practitioner when they talk about the utilization of TCM, but this is not mentioned when they discuss WM professionals? The characteristics of TCM, such as the diagnosis process of illness which only depends on TCM practitioner but no equipments, as well as the personalised and flexible prescriptions which are controlled by the practitioners, may explain elders’ concern about TCM practitioners.” (Field note – interview 16)

Integrated WM and TCM

The majority of elders in this study were not averse to using WM and they affirmed their trust in WM for curing some diseases.

“I actually used WM, however, together with TCM. By using both of them, I had better effect.” (Interview 22, ID 21)

Though they noticed that there were disadvantages of WM as mentioned above, elders valued that WM had accurate diagnostic procedures and symptom relief mechanisms as well as advanced techniques and equipment. One elder clearly summarised the characteristics of both TCM and WM:

“I do not dislike modern medicine. Both modern medicine and TCM have their own advantages. For major disease or acute disease, you have to use modern medicine. Modern medicine can control the symptoms fast, but for treatment of the roots (of disease), only use TCM. In this way, it can be cured gradually.” (Interview 10, ID 10)

From elders’ perceptions, WM had a natural weakness as it was comprised of artificial products. WM was considered as chemical medicine which stood for unnatural creation with many side effects. Therefore, when WM controlled symptoms, it also brought other complications. This awareness was deeply ingrained in elders’ minds. Elders believed that the removal of residual symptoms could only be achieved through the use of TCM. In this way, elders used TCM as a major approach for their self management of being healthy. Thus when facing specific health problems, they preferred combinations of WM and TCM since they could complement each others’ merits and drawbacks. From another perspective, this combination was also a custom which Chinese elders got used to in China. Elders in this study believed that the integrated TCM and WM was the usual and complete practice for illness treatment.

“In China, when I go to hospital, doctors will give you both western medicine and TCMPP. So I would think there is indeed something different. In here, when doctor makes the conclusion, I will believe him as well. However, I will find some TCM to use.
I will do some optimising and compensating by myself. This kind of situation never happens in China. They (Chinese doctor) give you the TCMPP as well.” (Interview 3, ID 3)

It was clear almost all elders integrated TCM and WM. Furthermore, they believed that this approach led to the most effective method of symptom control as well as getting back to a healthy state. Some participants reported that they manipulated the prescription from WM doctors to match their TCM. Data analysis reflected that there was some knowledge about the conflicts between WM and TCM in some elders’ minds. It appears that the elders were unwilling to entirely accept WM. However, as facts showed that WM did have an effect, they fell into a conflict situation. Few of them went to extremes either rejecting or accepting WM completely whilst most of them went for the middle ground. In this way, the majority of elders believed that after making their own personal alterations and adjustments to both kinds of medicines, the integration of both would allow for the best of both sides and thereby help them regain their health.

“Doctors of modern medicine prescribed a lot of hormonal medicine, and asked me to take those. But, TCM asked me not to take hormone. I knew that the symptom could not be controlled without hormone, so I took those still. However, I reduced the dose. Doctor asked me to take 3 pills a day, but in fact I only took 1 pill a day. Later I only took half a pill a day and then no pill at all… reducing dose gradually. However, I took several years of TCM. I kept taking TCM, for more than one thousand aliquots of the TCM recipe. Yes, (TCM is) very good, of course. The TCM recipe is for health keeping and fine adjusting of body. Basically its function is diuresis and inflammation diminishing.” (Interview 10, ID 10)

What was important about this quote was that this kind of behaviour could be a very dangerous practice and may cause potential harm. However, it was quite worrying that the elder felt satisfied with her adjustments because, as she believed, she used the best treatment (perfectly integrated TCM and WM) but did not consult or get advice from the professionals before adjusting her prescription. Another key strength of TCM from elders’ perceptions was the lack of side effects when compared with WM. One male elder cited his own experience to stress TCM as a supplementary support for side effects of a WM prescription as well as the relief of symptoms of unknown aetiology as follows:

“Recently there are some problems with my stomach. Ulceration of stomach, a gastric ulcer… There also are some medicines prescribed by the doctor. Now I still take these pills. But now there is a problem. I feel the side effect of these pills is very strong. I am not very sure about the components of the medicine, whether they are the same as in China. Because I did not have the gastric ulcer problem when I was in China, there is no comparison. So I do not know. I think their side effects are quite enormous. After taking these medicines I found there were bad influences to my joints. Because there are some problems in my joint of the fingers… this hand (pointing the right hand) has the
Tenosynovitis, it is very severe... The Tenosynovitis is a kind of special inflammation. There is no way to cure it. It only can be counterbalanced by my own immunity. Then it will recover gradually and slowly. Just like that... I had taken “Xinhuang Pian” for a period of time. Do you know it? “Xinhuang Pian” is kind of TCMPP. I heard it from my friend, another Chinese person living here. He told me that it is very good for joints. That medicine can relieve the pain and subdue the inflammation. Further, this medicine is not like the other painkillers. The effects are different among them. This one is especially for the joints. It is very good.” (Interview 34, ID 30)

It was clear from this quote and the previous one that elders had a strong idea about WM in their mind – they believed TCM had certain effects to reduce or confront the side effect of WM. In this way, they seemed to be overly self-confident or self-assertive in adapting and changing the treatment prescribed by professionals. This may bring potential risks for these elders. Noticeably, in this study, only one elder declined the combination of WM and TCM. She suffered from and worried about the interactions and conflicts between TCM and WM.

“Every three months I go to my GP to check my blood sugar. Every three months to check whether it is good or not... I haven’t used it (TCM)... I have a lot of problems (diabetes and hypertension etc.). Also I take various kinds of drugs. I think I cannot use TCM now. Why? I am afraid that the drugs from TCM and WM will have conflicts. I am afraid that so I do not use TCM... In fact, my physical quality is poor. I feel the cold weather more than the other people. This means my body is weak. Now I am very weak and have a lot of diseases. Further, I have to take a lot of medicines. Actually I really want to see TCM doctor. I want to use TCM to help me to promote my health. TCM is good at health promotion. But now I have to take a lot of WM. I am afraid of the conflicts between the two kinds of medicines... I feel my life is very hard, I do not know how to handle a lot of problems... I know these problems are chronic diseases but cannot be gotten rid of the roots...” (Interview 33, ID29)

However, it was clear this elder also emphasised that she trusted in the effectiveness of TCM in promoting health and was looking forward to using it if there was advice on how to integrate WM and TCM for her particular diseases. In sum, the integrative approach was the ideal one in elders’ minds.

Deficiency of TCM

Some elders, a minority, reported that they seldom used TCM. Though they acknowledged the merits and drawbacks of TCM, they set mainstream store by the disadvantages of TCM related to the treatment of health problems. These criticisms concentrated on several points, including the slow speed of treatment effectiveness and uncertainty of the effects of TCM.

“I am not saying that I don’t believe TCM. I just feel that TCM is too slow. (For example) Normal coughing or cold can be cured by several western medicine pills, but TCM is too slow to get some results. If it is something wrong with guts, such as heart or
lung, a surgery will be necessary. Since surgery is only in western medicine, it is much easier to stick to western medicine. Therefore I just don’t use TCM… It costs 4 or 5 days for TCM to cure minor illness. TCM is so slow; you can make a cold or coughing OK immediately by taking western medicine… I have never used TCM service in Manchester in these 19 years.” (Interview 2, ID 2)

“It is not that I don’t believe. TCM is too expensive, and has long period of treatment – one day, two days, three days, even more, you still can’t see much effect. This is my personal point of view, not representing anyone else. I think TCM is just using some herbs, and have insignificant effect…Therefore I won’t see TCM doctor in this place.” (Interview 6, ID 6)

The above quotations emphasise the importance of the speed of treatment effectiveness. Though few elders criticized the inherent effectiveness of TCM, the majority of elders in this study referred to the gradual and peaceful process of treatment when adopting TCM within which health problems were cured at the root and the body constitution was also improved. Additionally, all the criticisms of TCM tended to focus on TCM services in the UK. In the following section, the distrust of TCM in the UK was discussed in detail.

Lack of confidence in TCM in the UK

Though elders in this study reported their trust in TCM for health issues, including prevention of ailments and their recurrences as well as intervention of diseases, seeking help from TCM practitioners in the UK was uncommon. Almost all elders in this study reported that they did not have established contacts with TCM practitioners in the UK at the time of interview. Elders emphasised this was a consequence of a lack of effective TCM practitioners in the UK. However, elders also stressed their previously unhappy experiences with TCM practitioners in the UK which made them disappointed or even angry. Elders criticised the fact that there were many problems with TCM in the UK compared with the situation in China. Their main concerns related to perceived low expertise of TCM practitioners, poor quality and limited types of TCM herbal materials, ineffectiveness of TCM, as well as the expensive cost of TCM in the UK. The perceptions of many elders who reported negative aspects of TCM in the UK were incisively summarised by the following selected quotations:

“I have not used the TCM here. But my wife had tried TCM once. The effect did not seem good. Meanwhile, I do not know the quality of it here, so I have not used it. Moreover, the TCM is very, very expensive here… It is not necessary (to use TCM). In the UK, we are taken good care by the western doctors; and why go to see the traditional Chinese doctor? Further, we do not need to pay for the health service.” (Interview 5, ID 5)
“I never use TCM service here (in the UK)... The TCM service here is bad in quality. With that limited kind of herbs, how can they cure illness? I myself never believe the TCM service here. It is expensive too.” (Interview 7, ID 7)

It was clear that elders were not satisfied with the TCM health service in the UK. There were common concerns among some elders about the quality of care provided by TCM practitioners and their questionable qualifications. On female elder who had lived in the UK for more than 30 years, clearly narrated that the standard of care of the TCM practitioners in Manchester was not good and the unhappy experience of help seeking with an unprofessional practitioner eroded her confidence of TCM in the UK:

“Actually I have used TCM twice...er, in fact it should be just once. That time I went and saw TCM doctor. It made me very unhappy. I told you, I have some minor problem in my ear, a drumming in the ear. After the check in the big hospital, I still felt something wrong or ... then I thought maybe I should have a try with TCM doctor. This was not a very big problem; I thought maybe TCM doctor could deal with it. Then I went there... I have seen a TCM doctor here, in Manchester. After I went that clinic, I told him the problem about my ear. Then he took my pulse first and asked me to wait in another room outside the consulting room. That doctor was so funny, and he was reading a text book (laugh)... His trick was seen through by me. It’s so funny. But I still let him to continue... at the end, he prescribed me four tisanes. After that time, I have not gone to see TCM doctor here anymore. He was very unprofessional. I never see TCM doctor again, and I am very disappointed with the TCM here.” (Interview 30, ID 28)

Besides the view that TCM practitioners in the UK were unprofessional, a lack of confidence in the TCM materials, including TCM herbal products and TCMP, provided by TCM practitioners or pharmacies was widespread among elders in this study, regardless of their individual status. An elder whose previous job was a TCM practitioner in the UK made this same point. TCM materials in the UK were commonly described as “poor quality”. This term included several aspects of elders’ perceptions of TCM materials, such as limited availability of herbs, and the intrinsic quality of the materials. Indeed, some elders also mentioned concerns about the legalization of the sale of TCM herbal materials by the UK government. However, in most cases, elders did comment on the low quality and limited variety of herbal materials available in the UK compared with that in mainland China and Hong Kong.

“In this place, it is impossible for TCM in the UK to be comprehensive. Only limited kinds of materials are available, which makes it hard to give the correct prescription for the specific illness.” (Interview 6, ID 6)

“Another time I was in London. In the China town of London, I wanted buy some Liuwei Dihuang Wan (Pills of Six Drugs with Rehmannia). That Chinese pharmacy gave me out of date pills and even it was overdue, it still was on sale. I was very angry at that moment, and then I said “your pills are overdue, why you still sell them?” Do you know how that guy said to me? He told me there was no expiry date in TCM,
TCMPP. It did not matter. I do not want to say the name of that pharmacy. It made me very angry and disappointed with the TCM here. They just want to earn money and do not have any professional ethics. They are not TCM professionals.” (Interview 30, ID 28)

These perceptions about the deficiencies of TCM in the UK aggravated elders’ evaluation of the treatment effectiveness, including the negative influences of poor quality of TCM materials as well as unqualified professionals. These concerns affected their assessment of the expensive cost of TCM compared with the free WM health care service in the UK.

“Only once, I have already forgotten for what illness. I had two prescriptions, and there wasn’t significant change after taking them. I recovered from the illness naturally and slowly afterwards. So I think it does not work… I thought that TCM will effectively cure it faster. I can’t remember what illness it was. But at last it was just so so, and it cured by itself. TCM is too expensive here in the UK, I never used it again. It cost too much, more than 40 pounds for that, and it didn’t seem to be that good… expensive, and not that effective.” (Interview 4, ID 4)

A further important point regarding the high cost of TCM was noteworthy. The cost could not completely account for the occurrence of elders’ help seeking related behaviours. The majority of elders in this study described their help seeking experiences from TCM practitioners when facing problems even though they knew there were free WM services in the UK. Furthermore, these circumstances occurred in various conditions, including initial help seeking, follow-up visits and an alternative to the pathways of WM health care seeking. Though elders reported their repeated disappointments with TCM services almost every time after their help seeking, they still showed their reliance on TCM as discussed above. One elder who had Systemic Lupus Erythematosus (SLE), clearly articulated her faith in TCM and repeatedly sought help from many TCM practitioners in Manchester previously, during and after seeing WM professionals.

“I have one disease. Look at my face (she pointed the red blisters on her face), you see... Systemic Lupus Erythematosus (SLE)... I have seen many TCM doctors but no help. No one can cure this disease and the doctors told me this disease can’t be cured. Those TCM doctors I saw were all in Manchester... both Chinese doctors and western doctors... All of them told me that it cannot be cured. This symptom continues... in the past, I have taken more than 30 packs of TCM, but there was no use. There were no helps for my disease. The WM doctor said this disease cannot be cured and I just could take some pills to control symptoms, just for controlling... That’s it, and that’s why I again turn to TCM for help, though it needed money. But TCM doctors told me the same thing- it cannot be cured.” (Interview 20, ID 19)
A firmly rooted belief in the importance of TCM led elders to seek help from TCM despite their awareness of the limitations of the service in the UK and the expense of the treatment.

5.3.1.3.2. Utilisation of TCM in self management

After exploring elders’ perceptions of TCM and its characteristics, analysis of data related to the utilisation of TCM for self managing specific health problems revealed frequently unsupervised self treatment during daily life. As discussed, the preference of utilization of TCM by Chinese elders as the main pathway of self management of health problems was partially because of their confidence in TCM and also because their health seeking of TCM services was restricted by the poor quality of it in the UK. In this section, according to elders’ understanding, how elders used acupressure based on TCM principles to self manage their normal symptoms, such as pain is presented; and the corresponding TCM acupressure in elders’ perceptions are also discussed in detail.

**Massage for pain relief**

Some elders reported that they used acupressure (massage on the acupuncture points). From elders’ perceptions, TCM proposed that the human body had hundreds of invisible points which connected with the visceral organs internally and the skin externally. When acupressure of the acupuncture point was applied accurately and delicately, the flow of internal energy was facilitated and the corresponding part of the body was healed. The perceptions of elders who used acupressure as one of the major pathways of self management for relieving physical ailments were illustrated by the following selected quotations:

“I trust TCM. I know some knowledge about TCM, such as some TCM materials, as well as the acupuncture point around the body. I told you I had worked in the hospital in the past, and that hospital also had TCM department. Some TCM doctors were my friends and they taught me some knowledge about TCM. They told me the acupuncture point in the body and if some parts of the body are not comfortable or painful, press the relevant acupuncture point will help to release the pain. I know some knowledge about it and sometimes if I feel pain I will manage it in this way.” (Interview 28, ID 26)

“Look at this, this graph on the wall. These are the acupuncture points on the bottom of your feet. I massage my feet according to this graph... two weeks ago, and this leg (pointing at left leg) has some problems stepping.” (Interview 32, ID 5)

It was clear that the perceived benefit of acupressure lay in its characteristics, naturalness and simplicity. Moreover, elders believed that it had no side effects and was
very effective both for disease prevention and healing, especially for the relief of physical damage and fatigue. In this way, it was an accepted self-management approach for elders to alleviate physical problems during daily life.

5.3.1.3.3. Home remedies

Elders in this study reported that they had some knowledge of their illnesses and home remedies, though little was accurate. Elders’ remedies for their self management of ailments were not limited to TCM materials; some WM remedies were also accepted by these elders and even stocked for their common use. This could be traced to the customs of using over-the-counter (OTC) remedies as well as antibiotics in China (though the Chinese government does not allow antibiotics to be sold without a health professionals’ prescription, many are freely available in China) maintaining home stocks of remedies for family use was a normal practice. Elders also discussed their self management regarding home remedies, including vitamins and supplements, pain killers, antibiotics (brought from China) as well as some potentially dangerous drugs (brought from China) such as calcium channel blockers used in coronary heart disease.

Elders expressed three major reasons to explain their behaviours regarding the usage of home remedies. Firstly, if they self diagnosed minor health problems they believed that they had the ability to control those symptoms and it was therefore unnecessary to seek help from professionals. Also, as noted previously, contacting a professional may cause them considerable anxiety. The following selected quotation clearly indicates this attitude of elders:

“For minor problems such as coughing, I will go to pharmacy to buy some medicine and deal with it by myself. It’s not necessary to trouble my doctor.” (Interview 6, ID 6)

Secondly, when elders encountered a problem which was perceived as similar to a previously encountered problem, they would confidently self manage these symptoms, following professionals’ instructions which were given previously, believing that this particular self management strategy was a safe pathway. Following is a typical quote:

“For that day until now the symptoms have happened several times, very similar symptoms but not as severe as the first time. Just very minor symptoms... if I feel my heart beat quickly then I will take some medicine... If there is just minor problem, then I will deal with it in this way... I do not go to see my GP. There is no need to see doctor. Just take some pills and have a good rest and then I will be OK. Nothing serious... No need to see doctor.” (Interview 22, ID 21)
It was clear this kind of activity may put elders in danger. Additionally, potentially
dangerous drugs, calcium channel blockers, were used by one female elder on an *ad hoc*
basis; indicating that even when experiencing presumably untreated angina, this elder
still preferred self management rather than seeking help from professionals in the UK:

“There is something wrong with my heart. When I was in China, I had some symptoms
during a short period. My cardiogram was abnormal, ST segment depressed. They
(Chinese doctors) prescribed ‘Su Xiao Jiu Xin Wan’ (a kind of calcium channel blocker,
this is used for amending blood shortage in cardiac muscle, it functions by inhibiting
\( \text{Ca}^{++} \)) for me at that time. I have not mentioned this problem to the doctor here… In
here, I had headache several times; my chest felt uncomfortable and I can’t breathe
well. In these situations I took ‘Su Xiao Jiu Xin Wan’ immediately.” (Interview 3, ID 3)

It is clear how dangerous this situation was. Some elders emphasised the long-term
effectiveness and safety of OTC health care products, such as vitamins and supplements
rather than prescribed medicines which were considered as symptom-control with lots
of side effects. One female elder described her trust in OTC health care products as
opposed to antihypertensive drugs and her preference for using OTC health care
products on a daily basis in order to heal her hypertension:

“Generally, if my blood pressure is not very high, I won’t have pills (WM for
hypertension). About 140, 150, it is not very high, why should I continue taking pills? I
think if I keep having medicine, one day when I really get ill and need medicine, there
will no effect of the pills. Actually I consider my health a lot during the daily life. I have
“deep sea fish oil” everyday. That was bought by my daughter. There are also some
health-protective remedies, which were brought from China. Those are just some
remedies of nutrition, such as vitamin B group. My daughter told us those remedies
were good for our health, especially for the blood vessel. Seems good at lowering blood
sugar and blood pressure…” (Interview 31, ID 4)

Thirdly, it was perceived that the use of vitamins and supplements did not bring danger
to elders. However, when OTC products were used in preference to prescribed
medications there were potential dangers for these elders.

In addition, elders proposed that they were the people who were most familiar with their
own health situation. In this way, according to their self diagnosis of minor ailments,
they made decisions about treatment for themselves and took home remedies instead of
consulting professionals.

“All of these medicine I bought them from China. Every time when I go back to China, I
will buy a lot of medicine and bring them to the UK. Those are some common medicine
using during the daily life, such as pills for the bellyache, headache, cold and sore
throat. I know what kinds of medicine are needed.” (Interview 28, ID 26)

In this situation, the overly self-confident or self-assertive attitude to self management
was sometimes quite dangerous as the relief of some symptoms would conceal some
potential diseases; and “no symptom, no disease” made elders reluctant to seek help, it is clear that the situation could and probably would get worse and worse.

5.3.1.4. Summary: Category 1: Self management

Category 1: Self management, the first key category of being healthy, described elders’ perceptions of illness prevention and curing when they self defined situations as non severe, preferring a peaceful or gradual healing process which they were able to handle and achieve on a daily basis. Self management when facing health problems was identified in two areas: self reliance & self believing and personalised self care & self treatment. Although the majority of elders in this study reported negative views on the TCM services in the UK, elders still showed their preference for TCM treatment as well as self management via TCM during the whole healing process. A number of influencing factors, including their conventional customs and their cognitions of health and illness, which affected elders’ thinking pattern and decision making, were perceived as causes of their self management behaviours.
5.3.2. Category 2: Normalising/minimising to be healthy

5.3.2.1. Introduction

While the previous chapter highlighted how Chinese elders managed their health related events without seeking help from professionals, this chapter outlines the psychological adjustments that have affected the help-seeking behaviour of the participants of this study. “Normalising/minimising to be healthy” was the second category of the core category of “being healthy” and represents the ideas and attitudes that elders presented when facing health problems as well as their subsequent actions. Key concepts contained within this category were “knowledge of diseases”, “accepting discomfort”, “underplaying physical symptoms”, “bearing pain without treatment”, “self cognition”, as well as “psychological self-diagnosis and attribution”. Normalising/minimising to be healthy is presented in three sections: knowledge of diseases, accepting and carrying on and emotional stoicism and reserve. Field notes relating to elders’ perceptions of how and why they normalised or minimised their symptoms helped to identify the theme and name of this category.

As reported earlier, the elders in this study reported feeling normal as almost every participant described his or herself as healthy. Elders created a sense of normality to gain a psychological peace, partly because of incorrect knowledge of health issues or lack of such knowledge but also due to their desire to create the sense of being healthy. This will be presented first and then data relating to the knowledge which influenced how elders’ normalise their concerns about health problems will be detailed. The subsequent section presents data relating to aging as the major reason for elders’ explanation of being unhealthy, particularly in relation to mental health.

5.3.2.2. Creating a sense of normality

All elders in this study normalised or minimised their health ailments thereby creating a sense of normality in order to comfort and appease themselves. Elders viewed their health from a holistic perspective which influenced this process. They believed that avoiding anxiety, particularly anxiety related to illnesses, and keeping peace was helpful for their health. One male elder reluctantly discussed that he had “a minor problems in the heart… a blood vessel in the heart”. Then he reported how he managed this by adapting his emotion:
“I am very happy every day. Now I feel I am very healthy, without any disease. Thus I am very happy. I take a leisurely life every day. Well, I let nature take its course. Doing what comes naturally, I do not think about disease. I never think about I will get disease in the future. I do not know the things in the future and I do not think about them. I do not think whether there will be any problem or disease in the future. No, nothing. Now I am very healthy. I do not have any problem, even minor ones. I seldom see doctor… Just keep healthy mood, it may get OK later.” (Interview 35, ID 31)

In this situation, although acknowledging his health problems, this elder adjusted his thinking to concentrate on staying healthy and avoided thinking about any deterioration in his condition. Inherent in this particular strategy was that he stopped taking medicines to create a sense of health. Another male elder who had hypertension suggested that he did not worry about it and comforted himself that hypertension was a “chronic disease”, not a severe one. In this way, he could convince himself he was a healthy person.

“Now I am healthy and there is no big problem of my health. I do not take any pills for preventing any disease.” (Interview 36, ID 32)

It was noteworthy that elders defined themselves as healthy even when they were experiencing many ailments and even when they were aware of these health problems. They all normalised their problems through their use of the terms “minor” or “not serious”. Furthermore, two different forms of expressions were employed by elders when they tried to normalise their health problems during the conversations. Most elders simply described the existence of the health problem or problems, trying to downplay them, whilst few other elders provided a detailed knowledge of their health problems, attempting to show that they were aware of them and had the ability to handle them.

Many elders underplayed the seriousness of their illness and suggested that there was no need to be concerned. There were numerous examples from interview data where elders talked about their symptoms but they consistently underestimated the severity of them. The following excerpt represented a typical way of minimising health problems, focusing on a minor issue to evade the major one, therefore convincing herself that she was healthy:

“Actually I am feeling pain here (pointing at left waist) now… There is nothing to worry about for chest pain, just find some medicine to control it, and just take some pills to control it. What I fear most is that my body cannot move again.” (Interview 1, ID 1)

Another female elder was experiencing severe hypertension, describing symptoms where she reported feeling “very faint… dizzy… uncomfortable”. However, she avoided
talking about her symptoms, reported that she felt well and used the fact that she had not had a cold (an illness associated with being out of harmony) to create a sense of normality:

“I haven’t really caught a cold after moving here – only recently I had a little bit cold. But it’s not serious. I don’t really have any disease…I feel good actually.” (Interview 4, ID 4)

Other elders used a different strategy to gain a sense of normality. Some elders explained that they were able to handle these “minor” symptoms, which were actually major conditions or diseases, by emphasising their general health as the following data highlight:

“I am healthy, and I do not have any disease. I am always very healthy and I have not had any big disease except diabetes…” (Interview 25, ID 23)

“My ear… That is my left ear. I always felt uncomfortable in this ear... But to be honest, it was not very severe. It was a minor problem and a little uncomfortable. But it lasted a long time... I was feeling some minor problem in my kidney, but it was not severe, it was very minor uncomfortable feeling... not big problem...Nothing (wrong with me). Even the (problem of) ear, it was very minor uncomfortable feeling. No big problem... I also have another minor problem. My blood pressure... I have high blood pressure and I take pills everyday now.” (Interview 30, ID 28)

It is clear to see from these quotes that the elders in this study actively minimised their symptoms and ongoing potentially serious medical conditions and concentrated or focused on acute or short term illnesses as a way of assessing their general health.

Some elders used peer comparison as a way of judging their own health status and problems. Some preferred to compare themselves with peers whose health situations were worse than their own as a way of comforting themselves and normalising or minimising their own problems. In comparing themselves to other elders, the participants perceived themselves as healthier, therefore showing more satisfaction with their lives. Peer-group comparisons were direct and indirect; the comparators came from a number of sources, including other elderly friends surrounding them and some hearsay; the most frequent sources were other elders who might share the same illness experiences. One elder described how he judged his health situation positively after comparing himself with other elders:

“I thought that there is no reason for me to recuperate since I have no illness, thus I didn’t want to go... I had a look there, and found out that there were all very old people around – those using crutches. I thought I am healthy, so I came back.” (Interview 5, ID 5)
This typical excerpt suggested that the elder was clearly not going to be categorised as unhealthy. The avoidance of health care services and considering them as unnecessary was another way to create a sense of being healthy.

Generally, the majority of elders in this study had serious symptoms or conditions but minimised them. In so doing, a sense of normality was created and being healthy was gained from elders’ perception. A consequence of these actions mentioned above was that Chinese elders tried their best to hide or evade their problems. It is suggested that this would seriously affect the help seeking process.

5.3.2.3. Lack of knowledge

As discussed previously in Category 1: Self management, elders reported their self management as the major way of managing health care problems. In this way, knowledge of health issues and their specific health conditions had a direct impact on Chinese elders’ help seeking behaviours. In this section, the discussion will focus on how knowledge deficits resulted in a lack of concern about illness among elders. Inadequate health knowledge was related to less concern about chronic disease and made elders blind to certain symptoms. It was another reason for elders to normalise and led to poor help seeking.

5.3.2.3.1. Knowledge of cardiovascular disease

Heart is important

Although the researcher did not introduce the subject of knowledge of certain diseases initially during the interview, almost all elderly participants discussed these issues in the context of their specific health problems, therefore showing their concern about related health issues in their daily life. These health problems mainly centred on certain chronic diseases which were commonly reported among this elderly group of people, including cardiovascular disease, such as chronic heart failure and hypertension, as well as diabetes.

“I have high blood pressure, high cholesterol level and also diabetes.” (Interview 6, ID 6)

“Now I am fine. However, I have history of illness – I had Coronary artery bypass surgery before.” (Interview 7, ID 7)
In this study, cardiovascular disease was the most frequently mentioned health problem. Most elders initially reported their concerns and discussed heart related issues emphasising the important function and status of the heart in the human body.

“I know heart is important… it is the centre of human body.” (Interview 6, ID 6)

However, in most cases, the descriptions were limited to vacuous or vague generalisations, “heart is important”. The following was one typical example, showing lack of knowledge of heart function among elders:

“I have seen some information about heart. Heart is very important. Oh, I know it is very important for health. But I do not know too much detail about it.” (Interview 30, ID 28)

Interestingly, elders insisted on showing their concern about these health problems. It may suggest that they tried to make themselves and listeners believe that they were aware of the disease and whilst this awareness was often expressed, further exploration during interviews revealed that it was mostly superficial knowledge which served as a defence against feeling anxious or acknowledging serious illness,

**Mechanisms of cardiovascular disease**

When exploring further information related to cardiovascular disease following the nearly universal idea that “heart is important”, different levels of understanding were identified, from a relatively rare detailed knowledge of cardiovascular disease to a much more commonly encountered lack of any understanding about heart related issues. Among all the elders who participated in this study, only one elder who experienced heart failure gave a relatively accurate description of the mechanisms associated with episodes of heart failure and cardio-vascular problems. This elder provided a vivid description of the heart as a pump and the blood vessels as water pipes to demonstrate his understanding of the cardio-vascular system; meanwhile, he also mentioned that these pathological changes were gradual and long term:

“Maybe there was some fat inside the blood vessel, or some places of the blood vessel were some extent blocked. So the blood pressure becomes higher and higher slowly... Heart is for pumping blood, and when the blood vessel changes thin, or it is blocked, the heart will need loads of efforts to pump blood. So high pressure means heart needs more energy to pump blood. That is like water hydrant, if it is blocked, the water pressure will become very high. So if the blood vessel has problems, the heart will be damaged. In this way, the abrasion of the heart will cause the heart failure gradually.” (Interview 19, ID 18)

In this excerpt the elder indicated how he perceived hypertension and heart problems occurred. He illustrated that he had worried about the ongoing or chronic process of
cardiovascular disease. However, it was more usual to find a lack of knowledge about cardiovascular problems among the majority of elders in this study, which is detailed in the following sections.

**Considering cardiovascular diseases as an acute illness**

In contrast to the accepted view that cardiovascular disease is usually a progressive or chronic health problem, a high proportion of elders in this study had only a partial understanding of heart related problems. They categorised heart problems and certain acute diseases, such as myocardial infarction (MI) or angina and gave, in the main, a description of heart disease as being associated with acute cardiac episodes without any warning signs. The majority of elders, considered it as an acute disease and something for which nothing could be done before diagnosis:

“I think there is no symptom for heart disease. It happens as it comes. If you yourself do not know the high blood pressure, if this problem cannot be identified, and the heart disease happens suddenly, it will be very bad. It cannot be foreseen. I tell you one story of my friend. That friend I have known him from my 10s. My friend was much more active than me. Two years ago, my friend suddenly told me that his vessel is blocked, and the doctor needed to get one vessel from his leg to do the surgery. My friend was very active and is the energetic type. This thing happened very suddenly... but suddenly he did the bypass surgery and did the modification to his vessel. This is no symptom in advance, and comes suddenly. If there is no regular body check, there is no symptom. If the blood vessel bursts, we cannot do anything. In this way, heart disease is very dangerous.” (Interview 19, ID 18)

Also, some elders reported that certain acute symptoms were associated with heart problems, such as “myocardial infarction (MI)” and “angina”; meanwhile, many used the term “sudden” to show their astonishment and helplessness, indicating that heart problems were unpredictable and out of their control.

“Of course I will (pay attention to the information related to heart), I will concern this information... I will pay much attention to it because I fear that one day I may fall asleep and suddenly cannot wake up, dead. I am very worried about it; because I am likely to lose my breath often during sleep... I read books. I have heard of CHD, just myocardial infarction (MI), I know it.” (Interview 2, ID 2)

However, with more investigation, it was discovered that elders did not possess any actual knowledge regarding these medical terms. Linking this point with the previous excerpts, it may suggest that, on the one hand, elders had an image of the typical heart attack as involving dramatic, crushing pain and sudden collapse. Put simply, the use of MI or angina as the focus of heart disease partially indicated that most elders were lacking in correct knowledge of heart issues. They thought there was nothing they could do to prevent heart problems because heart diseases were sudden and did not have any
warning signs. In addition, elders also wanted to comfort themselves that they did not have any problems if they were without any acute symptoms, thus no help seeking occurred.

Knowledge deficits

For the elders in the study the heart was confirmed as one of the most important indicators for personal health assessment; for some elders’ heart related problems were the sole criterion for testing their bodily functioning:

“I feel that I am now very healthy. There is nothing wrong with my heart. Good heart, good body…” (Interview 13, ID 12)

Though elders realized the significance of the heart, it did not indicate that elders paid enough attention to heart related issues. Many elders who had experienced heart problems previously could not provide their detailed medical history, including the exact name of the heart disease. Furthermore, they also demonstrated that symptoms in remission or absence of symptoms indicated a healthy condition of their heart. The following excerpt highlighted that the low occurrence of symptoms meant no problem for most elders:

“Long time ago, I felt my heart beating a little faster. Maybe…I was not sure. But it was just minor problem, not serious… It was only my feeling, not… After I have arrived here, I have not had that kind of feeling anymore. Just like that…nothing wrong. I haven’t seen doctor about it… At that time, it was just a very little uncomfortable feeling and no need to… It did not matter.” (Interview 31, ID 4)

The data presented here indicated how dangerous these perceptions could be. However, elders did not acknowledge this potential threat. The main misconceptions about heart related conditions centred on the following aspects: if there was no symptom then no diagnosis can be made. Some elders believed that health professionals could diagnose heart related problems only when there were symptoms. One elderly lady repeatedly mentioned this point during several conversations with the researcher:

“I have not mentioned this problem to the doctor here. This is because that my son told me there is no symptom of my heart, and hence the doctor won’t check it for me. In here, I had headache several times; my chest felt uncomfortable and I can’t breathe well… I don’t actually know (why not seeking help) as well. Though my son said it can only be checked out when I have symptom, I don’t completely agree with him.” (Interview 3, ID 3)

“How can I ask doctor to check my heart, in here? If I have no symptom, how can I describe or tell the doctor? Well, I have certain uncomfortable feeling sometimes, but not too often… Also, the situation now – I do not have those (symptoms) very often, so…” (Interview 11, ID 3)
It was clear from this quote that this elder knew of the existence of heart problems and that it would potentially threaten her health, but she tried to find an excuse to hide her problem, therefore creating a sense of normality or healthiness for herself. This particular point could be seen in the following excerpt:

“My problem is supraventricular tachycardia (SVT) in medical name. In hospital here, they cannot check it out. Sometimes when I am too nervous it will break out... it was diagnosed in China... I am not bothered by this problem much here anyways. So I didn’t see doctor.” (Interview 12, ID 11)

This quote was important for a number of reasons. It illustrated a misconception that the UK health services would not be able to check the symptoms out or diagnose SVT; and this elder did have correct information of her health situation and SVT as nearly all SVT is symptomatic. Furthermore, this elder held a perception that the symptoms had to be constant or relatively constant or at least frequent before she sought help. When compared to previous quotes, this excerpt implies that elders did not seek help because they thought they had to be symptomatic to receive treatment; and they chose to believe their self-made knowledge or family’s suggestion and then keep a status of being healthy by hiding the health problem and avoiding seeking help from health care services.

Incorrect knowledge

Participants in this study were reluctant to attribute their symptoms to heart disease and were more likely to attribute symptoms to tiredness or other illness, such as physiological problems or even hormonal issues, rather than heart problems:

“I didn’t know there was something wrong with my heart in the beginning. I didn’t know it was that severe either. I just thought that I might not rest well, and felt that it could turn well if I rest more.” (Interview 7, ID 7)

“In fact I feel uncomfortable (around the chest) sometimes, but my main problem is depression, not heart…” (Interview 8, ID 8)

“Well, I have certain uncomfortable feeling (chest pain) sometimes, but not too often, and I take medicine myself. Also, the situation now – I do not have those (symptoms) very often, so... I reckon that the reason for the situation got bad in my 50s is that I was during my menopause. I guess it is related to that.” (Interview 11, ID 3)

Besides attributing possible heart disease to other problems, some elders in this study used incorrect or incomplete standards to assess their heart related symptoms. Some elders simply equated heartbeat or blood pressure to heart conditions:
“I don’t know. I thought about this (heart problem) before… I feel that there is nothing wrong. I had blood test before; there shouldn’t be anything wrong with my heart.” (Interview 15, ID 14)

In this situation elders felt certain and assured of their heart related health status and convinced themselves that they were healthy. Therefore a poor and incorrect knowledge of the heart and related issues led to poor help seeking activities.

Whilst most elders emphasised their concern about the significance of heart issues as discussed previously, some elders suggested that heart issues were not to be worried about if there were no symptoms. Therefore the prevention of heart disease was rarely mentioned. Here the prevention meant seeking help from professionals in preventing heart related health care problems. Elders thought that because of their self management activities there was no problem and therefore they believed that there was no need to seek help or to check their bodies when they were free of symptoms. Some elders asked rhetorical questions “why know it” and “why check it”:

“I thought I was still young and was quite healthy so I don’t need to have that kind of check.” (Interview 19, ID 18)

“... I think my heart is very good and I do not have any experience. En… there is no problem with it. Never… I have not had it checked. I do not have that problem why I should check it? I am not sure. I do not have any problem with it, so he does not need to check it.” (Interview 30, ID 28)

Although elders expressed their concern about heart issues, in this situation they were clearly not going to seek help until there were obvious symptoms. In addition, few elders directly reported that they were unwilling to seek any information about heart disease and refused to consider it in order to avoid anxieties or worry impacting their heart. One elder described how he felt avoiding information related to heart disease helped his healing:

“Now I am very good, have no problem. I do not want to think too many bad things (of my heart) and get worried. It is not good for my health, I do not want to know (the information related to heart disease); it does not matter with me.” (Interview 8, ID 8)

These exemplars indicate that Chinese elders had little knowledge and did not wish to openly acknowledge the possibility of cardiovascular diseases. This highlighted their ambivalent attitude towards gaining greater knowledge of their potentially existing cardiovascular related problems. They knew the importance of the heart but they did not want to admit that they could have heart related problems. When exploring this point further with a scenario related to the topic of heart issues, more than half the elders did
not have any knowledge of cardiac related symptoms which was alleged as the most important organ by these elders.

“I don’t know. I don’t understand these (the scenario).” (Interview 17, ID 16)

What these excerpts indeed showed was a lack of knowledge about the prodromal symptoms of cardiovascular disease among elders. However, it was noteworthy that most elders did not have any interest or passion in talking about this topic. Some switched the conversation to another subject or stopped talking about anything related to the issue whilst a few made comments such as “I am not the doctor” to imply that there was no need for them to know and it was unnecessary to talk:

“(The scenario) I do not know. I do not know what’s wrong with that lady. I am not the doctor so I do not know about it.” (Interview 21, ID 20)

It became clear that elders did not want to talk about it because it would cause them anxiety. Elders explained that they were not professionals, although their matter-of-fact attitude could be considered an excuse to normalise these knowledge deficits and comfort themselves. An extreme example of this is the male elder who had experienced many cardiovascular symptoms but refused to discuss it, explaining that:

“I don’t want to say anything about this. I don’t like this topic. The reason is... I don’t want to think too much about these problems...which will make me anxious.” (Interview 6, ID 6)

This particular excerpt (and the previous quotes) again indicated the fact that elders did not want to talk about the topic related to heart issue if nothing was wrong and they thought they would know when they had symptoms.

In sum, rather than a lack of knowledge of heart disease, elders’ denial and normalizing of their symptoms associated with their avoidance and lack of acceptance of the importance of their symptoms meant that they would avoid help seeking unless absolutely necessary.

5.3.2.3.2. General knowledge of other common diseases

Of those elders who gave accounts of other conditions the data demonstrated that they lacked a basic understanding of these diseases, what they were and what the consequences were for them. Some elders admitted directly that they did not have any knowledge about the disease. As one elder stated:
“I cannot say whether I am healthy or not. I don’t know and I have not thought about that.” (Interview 14, ID 13)

Some elders provided explanations of why they were lacking in health related information. They described mainly personal, rather than general, reasons for the lack of information based on their individual situation, which were variously attributed to unclear information sources, such as family members:

“She (daughter of this participant) didn’t tell me the causes of the disease. She only told me when you feel pain here take this kind of medicine and when you feel pain somewhere else take another kind of medicine. She didn’t explain the cause in detail. She always comforts me... I never know (the causes of those diseases). I even don’t know why it suddenly hurts.” (Interview 1, ID 1)

“I cannot describe it clearly. Sometimes it is not headache, it is... I think it is dizzy or faint. I feel everything go round and round in my head and I am very dizzy sometimes. I cannot see things clearly when I feel very dizzy. Every time when I am dizzy, the situation is like that. Another problem is about my arm, I feel that my right arm and also this shoulder are not comfortable. Sometimes they are painful up to the part of shoulder. It is uncomfortable feelings, no good, but just minor pain.” (Interview 37, ID 33)

It was clear from the data that there was a lack of knowledge among some elders with various reasons why they lacked information; lack of information from family or medical services was frequently mentioned.

On the contrary, some elders explained that they had enough knowledge of such problems and believed they were able to control these problems. However, what they said indicated incorrect information. One female elder explained that her blood pressure had been more than 200, and the GP advised her to keep it under 170. The number 170 was subsequently interpreted as an ideal numerical value for her that she trusted as it had been presented by a health professional:

“I measure my blood pressure every day, and it is always around 150. Doctor said it is Ok if it is lower than 170, and there is no need to see doctor.” (Interview 9, ID 9)

It was not surprising to find from the data that a lack of follow-up led to this misunderstanding. However, it was also important to note that, if this was the doctor’s advice, it was not necessarily up to date information, as 130 systolic is considered the ideal level for an elderly female. Many elders were not up to date with current guidelines and even when they had information, they interpreted it incorrectly. As mentioned previously, elders may have avoided information about their health problems in order to avoid anxiety and worry. Being willing or inclined to accept positive information and seek positive interpretation intentionally might explain why elders
normalised their health problems. By so doing, elders created a sense of normality and health which helped them stay in their world rather than seeking help.

5.3.2.4. Identity of old age and accepting

Many elders in this study attributed problems, symptoms and uncomfortable feelings to old age and this was an important barrier to health care seeking among these community-residing Chinese elders. Many elders in this study believed there was an inevitable connection between aging and diseases, particularly chronic ones. Identity of old age as well as accepting the health problems due to aging were the two inseparable themes which led to poor health care seeking among elders.

Old age was one of the major etiological issues which were frequently discussed by the elders during the interviews. Elders had a general tendency to associate functional decline or health problems with their old age rather than with certain diseases; old age equalled worse health and functional status. Furthermore, there was no clear definition of the cause and effect between old age and their health problems; elders considered them as associated entities. As one elder said:

“There must be something wrong when you are old. Older people always like that. Aging is like that. You will understand when you are getting old.” (Interview 4, ID 4)

This quote exemplified not only the identity of old age but characterised a conceptual change in how most elders accepted poor health in their later years. Old age was frequently described as the cause of health problems and elders related these problems to the aging process. Furthermore, it appeared that this association increased with increasing age. Two female elders who were suffering symptoms related to cardiovascular as well as musculoskeletal systems acknowledged their ailments, but were generally satisfied with their health status:

“Old people won’t be as good as before in every aspect. This is normal. Just my body, health condition... It is much weaker than before. But now it is alright and I am still healthy at this age.” (Interview 22, ID 21)

“In fact I feel uncomfortable sometimes... Anyway, I am so old, it good enough to be like this.”(Interview 8, ID 8)

Another male elder who had experienced heart problems for many years still attributed these problems to the aging process as opposed to coronary heart disease:
“I thought I was still young and was quite healthy so I don’t need to have that kind of check. In this way I only took blood pressure check. When I was young, I was very healthy, heart was healthy too. Now it is not as good as before. When I get old, heart is never as good as what it was when I was young, naturally not as good as in the past.” (Interview 19, ID 18)

What was important to note in these excerpts was the fact that the elders believed that chronic illnesses of every part of human body were associated with advancing chronological age. This concept was accepted by most elders in this study. From their perception, aging was an irreversible process for humans so they believed that there was nothing they could do to stop the progression of their ill health related conditions. In this situation, elders were likely to attribute their problems to advancing age rather than to think about pathological issues as the cause. Once again this hindered their help seeking from medical professionals.

By way of contrast, identifying with a younger age enabled those elders who were more ‘junior’ to create a sense of normality. One male elder who had had a “little chest pain” and reported this in the interview, considered himself as healthy and avoided any check-ups because he was “not too old”:

“Now I am just 60 years old… Now I feel my health is fine. But I have a plan. After few years, for example, after my 65 years old, I will have regular check every year. I will insist on doing this. Because when people get this age, older and older, the resistibility of the body is weaker and weaker. It is because the physical quality is not as good as it in the youth. Now I keep doing exercise is for enhance my physical quality.”(Interview 35, ID 31)

The integration of this new discourse with the previous quotes revealed that age identity acted as a major pointer which guided elders’ judgments of health conditions and influenced their decision making for seeking help.

According to elders’ perception, as aging and poor health status were closely associated, some elders with progressively chronic diseases underplayed their health problems and accepted them as the natural phenomena of aging. They were not likely to explore the cause of these problems within medical issues but attributed them to old age as the cause. Aging could be used to explain any physical declines or diseases from elders’ perceptions. Moreover, many elders with certain chronic diseases were likely to complain their difficulties or troubles were brought on by old age. The following excerpts typically indicated the attitude of accepting various health problems among most elders:
“Older people always have this kind of problem. It is not very serious now. If I feel I cannot breathe, I will have a rest and then it will be OK. I know how to control it and I know my own body, it is all right... I didn’t tell my GP about this. It is not serious.”  (Interview 5, ID 5)

“Many elders are like this. When you are old, you cannot digest as good as youth, and you will have this.” (Interview 9, ID 9)

These quotes were important as they represented most elders in this study in describing the cause of health problems. Elders showed that they possessed this cognition of acceptance. It might be stated that these elders were used to suffering their health problems and disregarded them in their consciousness, therefore avoiding recognising the issues relating to certain specific diseases. In this way, poor help seeking was inevitable.

On the contrary, only a few elders in this study who were likely to ascribe their physical problems to old age were obviously experiencing good health in comparison to other elders who had experienced or were experiencing illness or ailments. They did not frequently mention the terms “old” or “aging” during the conversation. They were sensitive to their health related events, tending to solve their problems by seeking medical help rather than directly ascribe their physical declines to aging. For example, a male elder, who was the second oldest among all the participants at the time of interview, explained that the reason for his worry about his health and illness was because he was usually very healthy. He would attempt to prevent diseases by frequently seeing professionals when there was any uncomfortable feeling. As he said:

“(I am) 83 years old. Ha-ha... I was born in 1926... I am always very healthy and I have not had any big disease except diabetes... for more than ten years. I was feeling tired all day and also very thirsty. You know I always worry about my health a lot and then I went to see my GP. The doctor helped me to check my blood and urinary. Then he told me I had diabetes but very minor one. At that time, it was no need for me to take pills... However, after three years, I began to take pills. But just pills, no injection... Actually I seldom have disease, even the minor problems such as small cold. I have the injection of cold vaccine regularly. If I have uncomfortable feelings I will go to see doctor.” (Interview 25, ID 23)

In this particular case, this male elder has a relatively healthy status. It might explain why these few healthier elders did not emphasise the issue of aging during the interview.
5.3.2.5. Summary: Category 2: Normalising/minimising to be healthy

Normalising/minimising to be healthy, the second key category of being healthy as a pervasive goal exemplified how elders decided to handle their concerns about health related events by normalising or minimising them. This normalising attribution made a considerable contribution to poor help seeking. A normalising style of attribution has the opposite effect and the stronger an elder's tendency to normalise or minimise his or her symptoms the less likely he or she was to seek help from professionals. A better understanding of how elders were aware of their symptoms might be the key to acknowledging this normalising/minimising style. In this study, Chinese elders' beliefs about their symptoms had focused on the dimensions of both physical and psychological levels. In addition, elders believed that psychologically normalising attribution was an effective way to promote the healing process. Furthermore, the aging process was considered inevitable and unavoidable. These were perceived as causes of normalising/minimising health related events, in order to gain the goal of being healthy. However, poor help seeking presented potential dangers for these elders.
5.3.3. Category 3: Access health services

5.3.3.1. Introduction

The internal beliefs and self management factors which impacted Chinese elders’ help seeking behaviour were discussed in Category 1: Self management and Category 2: Normalising/minimising to be healthy. This chapter outlines the external factors associated with the help seeking process.

“Access to health services” describes the external determinants of help seeking from the elders’ perceptions. Family and health care services were the two main elements frequently mentioned by elders, having a direct influence and affecting decision making in regard to help seeking behaviour when facing health related problems. The themes included in these two parts were the impact of family, health service delivery, and the beliefs of health providers. These various components acted as either the stimulating factors or obstacles in the help seeking process. This chapter aims to report how these factors have dynamically affected elders’ help seeking.

In addition, among these components, how elders faced and handled the interactions with health professionals as well as elders’ perspectives of those health professionals in the UK health care system were especially important; they will be highlighted separately in the last category: Being cured.

5.3.3.2. Roles of family

Many elders valued family intimacy and close relationships with their families. Harmony, affection, mutual trust, and family support were identified as the ideal relationships among family members in elders’ understanding. The interactions among elders and their family members, when elders faced help seeking related events are discussed in this section.

5.3.3.2.1. Family duty

It was universally suggested that consultation with close family was the elders’ first concern when (or if) they faced health problems:
“I have a daughter. If I cannot walk in the future, I have to rely on my daughter.” (Interview 13, ID 12)

The support they received from children was reported as essential to their daily life. However, support from children was not only instrumental but played a part in their psychological well being. The data suggested that, with their children’s support, elders felt a sense of gratification which was considered as a facilitating factor in improving their health. It was clear that family support was advantageous in providing both practical and emotional help to this group of elders:

“I feel good and healthy now, since children are having good life, and I don’t need to worry about them... But for me, my whole life is for my children. As long as they are healthy and happy, I am healthy and happy.” (Interview 8, ID 8)

A close family structure and a tight family relationship were mentioned frequently by elders, showing that the family had a significant influence on their life in general and on their health related concern and behaviour in particular.

**Family structure**

Although demographic information on family structure was briefly presented in an early part of this chapter, this section provides additional information on type of households with implications for relationships and mutual interactions among family members.

Three types of households could be categorised. The stem family living structure involved older parents living with a married child, together with the child’s family if they had any. This was the least common arrangement. More common was the empty-nest household arrangement which described the situation where elders lived with their elderly spouse. The third was network households, where elderly parents and adult children were living separately but usually close to each other in the same city. Whichever the type of social arrangement was adopted, most elders still emphasised the importance of support from them.

“I am not living with them. They have already grown up. They have their own families so we are not living with them. I have three sons and a daughter. Two of my sons are living in Manchester... Though I am not living with them, our homes are not far away. I will tell them if there’s anything, and they will come and help me.” (Interview 8, ID 8)

Generally, elders’ family size was small in this study and networked family structure was more common. The major support sources were provided by their family and they were the closest persons to these elders. It was clear from the data that families
maintained close proximity with each other and that intergenerational support for elders from their children was a recurring theme.

**Obligation of filial responsibility**

A high proportion of elders in this study believed that adult children were obliged to take care of their elderly parents, providing various levels of support including financial, functional and emotional help. Some elders used a popular Chinese proverb “having children (son) makes one’s old age secure” to describe their attitudes towards their offspring. Below is an example of one female participant who lived with her husband but separately from her daughter and constantly mentioned the support she received from her daughter. She proudly described her daughter’s filial duty, expressing her happiness and satisfaction about her daughter’s capacity, as well as willingness to provide care for her and her husband:

“A very nice TV... It is very big. My daughter bought it for us (she and her husband). It was last Christmas and she bought this so big TV for us. It is really very nice. (Laugh) Yes, she is very good girl and treats us very nicely... My daughter treats us very well. She bought this big house for us. She usually buys foods, living goods for us. We do not need to go outside. Everything is nice. She is very dutiful. Every weekend she comes to see us. Now I am very happy... My daughter usually buys many kinds of fishes for us.” (Interview 31, ID 4)

The integration of these discourses with the previous quotes in this section suggested a tight connection between elders and their family, particularly in the setting of a host society. To further explain, living in relatively unfamiliar surroundings, elders were eager and more likely to receive support from their adult children in many aspects of their daily life. In the following sections, the influences from the family members on elders’ health related issues will be discussed.

**5.3.3.2.2. Shared decision making**

Making medical decisions with family members was reported by many elders in this study. The opinion of family members was sought and sometimes they were expected to help to make the final decision when elders faced certain health events.

“I firstly tell my son or daughter-in-law and ask them about my (health) problems... if the problem is serious, they will send me to see the doctor.” (Interview 3, ID 3)
**Being urged to seek help**

Data analysis suggested that when symptoms occurred or got worse, this evoked active decision making involvement on the part of family members. The nature of the elders’ ailments often tended to be severe and their reported powerlessness forced them to seek family help. Under these circumstances, family members usually recommended their elderly parents to seek medical help immediately.

“Suddenly I feel a serious pain in my belly. Then I couldn’t move any more. The pain was very serious and I felt I cannot bear it. My daughter thought that it was urgent, so she called hospital.” (Interview 5, ID 5)

These quotes show that some family members were quick to react if symptoms were acute or severe and indicated that help seeking occurred when both parties felt out of control or the illness was beyond their experience. With long term or ongoing health care problems, family were not involved as much and it was usual for elders to self manage in this circumstance without consulting their children.

**Family as a hindrance**

Data analysis showed that the family did not always play a positive role in elders’ help seeking behaviour. In contrast to the situation mentioned previously, when elders experienced chronic and debilitating illnesses which progressed over a long time, family members sometimes made an inappropriate decision which hindered elders’ help seeking. The following was one typical example:

“I have not mentioned this (heart) problem to the doctor here. This is because that my son told me there is no symptom of my heart, and hence the doctor won’t check it for me. In here, I had headache several times; my chest felt uncomfortable and I can’t breathe well… Though my son said it can only be checked out when I have symptom, I don’t completely agree with him…” (Interview 3, ID 3)

Though this female elder expressed her concern, her son was still expected to make the final decision for her. This situation occurred frequently among elders who were experiencing chronic ailments. It was further noted that elders chose to follow their children’s suggestion of not seeking help. In this way, family members could hamper elders’ help seeking and may have contributed to negative outcomes in help seeking and treatment.

In addition, as discussed, elders had a tendency for remaining healthy by self management and normalising health problems. In this way, based on their family members’ view, elders became more convinced of their health situation and firmly
believed there was no need to seek medical help. In fact, these behaviours would again bring potential dangers for elders’ wellness.

“The doctor here did not give me the report of the result. My children told me that maybe there were no problem or only some very minor problems, so the doctor thought it did not need to send me the report.” (Interview 28, ID 26)

These accounts also highlighted the significant role of family members for elders when they had to make certain medical decisions. The following section explores the influence of this trust in various health related aspects further.

**Trusting children**

Decision making by family members did not only include making the final decision to seek formal professional help but also affected other forms of health related behaviours.

“There are Chinese doctors and I can change my doctors. However, my son and daughter in law... they think the British doctors are good so I have had the Western doctor until now.” (Interview 27, ID 25)

A common feature of these data was that elders were likely to consult with their family members about many of their health issues and although a few of the elders expressed their awareness of problems with the decisions made by their family members, almost all of them chose to follow the children’s’ suggestions.

**5.3.3.2.3. Expecting family support**

Chinese family members remained the cornerstone of daily support for most elders, including elderly spouses and their adult children, particularly when there were health related events. Even with a universal health service in the UK, adult children, in most cases, were also responsible for elder care. “First” was used by some elders during the interview to demonstrate their family’s importance in providing help, and showed a greater reliance on family than health services:

“If I feel uncomfortable, I will tell my daughter. Yes, first tell my daughter... If I feel uncomfortable, I turn to my daughter first.” (Interview 1, ID 1)

Although there were a variety of family support styles, according to elders’ perspective, the basic underlying dimensions were conceptualised as practical and emotional support.
**Required practical support**

This practical component of support described the tangible forms of assistance related to the help seeking process, including transportation, translation of communication as well as information support.

**Language**

A language issue was reported as the major reason for asking family members to accompany them to seek help. As a group of immigrants living in the setting of a host society, lack of local language skills acted as a barrier. The data suggested that providing language support could happen at almost every step during the help seeking process, including registering with a GP, booking an appointment, communicating with medical professionals, understanding medical terms and prescription instructions, as well as following up on treatment.

“We (the lady and her husband) can’t understand (English). My daughter can speak English. So our daughter takes us to see doctor... We have language barriers; we just can rely on my daughter. We have our daughter. She is good at English, and they (hospitals) call my daughter too – to her mobile. We gave them the number of my daughter, so if there is something happening they will call my daughter, and she will tell us. She will bring us there too... I still have to ask my daughter to go with me... Therefore, our daughter accompanies us every time we see doctor. In that GP, there is also a Cantonese doctor, but we didn’t go to him. Our daughter can speak English anyways. Nevertheless, we have to rely on our daughter, or we can do nothing, like dummies. Our daughter has to take all the job, translating, taking medicine, etc. She also has to drive us.” (Interview 4, ID 4)

“I cannot speak any English. In the UK, I am totally illiterate. I cannot make phone call to hospital so only I can do is telephone my daughter.” (Interview 31, ID 4)

This type of assistance from family members facilitated elders’ help seeking in this study. However, it did not mean that elders were always necessarily content with this approach. Many elders expressed their dissatisfaction of children’s translation and interpretation. Elders argued that this kind of interpretation was lacking in detail of professionals’ opinions and treatments. Sometimes they proposed that family members intended to conceal the state of their illness to comfort them.

“She (daughter of this lady) didn’t tell me the causes of the disease. She only told me when you feel pain here take this kind of medicine and when you feel pain somewhere else take another kind of medicine. She didn’t explain the cause in detail. She always comforts me.” (Interview 1, ID 1)

“They (family members) will all comfort me as well. They always comfort me, and tell me not to worry about the disease.” (Interview 2, ID 2)
In addition, many elders also expressed their desire to communicate directly with medical professionals, expressing their real feelings, asking questions and hearing from the expert. From elders’ perceptions, they believed that to communicate with professionals instead of a family member would give them a full picture of their health situation therefore helping improve their health status.

“However, I am not able to communicate with doctors. I really hope to communicate with them, but due to the language barrier, it’s very hard for me to make it. I have to ask my son for help. Maybe (my son) just simply explain it for me. Because of this, I am eager to understand all things by myself... I can’t, how can I? Sometimes it seems I cannot get what I want (from the doctor)... I am not sure.” (Interview 3, ID 3)

Inadequate assistance would hamper the quality and the utilisation of health services and a lack of detailed professional information made elders see few benefits in seeking help. Consequently they would gradually lose confidence in health care seeking from WM professionals.

**Transportation**

Elders showed their expectation of transportation assistance from their children when they prepared to seek medical help. Analysis of data showed that even though there were often no mobility problems or when elders were familiar with public transportation, family members were still expected to provide driving support for the elders. From elders’ perspective, this was not only a physical assistance but a kind of emotional support on the route to the doctor.

“She drives me there... My daughter drives a car to there, and it’s really convenient. I feel happy (with her driving me there)...” (Interview 1, ID 1)

**Information**

Besides offering practical support during the process of seeking help, some elders reported that their family members also acted as professional information providers. It was clear that the supply of medical information by family members formed a bridge between the WM professions and Chinese elders. To some extent, they helped elders improve their health states. In an interview with one female elder, this point was highlighted as she totally trusted and relied on her daughter’s information:

“I don’t know at all, neither about medicine. I don’t know much about those. I normally ask my daughter to help me. I ask her to get medicine for me, and to tell me about the medicine, because I don’t know. She tells me how much and when to take the medicine. Also, the materials I received from hospitals. Those letters are sent to my house, and when my daughter comes, she will explain and tell us what are on those letters... I also take some nutrition medicine which is bought by my daughter. She said it’s good for
health, just something like deep sea fish oil... she told us those remedies were good for our health, especially for the blood vessel.” (Interview 4, ID 4)

However, in this particular situation, one potential danger was the accuracy of the information as for many the reliability of the information from medical professionals was unknown. There were also data to suggest that some family members acted in a professional role, providing medical treatment information to their elderly parents based on other sources rather than medical professionals including websites:

“Then they (the doctors) talked to my daughter in law. They said I had gastric ulcer. My daughter in law did not know much about gastric ulcer. Then after we came back home, she did the information search in the website. She told me the information of this disease, such as the reasons for this disease or the matters needing attention. I went to the hospital; they just gave me pills... Just my son and daughter in law told me not to eat acid things and spicy food. They told me that I needed to concern my food a lot.” (Interview 27, ID 25)

Though there might be some useful medical information in this situation, it was clear that without professional consultation there are obvious dangers. What was more serious was that family members’ inaccurate information would mislead elders’ understanding of their health and illness. One elder’s narrative suggested that she had already noticed there were certain problems but after discussing it with a family member, she decided not to consult with medical professionals.

“I am taking aspirin all the time. Look at my hands, here, and here, and my knees, so many bruises. They are caused by careless hitting. My granddaughter was a medical student; she told me that this is because I take aspirin. This is the side effect of aspirin.” (Interview 9, ID 9)

The explanations provided by her granddaughter made her normalise the problem. Without seeking help from doctors, this medication related problem might bring risks to this female elder. In this way, the information provided by family members failed to improve the elders’ health and may have put them at risk.

In sum, being helped by their family members with aspects of help seeking, such as language support, was considered a requisite for an elder living in the UK. Some elders reported their inability to do anything during the help seeking process without the help of their family. However, attitudes towards this form of help varied among the elders. The data suggested that some elders felt free to ask children to provide support, taking it for granted and considering it as an understandable right from their children.

“It doesn’t inconvenience. It won’t be this bad, since I was always accompanied by my son, daughter-in-law or daughter. They will translate for me. They always accompany me, yes, they will tell me what the doctor has said, be my translator.” (Interview 2, ID 2)
On the contrary, some elders reported that they tried not to bother their children where they were perceived as being busy with their work and own business.

“Sometimes I feel that I troubled my son for asking him to accompany me. However, due to my language obstacle, I have a lack of the confidence and ability…” (Interview 3, ID 3)

“In addition, I don’t understand English, so I have to ask my daughter to accompany me, and interpret for me. It’s very troublesome.” (Interview 10, ID 10)

Additionally, some elders considered that they had some basic language skills and they could “guess” doctors’ meaning. In this way, they chose not to trouble their children but rather to seek help by themselves. This was a very interesting phenomenon that elders chose to seek help by themselves when there was no obvious family support or if they considered the problem to be minor:

“Sometimes my son or daughter in law does not have time, and then I only can see my GP alone. I cannot communicate with my GP and cannot explain my feelings to him. Sometimes I want him to do auscultation for me but I do not know how to describe. I can just use body language and some simple words. The complex sentences, I cannot handle at all, such as the names of some diseases or some drugs. I have no idea... The simple ones are alright but the complex ones are totally problem. I cannot express what I want to say. I cannot communicate to the doctor. For example, if there are pain feelings at some parts of my body, I can say where is not comfortable with some body language. Just some simple words, such as “here, there, pain”...actually, I cannot explain clearly. In this way, sometimes my GP only can refer me to the big hospital to take a photograph of that part. For example, I felt stomach-ache, and then I asked my son and daughter in law to accompany me to the GP and help me to describe my feelings to the doctor. If without them, I can’t explain what I want to express to the doctor. Meanwhile, I am afraid that I cannot understand what the doctor is talking about either. In this way, if no one can help me, how do I deal with this situation? Who should I ask?” (Interview 27, ID 25)

These extracts were important for a number of reasons. They exemplified the predicaments commonly encountered among some elders when they sought help. Further, as previously discussed, Chinese elders could be concerned about their health situation but had the tendency of not engaging in help seeking until the ailments progressed to a serious level. In this way, sometimes elders with serious health concerns, which they thought of as “minor problem” still, were forced to seek medical help. It may indicate that there were potential dangers for elders as they did not seek help promptly. There were some apparent examples showing this delay of help seeking was impacted on by family related issues. One female elder reported delayed help seeking because of the time schedule of both her children and herself. This might be a very dangerous and harmful situation, particularly in certain situations:
“I cannot communicate with doctor. I cannot speak in English, and not understand it. I need my children’s help. It is necessary. They must help me. Without them, how can I deal with it? I need my children to drive me there. You know, my children are very busy. They have work to do. So every time, when I need to see doctor, I need to consider this when booking the appointment. I should consider my schedule, my children’s schedules as well as the doctor’s. It is very troublesome to accommodate everyone’s schedule. I have activities every Tuesday and Friday. I sing songs and play Tai-chi at those two days. Sometimes when I have time, my children are busy; or when they are free, I have activities and I am not available. It is problematic and sometimes it needs several times to change the appointment time.” (Interview 28, ID 26)

It was clear from the integration of this quote with the previous ones that as a result, this unwillingness to bother family members acted as another reason for elders’ delayed help seeking or lowered the quality of health services they received, causing some potential dangers. Generally, because of the required help from family, the involvement of family made help seeking behaviour sometimes restricted or prohibited.

Feeling a sense of support
Besides the practical help from the family, emotional assistance meant having a sense of support. From elders’ perceptions, emotional support reflected sharing intimacy, trust, and confidences with others. Receiving support, particularly emotional support, had a positive impact on the psychological well-being of the elders and therefore enhanced their sense of security in promoting and maintaining their health status. Elders might experience feelings of alienation and estrangement from their families which may have led to considerable fear or anxiety involved with certain health problems. One female elder expressed her feeling of security when there were family members surrounding.

“I fear to leave my family members. If I just die in this way, I feel I still have a lot words to say to them. My grandchildren are still very small, I love them much, and I miss them very much… Sometimes I can’t get up in the morning, and my grandson will help me get up. In this way I can’t live apart from them, I have to live with my children. I care my family very much, I highly regard my children. I regard my children and grandchildren as my life… my daughter-in-law will drive me to the doctor… With my family member beside me, I won’t feel too worried. Even if I cannot breathe well during sleep and cannot get up, I won’t feel too nervous.” (Interview 2, ID 2)

On the contrary, some elders complained that their adult children seldom sought to explore feelings or discuss psychological needs in depth, expressing their lonely and isolated feeling. One typical example is shown below:

“I only ask them (son and daughter-in-law) for help when I need to see doctor, and don’t talk about health issues with them normally… I discovered that when people get old, there are fewer chances to make friends, or feel they are alienated by their relatives. Therefore they naturally develop a feeling of lonely.”(Interview 11, ID 3)
Most elders expected to receive help from their family. Feeling a sense of support from family was an important aspect of emotional assistance which might have a significant effect on elders’ emotional state which acted as one essential factor influencing the development of good health conditions.

5.3.3.2.4. Fear of being a burden

Fear of being a burden to family members was reported by some elders in this study. In China it would be usual for the elderly to rely on their family to pay for medical care; this was clearly not the case in the UK. As all elders in this study were entitled to free health services in the UK, the sense of being a burden to family members arose from the fact that they were no longer able to function independently or “self manage” their health care problems. Therefore, they began to rely on their family for practical support and help with some of their daily activities. This was often associated with feelings of uselessness and sometimes elders failed to acknowledge or denied their failing health as a way of regaining a sense of being healthy and normal. One field note made after an interview appointment setting via telephone recorded the informal conversation with the participant about her useful role expectation:

“I called the lady and wanted to make an appointment of the re-interview with her. I politely asked about her health situation and whether I could re-interview her. She thanked me and told me her time was flexible except the weekend, explaining that she needed to pick up her grandchildren from a Chinese school. Meanwhile, she emphasised that her health state was very good recently and she was very happy that she helped her daughter to look after the grandchildren. She kept expressing her happiness and being in healthy condition.” (Field note – interview 31, ID 4)

Whereas, during the interview, it was apparent this lady suffered from severe hypertension which she normalised and did not tell the family. In the research diary after the interview, a field note was made to interpret why this lady repeatedly claimed that she felt happy to look after her family and was therefore in healthy condition:

“Obviously she suffered the hypertension and did not take it serious… She still tried her best to look after her grandchildren and showed her satisfaction of being a useful elder. Performing household activities seemed an essential predictor for her self judgement of health and psychological comfort. From her perception, she gained a feeling of self-worth which seemed more important than the work she actually did for her family. In this way, she achieved the sense of being healthy.” (Field note – interview 31, ID 4)

Self-worth and being a useful person in the eyes of others were regarded as important components for elders’ definition of being healthy. The consequence of this for elders was that they were less likely to feel like a burden when they were actively helping their
family, if only in a limited way. The downside of this strategy meant that this potentially dangerous behaviour hindered their help seeking behaviours as it was important to them to deny or hide their illness from their family. In addition, some elders concealed their health problems from their family, wanting to avoid bothering others in case of a false alarm. Elders self comforted in the hope of minimising the negative feelings and as noted previously maintaining a stable psychological state. Only when these ailments could not be handled or self managed did elders chose to inform family members about their illness:

“No. I didn’t tell (the problem to) them (my family) at the beginning. You can think it over. At that time, I still hadn’t known the reason; I did not want to tell others. I do not want to make others worry about me. If that was just because I was tired and if there was not a disease… the whole family would be upset all the time.” (Interview 7, ID 7)

It suggested that elders’ fear of being a burden on family and the urge to feel that they were useful and valued by their family revealed that what elders actually worried about was the idea of becoming ill. If they acknowledged that they were ill, and others knew about this then their sense of being healthy and useful would be violated. This is an obvious and sometimes worrying barrier to help seeking as elders fail to ask for help even from their nearest relatives.

5.3.3.3. The perceived advantages and disadvantages of health care services in the UK

The data revealed that perceptions and attitudes towards health services impacted elders’ help seeking behaviour. As an ethnic minority group, Chinese elders in this study instinctively compared (without prompting from the researcher) the health systems both in the UK and their home country China, spontaneously referencing “Chinese”, “traditional”, “the UK doctors” as well as “ours (Chinese)” or “theirs (English)” to distinguish between different ways of being Chinese even living in the setting of this host society.

5.3.3.3.1. Feeling content with health system in the UK

Analysis of the data regarding to the evaluation of health service system in the UK revealed that to a large extent, elders suggested that they were content overall with the current system of health care, emphasising how good health services in the UK were:
“I think the UK government treat Chinese immigrants well enough… Elders enjoy nice treatment in the UK, and all of them are free. For example, regular checks, vaccine injections – we elders are all treated well, therefore it’s nice.” (Interview 10, ID 10)

It was notable in these extracts that a free health service was considered a major advantage when elders appraised the health system. Clearly, as elders’ main concern was their health issue during their elderly years, the assessment of health care service played an important role of evaluating their own quality of life. When discussing health services in the UK, most elders expressed their gratification and then they naturally described their previous experiences of poverty in their early years. Some elders reported that they had a hard time in the past, often as illegal immigrants and therefore they were not entitled to health or welfare benefits. Some compared the payment system for health services in China with the free services in the UK. The difficulties of the past and the beneficial situation of the present formed a striking contrast in elders’ minds:

“It feels really good – we old people are well respected by others. Whenever you feel uncomfortable or ill, you will be asked to see doctor immediately. Everything is free. Sometimes I am not able to walk, and feel painful with both my arms and legs – you see, my knuckles are of abnormal shape due to my work in the past, it was really very hard for me living here (in the UK), and the work was very hard – but now it is good. The doctors will come to my house to visit me… There is no such welfare in Hong Kong.” (Interview 2, ID 2)

“Here everything is fine, and if there is some disease, then go to see GP. The doctors are very nice too. It is not the same as China, if you do not have money, so you cannot see doctor. In China, so much money is spent in seeing doctor. Here, the health services are free; we do not need to worry anything. Just go to see doctor if there is disease.” (Interview 31, ID 4)

Cost was the main concern amongst a high proportion of elders. However, what was important about these excerpts was that they opened up scope for revealing an interesting thought among the elders; the fact that services were free outweighed the many disadvantages for many of the participants. From elders’ perspective, they believed that since the service was free so it was generally unreasonable to complain about anything! (However, many were willing to offer advice on improving the relative aspects of services.) Compared to the lack of basic health coverage in China, the UK government provided a free health service to these elders and consequently most of them believed that it was wrong to criticise the system.

Though elders frequently reported their satisfaction, many elders still complained about aspects of the health service using euphemisms which were explored further in the
interviews by asking “is there anything needed to be improved”. They usually answered as “there are no problems” but they consistently listed many barriers at system level.

**Waiting time**

Compared with the situation in China, elders reported a lack of satisfaction with the process of making and obtaining appointments as well as the prolonged waiting time when seeing a health care professional in the UK. The difficulties in getting a timely appointment and the inconvenient referral system acted as barriers and hindered them from using the services to which they were entitled:

“To seek help here, you have to go to the GP first. If you have an illness, maybe a big illness, you still have to go through GP. It’s quite troublesome, not so convenient. My son-in-law told me that once he had a small car accident, then he waited in the queue in hospital for several hours. That was a long time and he was bleeding all the time, but hospital didn’t give him more treatment... You know, in China, whenever I have any illness, I just go hospital immediately and doctor will treat me. That’s convenience in such way. How about here? You have to make appointment with GP. This is very troublesome and time consuming... certainly I felt that it is not as convenient as in China. We have to arrange meeting with GP and wait patiently.” (Interview 10, ID 10)

“Sometimes when you go to big hospital, A&E, those places, you have to wait for a long time, several hours. Queuing is the thing, waiting for a long time, and no one takes care of you...just this big problem - waiting time is too long. It will be better if it can be a little bit quicker. Once, we waited for a whole night. I accompanied my husband there for a whole night. This is the worst thing. All else are fine.” (Interview 15, ID 14)

It was not surprising that inconvenient waiting times and delay in seeing a doctor made elders unwilling to seek help. What was worrying about this behaviour was that elders indicated that they often cancelled the appointment because the symptoms went away:

“It is not as convenient as in China. In China, since I am retired, I am eligible for free medicine. It is almost free for me. There are several hospitals which I can go to; I can go whenever I feel uncomfortable and don’t need to wait. In the UK, you know, you have to make an appointment with GP in advance. If you have a minor illness and you have arranged the meeting, after approximately one week or more, my illness can already be cured. During the waiting, my illness may already be cured, or lightened, hence there is no need to go to the GP and see doctor anymore. The appointment thus will be cancelled.” (Interview 3, ID 3)

As discussed, for most elders, they reported their self definition of illness based on symptoms. In this way, after cancelling a necessary appointment, elders could miss beneficial treatment which could lead to a harmful situation for these elders. Minor symptoms are often associated with chronic and ongoing health care problems, which, if attended to early can give many benefits.
Printed materials
Some elders reported that communication through printed materials acted as a barrier for elders’ help seeking and information gathering. Because of lack of local language skills, elders did not understand the information delivered by the health service but had to rely on others. However, they indicated that they would appreciate Chinese translations of the information:

“Those letters from hospitals are all written in English, it will be very nice if they are written in Chinese. That will make me very happy since I can read them myself and don’t need to ask the others. That will be so nice, if it is Chinese it will be so nice.” (Interview 2, ID 2)

“I hope I am able to understand about the health problem. When I receive the letters from hospitals, I hope I am able to understand them.” (Interview 3, ID 3)

It was clear that lack of detailed translation and being eager to gain the accurate health related information made elders desire to seek the information themselves. In addition, during the informal conversations, a few of the elders mentioned the translated information and educative materials provided by their GP or hospitals. They complained that the lack of appropriate information could hinder and sometimes made them lose their legal right to some necessary health services. One elder critiqued the health information which made him fail to receive certain health services, in this case the yearly flu vaccination:

“In the past, the clinic would post some letters or information sheets, which are all in English, to inform us to come to the clinic to have some checks or injections. But now, this year, there is nothing. The clinic has not posted any letters to me. There are just some notices in the GP. But for me, I do not have any disease or pain in my body, why go to GP? So, of course, I do not know those notices… I do not understand the situation about the health care system here. I do not know how it works. Sometimes I had the body check every year; sometimes I did it once every two year. But sometimes several years there was just one body check in the hospital. I do not understand why it likes this.” (Interview 18, ID 17)

It was clear that elders worried about their health a lot and many of them reported their willingness to have regular medical check-ups. Lack of information about what they were entitled to acted as a barrier which hindered elders in having periodic physical examinations and check-ups. For many of the elders, regular check-ups were acceptable and did not cause the same anxiety as seeking help for non diagnosed health care problems. The lack of awareness of service availability inevitably restricted the use of primary health care and missing the opportunity to have a regular body check might cause delay in help seeking as well as placing the elders at risk.
Interpreter

The interpreter service was praised by many elders in this study. With interpreters, elders reported that their language problems were solved to a large extent when seeking help:

“Pretty good... There is interpreter, someone works as interpreter. This is good enough. (For me) mainly is language problem.” (Interview 17, ID 16)

However, in contrast to the positive appraisals, some elders reported their preference of translation provided by family members rather than interpreters.

“The government is paying for this service, and it is kind of waste. It is wasting the money. It is alright to have a family member to do this job, my daughter can do it, and she is good at English. It is not necessary to employ a translator by the government. It is quite expensive to employ them. I heard it costs over ten pounds an hour. The load of the government is too heavy. Though the government is actually paying and I don’t need to spend money, I still think that if let my family member, my own relative do the work then there will be no waste of money for the government. The government is really paying lots of money (for this service).” (Interview 1, ID 1)

Here it seemed that besides the emotional support from family, different communication styles and varying cultural translation might explain this phenomenon but there was no information about the extent to which interpreters facilitated the effects of elders’ help seeking in this study.

5.3.3.3.2. “Free doesn't mean good quality”

The data showed that most elders politely proposed suggestions for their ideal of a health service. However, a number of the elders severely criticised the existing services in the UK. During the interview, they expressed their frustration, dissatisfaction and lack of confidence in the UK health care system. These elders considered quality more important than the fact that it was a free service; “too bureaucratic” was used as the general interpretation of the UK health system which was criticised as a “staff oriented” health care system. Elders also argued that long waiting times led to them thinking “do not seek their help if there is no emergency.”

“It’s not good. It is too bureaucratic in health care service system in the UK. In the hospital, clinic, every small thing, every link, we need to wait, to arrange and then wait. Here, in the UK, the health care system concentrates on its staff, not focus on us, patients. That is to say the health care system does not take care of us but the staff, doctors. It focuses on their staff a lot... Health care service, it is very troublesome or inconvenient. Doctors are usually not at the clinic. Those doctors are always on their holiday, enjoying their journey. If you want to see doctor, to see some specific one, it usually takes 2 or 3 weeks to wait, sometimes even 1 month... There are lots of things need to be improved. Initially, the doctors’ attitudes towards patients need to change.
They should focus and attend to patients. If there are too many patients for the clinic, then the clinic should add more doctors. When there are too many patients, the clinic just has the same number of doctors as usual; when there are fewer patients, the doctors are on their holidays… Those doctors are not doctor but officer.” (Interview 18, ID 17)

The irony of this situation was that the perception of poor health care services made elders lose their trust. Clearly, under this certain occasion, elders were not likely to seek help except in an emergency.

5.3.3.4. Summary: Category 3: Access health services

During the help seeking process, elders’ self awareness of health and illness played the major role which impacted their behaviour. Other factors also influenced elders’ decision making and willingness to seek help, among them, their families and the UK health care system were two major aspects.

‘Access health services’ exemplified how elders experienced and appraised the influencing factors in their help seeking behaviour and how they handled them in the health care setting in the UK. As the target population in this study were Chinese elders and the data suggested that they held strong Chinese traditions, family was still reported as the primary source of assistance for elders in difficulty or in need. Although the majority of elders agreed that they accepted their family’s help, many also reported a discomfort with this. They reported feeling powerlessness and falling self worth, a striking contrast with their main aim of “being healthy”, and showed elders’ resignation in some cases, reluctantly, to receive family care. Similarly, though there was overall satisfaction of the UK health care system, elders still highlighted many weak points which acted as barriers and hindered help seeking. Long waiting time, bilingual issues and some organisational factors were perceived as causes of elders’ delayed help seeking.
5.3.4. Category 4: Being cured

5.3.4.1. Introduction

While the previous chapter has discussed the concerns and awareness of external personal factors related to the help seeking process; this section deals with yet another factor which was a feature of Chinese elders’ help seeking. “Being cured” is the fourth and final category of Being Healthy and it was clear that there were two levels or approaches to treatments from the elders’ perspectives. Being treated holistically, treating the root cause of the disease or illness and receiving treatment that dealt with the whole body and mind was the highest ideal in terms of treatment. By contrast being cured, typically associated with WM approaches, was identified as a lower level of treatment and was defined as getting treatments only for symptom control in the elders’ mind. This category represents the cognitions and dilemmas that elders experienced in appraising WM, which influenced their decision making and help seeking behaviour.

Category 4 is named as “being cured”. It was a direct translation from Chinese which, from the perspective of the participants in this study, meant the symptoms were relieved but the root cause of the disease was not eradicated. This category is presented in five sections: the dual character of Western medicine, variations in their appraisal of professionals, ineffective culturally related communication, avoiding bothering doctors unnecessarily, and passive dependence upon doctors. Key concepts contained within this category were the advantages and disadvantages of WM, ideals, acculturation, adjustments in expectations, degrees of satisfaction, lack of care for patients, and problems with communication. Field notes relating to elders’ descriptions of how they felt about WM and health professionals helped to identify the attitudes and beliefs in elders’ mind thereby helping to recognize the themes and their codes.

5.3.4.2. The dual character of Western Medicine

Elders in this study reported a set of ideas about WM within which they associate this awareness with the concept of WM itself as well as the WM practitioners. These cognitions were reported as both facilitators and barriers to their help seeking in a range of situations. Generally, WM was widely accepted by the elders as being characterised by advancing and new technology, sophisticated techniques and equipment. As WM originated in the western world, elders always considered it as much more advanced
than WM as practiced in China. In addition, surgery was particularly mentioned by elders who generally praised the “magical” strength of WM for certain acute and serious illnesses. The drugs associated with WM were considered to be powerful and effective for controlling symptoms:

“If it is something wrong with guts, such as heart or lung, a surgery will be necessary. Since surgery is only in WM, it is much easier to stick to WM... you can make a cold or coughing OK immediately by taking these medicines.” (Interview 2, ID 2)

“I hear that it is better here. I hear that for cardio diseases, brain vessel diseases, and traumas, it’s more advanced than China.” (Interview 36, ID 32)

It was clear that elders believed in the efficacious effects of WM in controlling symptoms and treating acute and surgical problems. However, it did not mean that WM met the requirements of the elders in terms of their general health. There were also weaknesses in Western medicine’s approach to treatment. It was interesting to note that in elders’ mind, WM was more powerful, sometimes too powerful, bringing with it certain significant side effects. Furthermore, it was argued that elders’ negative perceptions of WM did not only derive from the characteristics of the treatment process itself, but also sprang from the way the doctors prescribed medicines. This phenomenon could be tracked back to the general situation of health care services in China. During interviews, elders reported that despite the dominance of WM in China, both western and Chinese medicines had been used concurrently. As discussed in early chapters, Chinese elders were used to a treatment which integrated both TCM and WM and they believed that when they had these together then, both symptoms and the roots of the disease were eradicated. In this way, elders in this study expressed their dissatisfaction of British doctors’ treatments and prescriptions, complaining that the functions of those medicines simply aimed at the symptoms of their diseases:

“In China, when I go to hospital, doctors will give you both western medicine and TCMPP. So I would think there is indeed something different.” (Interview 3, ID 3)

“But in Guangzhou (a city in China), the doctors prescribe some medicines as the supplement for your whole body. These medicines will prompt the whole body condition.” (Interview 28, ID 26)

It was clear that elders showed the lack of trust of doctors’ prescribing style as well as expressing doubts about the effectiveness of certain western medicines. Among them, painkillers and antipyretics were the two kinds of medicines about which the elders had strong negative feelings. Elders expressed their discontent about the way in which WM doctors prescribed painkillers rather than treating the actual disease (the root or the cause). Elders believed that painkillers were a temporary medical relief for the
symptoms. Some elders stubbornly refused to use painkillers and even refused to seek help from professionals because of their view that professionals prescribed painkillers too often:

“I never ever take painkiller. Even when I feel pain, I will just bear it without taking painkiller. I can bear it no matter how painful it is.” (Interview 2, ID 2)

While most elders expressed the view that they had no alternative to using painkillers, they also reported their dissatisfaction of the prescription of this type of medication:

“Just some painkillers... Doctors here seems not checking you carefully. They just give you painkiller if the patient feels painful somewhere and never do detailed checks.” (Interview 12, ID 11)

It was clear from the previous quotes that elders held extreme views on the use of painkillers. They did not consider them as a treatment and claimed painkillers might bring certain serious side effects or even conceal or mask the underlying problem or diseases.

Antipyretics were another medicine mentioned by some elders in this study; similarly to the ideas about painkillers, they were seen as unacceptable by elders as the superficial symptom control.

“I had the fever for more than three days... when I went to hospital; they prescribed some antipyretic to me. They normally prescribe antipyretic, ask you to drink more water and have more rest. I feel that the health service here is different from that in China...” (Interview 3, ID 3)

These previous quotes exemplified the typical ideas of elders to certain specific medicines. For most elders, the orientation of WM was viewed as being symptom oriented. Several participants summarised this phenomenon, expressing a general view of WM prescribed in the UK health services:

“I have diabetes and high blood pressure... GP prescribed some medicine for me to control them. Only TCM can cure the source of illness like peeing too much. Modern medicine can only control the symptom.” (Interview 7, ID 7)

“However, in the UK, the doctors here are some extent “suit the remedy to the case”. If the patient has the high blood pressure problem, the doctor just give the medicine for blood pressure; if the patient has the cholesterol problem, the doctor just give the pills for the cholesterol issue. That is the medicine only for the symptom. Do you understand what I mean? That is if you have headache, the medicine is just for headache and if your leg is painful, there is only the pills for the leg. The medicine is only for the place where you have pain.” (Interview 28, ID 26)

It was clear from these two excerpts that elders still held a stereotype of western medicines. Moreover, elders did not only relate their feeling of antipathy towards such
medicines to the limitations of drugs themselves, but linked this with WM practitioners. Elders proposed that the ineffectiveness of such prescriptions and the way in which Western practitioners approached treatment, when compared with China, often led to criticisms from the elders:

“I feel that the doctors are really cautious to give out medicine. Their prescriptions are quite simple, not like in China. We normally get examined in more detail, and give more medicine all together. It’s not like that here.” (Interview 36, ID 32)

Here, in this elder’s mind, the doctor acted irresponsibly which affected his faith in British doctors. The interactions between professionals and elders played a particularly essential role in their appraisal of the effectiveness of WM. There was a general sense that, in the UK, when they approached health services, what they could gain in consultations about their diseases were treatments for symptoms rather than an assessment of the whole body. This kind of treatment was defined as being cured or merely symptom relief from elders’ point of view, and it was in conflict with their ultimate goal and main concern of the elders of being healthy. This was one essential factor limiting and often hindering elders’ utilisation of WM health service in the UK.

Data relating to professionals’ performance and a series of consequences produced by these interactions are interpreted in the following section.

5.3.4.3. Variation in appraisal of WM practitioners

Data analysis showed an important reason why elders were reluctant to use WM was because of the indifferent attitude of the doctors. Elders reported that they experienced neglect by WM medical practitioners.

Elders expressed various degrees of satisfaction with doctors. However, no matter how the evaluations were made, the majority of elders expressed their feelings of a lack of concern from the UK health care professionals compared with their experiences in China. This section begins with a discussion of a degree of satisfaction among different elders in this study, although even this was conditional and continues by discussing levels of dissatisfaction which ultimately shaped elders’ help seeking behaviour.
Very content

Some elders indicated that they were totally satisfied about the services offered by the UK professionals. It was noticeable that this emotion of being content should be accurately interpreted as being inclined to accept. From these elders’ perspectives, they proposed that the WM professionals had done their duty but little else:

“Anyways doctors said that my health condition is good. My GP cares for me a lot, and he said that he feels happy when he sees me… He insists that I should go (to have some checks). I always obey him. I feel that doctors are like fathers, so in fact they are for my good. Therefore I cannot disobey him.” (Interview 13, ID 12)

“The GP will post me the letter and asks me to have follow-up check. Then I will go to see my GP. My GP is very nice and treat me patiently. I am very satisfied… I am at ease as my problem is cured. But promotion of health needs to continue and it depends on me. It helps to recover the health to a good condition.” (Interview 30, ID 28)

In this situation, elders were more likely to accept the reality of the situation, which for them was a limited approach to treatment. With more investigation these elders’ confirmed their beliefs that regaining health was their own affair and it was clear that they did not expect too much and/or ask for more from the professionals to achieve their goal. They believed health promotion and restoring health relied on self management and not on professionals’ treatments. The elders expressed their satisfaction with the WM professionals but accepted the limitations of the treatment and reverted to self management and often traditional Chinese approaches.

Interestingly, the elders seemed to have more faith in professionals based or working in hospitals. During the conversation, elders always used “big” to highlight the scale of the hospital, emphasising the advanced techniques and to make a distinction with the GP clinic:

“I have my doctor in GP, and I will find him when I have a problem. If there is anything serious, he will introduce me to big hospital. I feel that doctors have good attitude towards patients. They examine you when you have a problem, if a surgery is needed, they will do a surgery. Hospital will help you.” (Interview 6, ID 6)

“The doctors in the hospital were more responsible and nicer (compared with the GPs).” (Interview 14, ID 13)

This interesting phenomenon can be traced back to the health care system in China. As there were no GP services in China and the hospital was the only service available, therefore elders were used to seeking help from the hospital directly. Furthermore, elders were also accustomed to having certain regular check-ups using various equipments before having any treatments in China. When they attended the ‘big
hospital’ in the UK, elders considered it as both a professional and effective approach to treat their health problems and made comparisons with the Chinese medical system. In this way, weighing up the similarities between hospitals in China and the UK, elders had relatively more faith in the hospitals here in the UK over the GP clinic.

“Actually these checks, such as gastroscope, in our country, China, we just go to hospital directly and that’s OK. These checks are not very complex, such as type-B ultrasonic and gastroscope. Even the CT and NMR (nuclear magnetic resonance)... I think these regular checks should not be done only in the big hospital. In the GP clinic, I think they also can do these checks. You know, in China, even those very small clinics, such as a local clinic, or local district health centre can conduct these simple checks, such as type-B ultrasonic and X-ray. They can make... these simple checks can be conducted in these small clinics. I think these things are not very complex. They are just some equipment. The small hospital is only lack of big equipment, such as NMR. It needs to go to the big hospital. That simple equipment is not very expensive. But here, the situation is different... GP cannot do... but without these checks, how can they provide treatment accurately? Big hospital seems better in this way...” (Interview 34, ID 30)

In addition, specific positive appraisals given by elders were mainly related to the Western practitioners who had some experience of Chinese approaches. From elders’ perceptions, cultural sensitivity was the key point during their interaction and communication with the practitioners. This mutual understanding made elders feel at ease when conveying their health problems and furthermore, they expressed their satisfaction with treatment as elders perceived that professionals understood the key points of their health problems they wanted to articulate:

“I won’t feel anything different (for the westerner doctors). They are all the same, though I think my family doctor is better. Although my family doctor is a foreigner (westerner), he had worked in Hong Kong before. I think he has got experience with Chinese origin people, also his skill is good; I think he is very nice. In this way I don’t need to go to the Chinese medical centre. I would suggest that westerner doctors are better than Chinese doctors.” (Interview 2, ID 2)

“It’s [Doctor Name], a Chinese offspring. We have moved here for 10 years, and always have [Doctor Name to see me]. He treats us well, very carefully. He is very careful, and pays a lot of attention on us.” (Interview 15, ID 14)

It was clear that elders were always aware of the culture background of the professionals and believed that, when sharing a similar background, mutual understanding was gained between the professionals and themselves which would make more effective treatments.
Acceptable Treatment

Some elders maintained neutrality or avoided appraising health care practitioners, indicating that they accepted the current health care situation in the UK. One female elder discussed her attitude towards British professionals twice:

“In here, when doctor makes the conclusion, I will believe him as well. However, I will find some TCM to use. I will do some optimising and compensating by myself. This kind of situation never happens in China…” (Interview 3, ID 3)

“I think if you are here, and the system is just like this, and then just let it be. If it is necessary to go big hospital, GP will surely send you there.” (Interview 11, ID 3)

Though this elder did not criticise the health service providers, it was clear that she was not satisfied with them. It could also be interpreted that these elders seemed to be saying that it was just acceptable but that they did not totally believe the WM professionals as well as the treatments provided by them. As a group of immigrants living in a host society, there might be a gradual acculturation and acceptance which has shaped these elders views and ideas. Many elders chose to give a full appreciation of the advantages of WM for the purpose of being cured. However, there was an undercurrent of a reluctant acceptance that the services were just adequate according to the standards of the UK health service. What was clearly important was that they automatically involved their own self management strategies, which as previous sections have outlined may be either complimentary or detrimental to the prescribed treatment. Their over riding goal to achieve health with or without the help of Western Medicine was evident in these data.

Unsatisfactory care

Some elders were keen to compare the merits of Chinese practitioners and health care services in China with their unsatisfactory experience of help seeking in the UK. In so doing, these elders identified a variety of complaints about practitioners in the UK, describing their attitudes and behaviours as “irresponsible”, “indifferent”, and “unprofessional”. Elders expressed their disappointment, frustration, sadness and even anger about their interactions with the practitioners:

“The health services here have serious problems. My husband had the disease- ictero-hepatitis… The doctors here seemed not knowing this (disease). Unprofessional? I don’t know, may be just not good at this kind of disease. He died after staying in the hospital for two months! … He lived in the hospital, and doctors always say there is nothing to worry about… I think the doctors here are not very good, just my opinion. My husband slept there, in the hospital, all day, and no one had ever taken care of him. It is not like that in the hospitals in Shanghai, doctors there really care for patients. If he was in Shanghai he wouldn’t have died. He just arrived last year, and then died for a disease.
That really hurt me, and I am so angry (crying)... The English doctors acknowledge this disease as a minor thing, nothing important. They never know what this really is. I don’t know why either. What’s wrong with the medical service in here? Maybe they don’t do good research on it (i.e. the one her husband had). (We sent him) To the hospital, they said how this can be a disease. They don’t know. That’s lethal. I don’t know why either. What’s wrong with the medical service in here?” (Interview 12, ID 11)

“There is one kind of injection named “anti-flu injection”. I have that injection every year. But last time, just in this year, I went somewhere to have a holiday there, and then I missed the time to have that injection... miss the time, so I lost the chance to take that injection. There is no chance. Those British doctors did not do anything about me, and they did not help me to re-arrange the time. I thought they should help me to ask whether there is some other clinic to offer the injection and let me to take it this year. But they did nothing and did not help me... The doctors’ attitudes towards patients need to change. They should focus and concern patients.” (Interview 18, ID 17)

These data obviously illustrated that some of the elders were discontented with WM practitioners, particular among those elders who had experienced problematic help seeking events. One female elder reviewed the characteristics of WM doctors’ attitude towards patients below:

“Here, the doctor does not care about it (patients’ problems). They do not concern it. Here the doctors do not take care of the patients...” (Interview 28, ID 26)

This dissatisfaction with their encounters directly resulted in a reluctance to use the health service. Rumours about poor care and experiences with health care services in the UK were widespread among certain elderly Chinese groups. One male elder summarised:

“I heard about a lot of complaints for the troubles in seeing doctor here after my arrival. Therefore I seldom see doctors here for all these years I had been here.” (Interview 36, ID 32)

The data presented so far have indicated that the degree of satisfaction with WM practitioners was influenced by elders’ expectations and the actual health services they received. Furthermore, it was noticeable that elders’ expectations were adjusted by some ideals of what health services should be offered. Data relating to elders’ ideals of health care practitioners showed that it was affected by the situation they were used to in China and this was ingrained in elders’ mind. The comparisons between the health service in China and in the UK were commonly encountered in interviews and informal conversations. Elders illustrated their concerns about health issues and attitudes about the UK health care professionals, intending to explain their reasoned but problematic help seeking behaviours in the UK which actually might act as a significant barrier for their help seeking. The interactive components are summarised in Figure 5-5 as below, showing a dynamic process when elders assessed the health service in the UK and made
decisions on whether to seek help. This figure highlights the expectations of WM service among Chinese elders was basically determined by the influence of their previous experiences in Chinese health service and the level of acceptance towards the UK health service. This expectation in elders’ mind and the actual treatment these elders had received in reality, together decided their degree of satisfaction towards the health care service in the UK.

Figure 5-5 Variation in appraisal towards practitioners

5.3.4.4. Ineffective culture related communication

The majority of elders were likely to explain and understand their health and illness issues using Chinese medical concepts rather than Western medical principles. From elders’ perceptions, it was difficult to convey their inner feelings and needs as WM doctors did not understand Chinese culture therefore could not get the problem into focus. Elders reported that they felt a lack of care, which was mainly the result of ineffective culture related communication:

“I cannot express what I want to say. I cannot communicate to the doctor... Do you understand what I say? I mean that we, Chinese people, sometimes what to express the exact feelings of our health problems and the westerners do not understand us. It’s not only the language issue. Sometimes they cannot understand the meaning. It is very difficult for my GP to understand me. For example, sometimes I feel my body goggy, listless, sore all over, or paralysis. I can’t express the clear feelings. Maybe our way of description of symptoms is different with theirs. I am not sure.” (Interview 27, ID 25)

“The state of the illness, I cannot express it clearly to the doctor. It is very difficult to describe the state of the disease. Thus I cannot let the doctor know what I want to express. This is not just the language issue, it is related to... more things. I do not know... My GP just know the very superficial meanings.” (Interview 34, ID 30)

In this situation, the ineffective communication worsened the partnership between Chinese elders and the UK practitioners. The communication between the two cultures might act as a barrier for elders’ help seeking as patients’ needs might be misunderstood
by professionals. The elders indicated that it seems more difficult to arrive at an appropriate diagnosis which was their main concern. Furthermore, it may enhance elders’ feeling of only being superficially cured by the treatment they received from health care providers. This again acted as a barrier hindering elders’ WM help seeking.

5.3.4.5. Avoiding bothering doctors unnecessarily

In the interviews, elders expressed their views of WM doctors. In general, from elders’ perception, doctors were considered as the persons who had the right and authority to prescribe the medicines for patients. However, elders did not approve of them as the ideal health service providers who were supposed to give full and useful health related information which may treat the whole body and promote the health of patients. In this section, the previous unsatisfied help seeking experiences are presented initially. Because of these experiences, elders reported their unwillingness to bother doctors. This “avoiding bothering doctors unnecessarily” is then discussed.

Elders reported that when compared with the ready availability of medicines in China, in the UK, the supply of medicine was disciplined and strictly controlled. A consequence of this was that one major purpose of seeing a doctor was for getting medicines.

“I went to my doctor. He gave me some medicine, but I don’t know what it does.” (Interview 6, ID 6)

“When finishing the diagnosis, then get the tablets. That is it.” (Interview 31, ID 4)

Furthermore, as prescription only medicines were restricted and could only be sold or supplied by professionals in the UK, many elders stated that sometimes they were forced to see doctor because of the medicines:

“The purpose for me to go to the clinic is to get some medicines... If I need, I go there and tell him. Then he gives the medicine for me...I need the antibiotics from the doctor. Antibiotics are prescribed by doctor, so I need to see doctor.” (Interview 30, ID 28)

These excerpts captured the elders’ view of the role of doctors. Besides prescribing the medicines, doctors were reported as being “not very helpful”, which was exemplified through a lack of active check-ups or no information provision.

Some elders argued that they might not be taken seriously enough because doctors were not willing to help them do the body check when seeking help:
“How can I depend on doctor? Here the GP do not want to do the whole body regular check for us. GP will ask you what kind of problem you have or where you feel uncomfortable. If you are OK, without problem, they will tell you that there is no need to do any check. For example, if your nose has some problem, and you want it to be checked, then the doctor just has a look and prescribes some pills. I feel the doctor do not want to do check for us. I do not know why.” (Interview 35, ID 31)

“Here, if the patient mentioned something, by himself, then the doctor may help him to check. If the patient doesn’t mention, doctor will not do the check.” (Interview 36, ID 32)

It was clear that from elders’ perception, the consultations and treatments provided by professionals were too abrupt. The integration of this new analysis into the point of “only getting some medicines” might suggest that elders raised their distrust with WM doctors and had a tendency of self management to gain their main objective of being healthy rather than seeking help from professionals.

Besides the language barriers, many elders illustrated another major communication problem. Elders believed that doctors did not tell them as much about their condition as they would have liked.

“The doctors here do not tell you the reason or the impacts of these problems. Meanwhile, the doctors do not tell you the side effect of the medicine or how you can recover the side effect. They seem do not care about these issues… Here the doctor did not say anything (after being checked heart). The doctor here did not give me the report of the result… Where should I go and who should I ask? I have not received any report.” (Interview 28, ID 26)

“And after he diagnoses, then it is like that. I do not ask doctor for detail… Then I go back home. From whom (I can get more information)? I do not know…” (Interview 31, ID 4)

What was important to note in these quotes was the fact that elders believed that they did not gain proper health care. Further information was explored to illustrate the reasons why the interactions went wrong from elders’ perspective. Besides the barriers of language and culture related communication, elders also described that being snubbed by practitioners’ activities, including their shortage of time, simple and perfunctory answers, caused elders to feel rushed, pressured and unable to ask certain necessary and important questions.

“Actually, every time I go to see my GP, the conversation with my GP is always very brief…just use some simple words. That’s it…” (Interview 30, ID 28)

“He (GP) does not tell me anything actively. Generally, I should ask him something first, then he answers me… No clear. Just very few words… the answer is always very short. Seems not very patient… I ask, he answers in one sentence… not clear… But the doctor usually answers very briefly, some simple words… If you go to see doctor, you
must ask questions actively. Unless you ask first, the doctor does not tell you anything. Even asking some questions, the doctor’s answers are still very brief, very few words… He just briefly answers what I ask, no more information…The doctor is very busy, I think…” (Interview 37, ID 33)

It was clear that these comments about the negative effects of practitioners’ communication and practices had a major harmful impact on elders help seeking. Though elders sought excuses for the doctors’ impatient attitude and absolved them of any responsibility for their inappropriate supply of information, the consequence of this phenomenon was that elders would lessen certain necessary communications with doctors and the quality of the services would get worse and worse. One female elder simply summarised her viewpoint of help seeking, emphasising doctors’ impatient attitude in her impression and the trepidation in seeing the doctor:

“I won’t go in normal time… I only see doctor when I feel uncomfortable. It’s is too troublesome to see doctor too often, I can’t do that… I do not want to bother the doctor. If I see doctors whenever I have any minor problem, they will feel impatient when they see me. Just deal with it myself.” (Interview 2, ID 2)

In this situation, the elder gave a strong message that she should not trouble doctors. It is not surprising that this acted as a barrier to the treatment as well as the help seeking both for patients and professionals. In addition, because of the ineffective communication between elders and practitioners (integrated with previous quotes), it was apparent that even after seeking help from professionals, elders were still lacking in correct or appropriate knowledge about their health.

One male participant, who was a TCM doctor working in China and the UK previously, summarised the viewpoints about the behaviours of WM professionals in the UK. As an insider, he pointed out the doctors’ irresponsibility and unwilling help, including no active body check and no health related information offered along with the rushed treatments. However, as a traditional Chinese medicine practitioner, the narratives of this elder revealed that self discipline was deeply rooted within him. The ultimate behaviour “not to trouble doctors as much as we can” showed that the traditional Chinese principle dominated the behaviour which made elders avoid troubling others,

“I feel the doctor here don’t do well on telling patients how to take care of themselves and how to promote health, they don’t talk much with patients. This is not good. I feel the GP doctors are very busy. They finish one patient fast and then go to the next. They are in a hurry, and want to finish treating you quickly. After the treatment, you are done, and then come the next patient. They don’t do well in this aspect. They don’t say enough. If the patient can ask something on his own, doctor will somehow answer. They answer if they can, if they cannot answer, they just finish the talk in several words... This means you as a patient should know it firstly. If you do not know it, the doctor won’t tell you
actively. It needs be requires by yourself... It is very inconsistent here to see doctor. I think they should concern what patients want. That means they need think about what patients could not consider. They should mention things first, actively...or help patient...Yes, you see, I know these things or information related to the medical issues, but most people have no knowledge about medicines. They totally rely on the doctors. So I think the professionals do badly in this issue. They only think about how to cope with patients. They do not think more... just coping with patients one by one... just something about speed... Maybe this is because there are so many patients but just few doctors. They have heavy pressure. But my opinion is... I think it is better not to trouble doctors as much as we can. To reduce their busy work... not trouble them. If the doctors want to help you or do something for you, then he will do voluntarily. If they do not want to help you or... then I do not mention again. Such as me, I think my GP is very good, I am lucky because I have a good GP. My friends told me their GP was very inpatient and every time seeing doctor, he just said two or three sentences. That's all. If there is lack of communication, most people do not understand the situation of the disease. That's a big problem.” (Interview 36, ID 32)

What was important about his quote was that it provided a clear and a common appraisal of the UK health care professionals from Chinese patients’ eyes as well as the significant feature – self discipline of Chinese people. On the one hand, from elders’ perceptions, the overwhelming and authoritative status of professionals made them to some extent hesitate in communicating and to lack the confidence to ask questions. On the other hand, given the specific characteristics of Chinese people, such as self discipline, some elders reported their unwillingness to bother the doctor if the situation did not progress to a very severe level. In addition, it may suggest that Chinese elders thought that professionals were not likely to help; however, doctors might think there was no more information needed by these patients. In this way, the situation became a vicious circle which acted as an obstacle for elders’ help seeking as well as effective service delivery, even when they had overcome the many other barriers and had sought help.

5.3.4.6. Passive dependency upon doctors

As mentioned previously, many elders had a lack of trust in GPs because of the perceived lack of care and differing treatment approach. However, some elders reported that they apparently relied on these doctors to some extent. Though it seemed a conflict in context, to further analysis, it was not difficult to identify that in fact, elders were talking about symptom control and “cure” rather than health and wellbeing:

“I have already had these problems then the doctor will cope with them. What the reasons are and whether I know about them, I think it does not matter... Doctors will try to control me in a safe range. If I can be kept in this safe range by taking medicine, I just keep taking it. When the medicine is not able to do so, doctors will tell me and treat
me again... My doctor is clear about my situation, so there is no problem.” (Interview 6, ID 6)

What was important in this particular situation was that elders sought help only because something had already gone wrong. Their reliance on professionals was limited to the occasions of certain serious health problems and elders only wanted to get their ailments cured. As one female elder said:

“When getting older, people should understand the importance of health promotion. Only in this way, the health condition will get better and better. Everyone knows his/her own body than anyone else, not doctor... doctors only helping some acute situation...” (Interview 30, ID 28)

In this way, elders did not necessarily expect a lot, or to get well, but rather expected to be treated or cured of the symptoms. Help seeking behaviours were generally described as being passive in nature. It did not mean that elders were indifferent to their health problems; on the contrary their main concern was still being healthy. Elders reported that the function of WM doctors was to cure symptoms but indicated that being healthy could not be achieved through contact with these practitioners. It is clear that they had a strong idea that doctors were for treatment when problems were either ongoing or worsening and was out of their control and beyond their self management skills. This led to a passive and somewhat reluctant dependence on doctors. Field notes relating to elders’ non-verbal behaviour when describing their perceptions of dependency upon doctors reinforced what they were saying and also the interpretation of the data. When describing passive dependency upon the practitioners, especially the GPs, the majority of elders quoted above used negative non-verbal gestures, such as head shaking, helplessness in the eyes, frowning, or wry smiles. This body language and gestures were interpreted as elders being unhappy with, and uncomfortable about, what they were revealing. The following is an example from a field note made in relation to elders’ passively relying on GPs:

“This elder showed her helplessness; and unhappy, uneasy or uncomfortable feelings when forced to self manage to gain her main concern of being healthy. On the one hand, she realised the functions of the professionals; on the other hand, she also recognised that wellness could not be passed to WM doctors... She appeared to be content with what the GP had done apparently; however, she actually did not pin her hope on the professionals.” (Field note – interview 30)
5.3.4.7. Summary: Category 4: Being cured

Being cured was the term summarised by elders, describing the outcome of treatment from health care services in the UK. It was the fourth and final key category of being healthy, exemplifying elders’ attitudes about health care services and WM practitioners in the UK which acted as a major element affecting their help seeking behaviour. Elders were repeatedly moving between two worlds in their appraisal of health care services. The majority of elders in this study had faith in WM in certain circumstances and for certain problems and in general they felt that the WM services provided by the professionals were acceptable in these situations. However, a number of negative factors were identified which affected their decision-making and help seeking behaviours. The Chinese cultural tradition, such as self identities and self discipline, the different social experiences in the setting of the UK, as well as the ambivalence about the duties and responsibilities towards their health events between both themselves and professionals were perceived as the main factors that comprehensively impacted elders’ cognitions of WM health services. These were significant barriers to help seeking.
Chapter 6 Presentation and discussion of the emerging theory of being healthy

This chapter proposes and discusses the theory that emerged in this study on a theoretical level and compares it with existing empirical evidence.

6.1. Introduction

In this study the phenomenon of interest was Chinese elders’ perceptions of help seeking in the UK. The substantive theory of being healthy explains elders’ main concerns about their health and their overriding tendency to remain in their traditional Chinese world rather than seeking help in the western world.

The theory of being healthy proposed here should be regarded as emergent. The initial theoretical framework was constructed inductively from the data provided by Chinese elders who participated in this study. Categories inductively generated from the analysis were used to construct a theoretical formulation that captured the essential features of Chinese elders’ perceptions of help seeking in the UK and described how elders behaved to maintain and improve health in everyday life. The result of the analysis was a core category, being healthy, comprising of four key categories containing concepts and themes which embodied the component elements that described elders’ perceptions of how to maintain healthy status while balancing their traditional Chinese beliefs and western influences.

The construction of the proposed theory will be described in two phases in the following sections. First, the elements will be identified and defined; second, the relationships among these variables will be postulated and then presented in a narrative form as a whole story.

6.2. Elements of theoretical framework

6.2.1. Theoretical definition

As recommended, theoretical definition may provide the theorist with a way of expressing the richness of the concept within the theory and the means for classifying a phenomenon as they are used in the context of the proposed theory (Walker and Avant 2004). The core category, being healthy, comprised four sub categories, containing concepts and themes which embodied the component elements that represented elders’
perceptions of being healthy whether they are experiencing illness or not. These key elements were identified as representing Chinese elders’ perceptions of being healthy, which were synthesised in Figure 5-4 (on page 137). These theoretical definitions will be used to represent the theoretical concepts when discussing the proposed theory of being healthy.

6.2.2. Definitions of theoretical concepts

**Being healthy**
Being healthy was used to indicate the way in which Chinese elders maintained a stable psychological state in their everyday life. It included many different aspects in relation to their health, especially when they faced illness and experienced interactions with the WM health care services. Being healthy was an individual cognition, impacted by elders’ beliefs of their own principles of health and these beliefs led to distinctive health seeking behaviours. Being healthy was exemplified by a desire in individuals to resolve the physical health problems they experienced and involved adjusting their lifestyle based on their own perceptions of healthy restoring strategies so that they could restore themselves to a perceived state of health. Also, being healthy drew a distinction with the concept of being cured. This distinction was mainly created by elders’ understanding of TCM and WM. From Chinese elders’ perception, they were able to gain treatment for both symptoms and the root cause of illness via TCM, although the function of WM was reported as symptom remission only.

**Self management**
Being healthy involved a significant degree of self management. Self management was defined as personal health maintenance among elders in this study. Elders took personal responsibility for activities and strategies which had the intention of improving or restoring health and treating or preventing minor ailments. Based on their own understanding of health related events and health care problems, elders made personal health decisions which on the surface, helped to maintain and improve physical fitness and sustain a stable psychological state which was extremely important to them. Chinese elders showed a heightened consciousness about their health, sometimes to extremes and they strongly believed that no one else could comprehend the nature of their body better than they could themselves. Being healthy was their own affair and they indicated that they wanted to be in control of their own health and treatment.
Normalising/minimising to be healthy

Part of the desire to be healthy and maintain a stable psychological state was seen in the way that most elders reported experiencing an illness, sometimes a major and ongoing problem but almost all evaluated themselves as normal by denying negative disease related events and symptoms. Often they provided other physiological explanations for the signs and symptoms of ongoing health problems in particular the natural process of aging. This view of life was defined as minimising or normalising signs and symptoms of illness or ongoing health problems. Minimising involved downplaying the severity of symptoms or diseases and the impact these ailments had on their lives. Normalising included declarations that they were as healthy as they had been in the past, just a little bit older and less able. Normalizing and minimizing were often used together when elders stated that life was still normal.

Access to health services

In the UK basic health services are generally accessible. Access to health services in this study was focused on Chinese elders’ perceptions of the factors that impacted on their initial help seeking approach. Family’s comments as well as the service delivery problems in health services were two main elements that elders were likely to consider. The role of family was reported as both promoting and hindering the help seeking process. Other institutional factors such as long waiting time, and language barriers were also considerations in whether or not the elders sought help.

Being cured

The term “cured” in the context of this study, meant that the symptoms of the disease were controlled but the root causes were not eradicated. From the elders’ point of view they reported that they had experienced concern, dissatisfaction, distrust and fear of WM services, particularly their interactions with professionals. Concern about WM professionals was one of the major indices for elders in making decisions about seeking help. Failure to gain holistic treatment from professionals caused elders’ much dissatisfaction and distrust. This discontent towards professional health care was also pronounced with regard to western medicines prescribed by those professionals. The strength and invasive nature made elders feel anxious about long term prescriptions. Furthermore, compared with the situation in China where doctors prescribed TCM as a way to treat the side effects of western medicines, elders showed their negative view
towards the British WM professionals and those medicines. In addition, lack of useful health related information from doctors also led to elders’ dissatisfaction and distrust as they felt ill informed and unable to understand their treatment adequately. From elders’ perceptions, the authoritative and professional identity of WM practitioners made elders reluctant to seek necessary assistance further. Although elders acknowledged the effectiveness of WM for certain disease, they still believed that the treatment only cured the symptoms but not the roots of the disease. In addition, the lack of communication with the professionals strengthened elders’ belief that the main function of WM practitioners was prescribing the medicines for their symptom remission. In this way, the result of this help seeking process was defined as being cured rather than being healthy which obviously acted as a barrier for elders’ help seeking for their health problems.

6.3. Relationships between the elements

As Glaser and Strauss (1967) stated, one of the aims of Grounded Theory was to describe and explain concepts and their relationships. According to Glaser’s (1978 and 1992) classification, substantive Grounded Theory consisted of hypothetical generalisations which explained certain phenomena and proposed relationships. The nature of the relationships between the elements of the theory of being healthy were conceived as dynamic, cyclical and interconnected. Rather than propose causal relations, the theory of being healthy sought to clarify and explain concepts and their relationships in a narrative form as below.

Being healthy was really very important for Chinese elders. Elders reported that their main concern during their advancing age was related to health issues, by governing and controlling any activities on an everyday basis in order to maintain and improve health. It was influenced strongly by a variety of personal and external factors. With regard to the factors which were internal to the elders, self management was the most preferred approach for Chinese elders to deal with health issues. They had a wide range of self management strategies. Chinese elders paid attention to their everyday lifestyle, including diet, sleep and exercise. In addition, psychological issues were also an important concern for Chinese elders as they played a major role which influenced their physical health. When they detected health problems, elders actively adopted further measures to handle them. Elders believed that they had abilities to manage these
“minor” symptoms or diseases (from their perception) and demonstrated how they successfully managed their ailments using various strategies. For example, elders often chose certain foods or herbal supplements as a traditional diet therapy in order to remedy their ailments. TCM materials and some home remedies were other important sources for elders’ self management. They brought these medicines from China and/or bought them in Chinese shops in the UK. Rather than consulting with professionals, elders used these medicines at home to handle their ailments in terms of their previous experiences and their own general understandings.

Another part of self management was normalising and minimising. When experiencing difficulties from many ailments, elders had a tendency to deny the problems and created a sense of normality. They believed that being anxiety free was essential in preventing “psychological nervousness” which was in turn good for their physical health. Elders found reasons and excuses to explain their symptoms in order to claim they were in a healthy state often attributing these to a lack of rest or the general, but normal process of aging. Furthermore, elders were likely to attribute all the symptoms to minor illnesses, such as the common cold. They wanted to minimise the problems and tried to alleviate these symptoms themselves. In practical terms the variety of self management strategies meant that this group of elders preferred living in the familiar Chinese world, avoiding western medicine treatments which may cause them distress. The motivation for them to undertake these activities was to keep themselves healthy and convey that they were healthy thereby avoiding the psychological distress associated with worrying about ongoing conditions. But there were a lot of problems associated with minimising and normalising certain symptoms. The consequences of self management were sometimes quite worrying. The delayed treatment may result in serious or potentially fatal health problems being ignored which could ultimately put these elders in danger.

When elders detected that they had problems which were out of their control, then they had to seek help from professionals and have western medicinal treatment. In this stage, elders went through complicated processes which were both influenced by their personal factors as well as external factors. Before they went to health services, in the “big hospital”, elders experienced difficulties which were not only with symptom recognition, but also the problems of where they should go. When they had to be there (in hospital) it was because they could not control their symptoms and they judged the situation to be serious. Otherwise they tried to continually carry out self management.
Usually, elders preferred to go to TCM clinics first. From elders’ perception, TCM treated patients in a holistic way which was good at eliminating the root cause of the disease. TCM herbals were recognised as natural materials with no side effects from elders’ point of view, as opposed to the strong and often persistent side effects of western medicines. However, there were a number of problems when they accessed TCM services in the UK, including the high cost and the poor quality of the TCM services. So they sometimes had to abandon their desire to access TCM services and usually ended up in WM services. This was often a last option. It was notable that when they decided to seek help from WM, they perceived that they had very severe health problems, such as heart attacks, surgical problems or acute problems which may need surgery. They were quite happy and felt reassured to go to WM when they had acute symptoms because elders believed that the WM services had the ability to treat these diseases and cure them.

The problem here was that when they decided to seek help from WM, they usually presented very late. It depended on their recognition of symptoms and the perceived severity. This is a crucial point in that their variable levels of self management meant that they could mask potentially cardinal symptoms of major illnesses. It is clear that their self control strategies may be very dangerous to their long term health.

Besides the recognition of symptoms, another major factor which impacted elders’ decision of seeking help from WM service was their family’s influence. Family shared the decision making involved in seeking health services with Chinese elders and provided assistance for elders’ help seeking, such as transportation and interpretation when they approached WM services. However, sometimes, family also affected the help seeking process negatively. For example, family members sometimes provided incorrect information to the elders or tried to comfort the elders by minimising health problems. In this way, the family may act as another barrier to elders’ help seeking.

When elders finally got to WM services, there were a number of problems, such as long waiting times, communication with the doctors, and cultural interpretation of their health problems (i.e. elders thought that WM doctors did not understand the type of symptoms from a Chinese point of view). Because of the ineffective cultural related communication, the information elders received from the professionals was quite
limited and far from their ideal. Furthermore, elders thought that the main function of seeing a doctor was to receive medicines for curing their symptoms and unfortunately many consultations often confirmed this.

Elders perceived that they only get their symptoms cured rather than being treated holistically. Compared to the situation in China, besides some practical advantages when seeking medical services (e.g. very short waiting time, no referral system), elders paid much attention to the treatment they gained from professionals. In China, doctors checked the whole body and looked for the root cause of the illness for the patients and prescribed TCM as well as western medicines which sought to eliminate both symptoms and the root cause. Elders believed that in China they would get much better services than in the UK. When elders tried to contact health care services, they generally went to seek help from the GPs. Elders were not happy with general practice doctors, because they felt that they did not get the right type of services. They felt that their GPs treated them badly because the treatments were not holistic. The elders’ big concern was getting rid of the root cause of the disease, a desire based on their experience of treatment in China.

Therefore, this very remarkable contrast between the situations in China and in the UK made Chinese elders unlikely to seek help from WM service because they perceived it did not treat them holistically. They described their dissatisfaction with this type of treatment provided by WM professionals in the UK and their fear of the side effects of western medicines.

Another main reason that Chinese elders felt that doctors were concerned with curing symptoms was because of a lack of health information provided by these doctors. Elders complained that the WM professionals seemed too busy to give the necessary advice relating to their health problems. Doctors did not discuss the cause of the illness from a holistic perspective which was confusing and sometime disorienting to the elderly patients. In the same vein the elders were also surprised and concerned that they were not given any health promotion advice. So, the combination of a brief diagnosis and their perception that the tablets were a “cure” for symptoms along with the lack of explanation confirmed their beliefs.
In this way, elders believed that the WM service got their symptoms cured. When they thought they were cured (according to their own judgement), they went back to their own Chinese world to carry on and continue with their self management strategies as quickly as they could. Although the WM approach would expect people to continue to have follow-up treatment, the data show clearly that elders did not actively follow advice after help seeking. Elders did not want to stay in the western world using WM service. Being cured was the way elders could maintain a perceived healthy state as they went back to normal; and not being cured meant they were not healthy. After they returned from the WM world and resumed self management in their own Chinese world, elders gained the peaceful, psychologically more stable life free from the anxiety they sought to avoid at all times. Another typical example was that all routine checks (non diagnostic) were acceptable for elders, but if the checks were for illness, elders reported their reluctance to attend. This was because they did not want to be diagnosed with an illness or disease which would cause anxiety to them. This was an important process in understanding elders help seeking behaviour and acknowledges the reason why elders did not want to see doctors.

In sum, Chinese elders preferred self management in promoting their health status and also in treating minor (and sometimes major) health related problems. On the one hand, elders reported that health issues were their own private affair and needed to be managed in their daily life. Thus, only the elders individually have the ability to take care of themselves. To some degree this was confirmed by the elders in the attitude and approach of WM practitioners, who because they do not offer holistic advice and/or health promotion information confirmed the elders’ notion that they have to look after themselves. Other factors were that elders faced many barriers when they sought help in the UK, including linguist, cultural, and social ones. These were all barriers preventing Chinese elders from seeking help from the WM service.

As below Figure 6-1 diagrammatically represents the proposed relationships as a theoretical schema:
Figure 6-1 Dynamic process of Chinese elder’s help seeking

Chinese World

Being Healthy

Self management
Normalising/Minimising
Being anxiety free

The UK World

UK Medicine

Being Cured

- Self cognition – perceived severity
- Family’s influences
- Practical difficulty
- Do not get healthy, just get treatment
- Do not get treated as a whole person
- Inadequate information
6.4. Discussion and comparison with existing knowledge and evidence

6.4.1. Introduction

In Grounded Theory a comparative literature review is driven by the theory that has emerged from the study and the aim of the review is to locate the literature within the current body of knowledge (Glaser and Strauss 1967; Glaser 1978; Glaser 1992b). This has the advantage of enabling a direct and focused comparison with the emergent theory. This chapter presents a comparative literature review by using relevance according to perceived areas of the theory as the logical filter to address the similarities and differences with the existing evidence. Following this approach, the review concentrates on exploring the comparison and support from the existing knowledge with the emergent theory.

Given the extensive literature from these approaches, the comparative literature review in this study concentrated on exploring the main areas of perceived relevance and direct comparison with the emergent theory. The current theory of help seeking behaviour among Chinese elders illustrated a more general process when elders faced perceived (or not) health related problems and drew out the systematic approaches of their decision making which were impacted by various facilitators or hindrances. In this way, two main themes emerged from the theory generated in this study: the general process of Chinese people’s help seeking overseas as well as the core category and its major themes within the unique life principles among Chinese elders have been selected in the comparison with the existing literature. It is intended to add density to the theory of being healthy through a comparison of these relevant existing works.

The emergent theory of being healthy demonstrated how Chinese elders resolved their main concern of health issues during daily life as well as when facing certain health problems in the setting of the UK. The basic social processes and core category of being healthy showed that Chinese elders utilised their own strengths and abilities and took social conditions into account in order to gain and maintain their health status. Guided by the continually refined focus, this section begins firstly by outlining some conceptual elaborations relevant to the theory in the current picture, and secondly by highlighting the literature around ethnic Chinese health seeking behaviour in general. Meanwhile, thorough and rigorous literature searches are also undertaken to identify multiple and complex connections between the concepts, elements and categories of the theory in this
present study and existing knowledge. The literature included in this secondary review are summarised in a narrative review table in Appendix 6-1.

6.4.2. Representation of being healthy

The concept of health permeates most work linking to health related aspects but has many definitions. In 1948, WHO defined health as being “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO 2006). In contrast and in relation to Chinese medicine, health is defined as the free flow of Qi and the dynamic balance of sufficient “Yin” and “Yang”, terms that have mental and spiritual meanings as well as physical ones for Chinese people (Kaptchuk 2000). It is clear to see from the start that there are significant differences in the understanding of the definition of health.

The core category in this study, Being Healthy, and its four key categories, can be linked through the concepts, including traditional Chinese representation of health and illness as well as certain Chinese self disciplines. This concept was in the context of the integration of many areas, such as social, psychological, and cultural variables.

According to the findings in this study, the concepts of health in the context of elders’ everyday life and in the situation of illness are differentiated. Usually, Chinese elders considered health as the balance and harmony of their own internal body as well as the accordance between them and the social, natural and even supernatural factors. When there are certain diseases, the representation of health from elders’ point of view was the asymptomatic situation and the root cause elimination.

Of particular relevance are other studies also conducted in the setting of the UK as the cognitions of health and related behaviours do not simply link to people themselves but the social context. Evidence related to the meaning of health among Chinese people in the UK spanning the last 10 years or more were identified. Jovchelovitch and Gervais (1999) and Green and colleagues (2006) described similar representations of health among Chinese people. These two studies reported that Chinese people shared a common representational system with respect to health and illness, highlighting the cognitions of balance and harmony to judge health and illness. The findings of these qualitative research papers showed that Chinese people were concerned about every
aspect of their everyday life from a holistic perspective, including the individual, the social, the natural and the supernatural environments which were seen as crucial elements linked to health and illness, explaining the aetiology of disease and the prevention and cure of ill-health.

These findings were very similar to this present study but were not as detailed. For example, Jovchelovitch and Gervais (1999) and Green et al. (2006) only mentioned the food rituals in Chinese people’s daily life, demonstrating that dietary management was an important way to self maintain bodily health and cure minor problems. These findings were congruent with the results of this present study in general. However, there was no articulation of how Chinese people behaved in order to gain the “harmony” or “balance” referred to in their studies. Within the current study, the type of food, the manner of eating as well as “diet as a cure” were conceptualised as “healthy diet for wellness”. These ideas, together with dynamic changes in different circumstances confirmed how Chinese people undertook activities to manage their everyday diet to gain a well-balanced meal in order to maintain their health. Furthermore, all the important themes addressed in the interviews were deductively derived by the researchers, such as the distinction between TCM and WM. The deductive approach to understanding the representations of health and illness among Chinese people yielded interesting conceptual frameworks. However, what it was unable to clearly uncover was the detailed process of how those people actually experienced their health related events and the help seeking process.

In contrast, this present research commenced with an exploration of the main concerns about health and help seeking among Chinese elders. The emergent theory was able to go beyond the concepts to inductively reveal the detailed basic social process of how to be healthy. It provided a fully articulated context in the data which emerged through elders’ description of everyday experiences related to health. It was based on proximity and time and enabled readers to understand how Chinese people were self promoting their health.

In addition, it should be noted that though the target population in these studies were all Chinese people living in the UK, they were from different age groups, such as two different age groups (20-27 and 37-44 years old) in the study conducted by Jovchelovitch and Gervais (1999), elderly Chinese people (60 and over) in this present
study. They also differed in occupation (professionals and lay persons in Jovchelovitch and Gervais’ (1999) study versus lay persons in Green et al.’s (2006) study and the present study). Gender was another characteristic here. Green et al. (2006) only investigated Chinese women. However, though the bibliographic features were diverse, including age, gender, education and degrees of acculturation, the social representations of health and illness among the Chinese community in England was quite similar. Harmony and balance were the key words used by Chinese people to describe the wellness.

In the US, Ma (1999) also supported the findings about the representation of health and illness. Ma (1999) investigated the utilisation of traditional and western health services by American Chinese (Ma 1999). Qualitative ethnographic methods including participant-observation, face-to-face interview and case study were used to collect data from 75 participants and the findings showed that the concepts of holistic health and “Yin” and “Yang” balance appeared to dominate the perceptions of health and illness among the majority of informants. Consistent with this study, when talking about health and illness, Ma (1999) reported that the majority of participants defined themselves as healthy persons because they did not have terminal or acute diseases. These participants did not judge their minor symptoms as illness and all of them believed that discomfort and chronic pain were associated with the natural aging process. However, this current study added depth and breadth specifically relating to the details of describing health or illness. In terms of decision making, identity of older age was a significant excuse for Chinese elders’ not seeking help. The reason why elders were likely to make this attribution was that it was a necessary way to keep themselves in a psychologically peaceful state. Thus being anxiety free helped to achieve their balance and harmony. By so doing, their ultimate goal of being healthy was gained. This link formed one of the major processes in how elders’ psychological changes influenced their help seeking behaviours. It was clear that the more peaceful and undisturbed the mind, the healthier the physical situation and consequently there was an unwillingness to seek help.

As discussed, these previous identified studies reported some similar findings, emphasising that keeping balance inside their body as well as maintaining harmony with their surroundings, such as social and natural environments, were quite important for their health. However, in contrast with these studies, one Grounded Theory study of health-related events which was conducted in the US emphasised that supernatural
elements were a significant factor for Taiwanese elders’ gaining health. Using the theoretical framework of Symbolic Interactionism, Chen (1996) conducted in-depth interviews with 21 Taiwanese elders to explore their views of illness prevention and health promotion. In Chen’s (1996) study, the issue of traditional Chinese principles strongly influenced these elders’ approaches of maintaining health. The author presented a theory, “Conformity with Nature”, demonstrating that Taiwanese elders had a unique way of achieving health and wellness which was the process of knowing nature and trying to modify oneself to best fit nature’s flow (Chen 1996). Three interrelated sub themes, harmonizing with the environment, following bliss, and listening to heaven, were identified, and facilitated an understanding of the Chinese way of getting healthy (see Figure 6-2 below).

Figure 6-2 Relationships among core variable, categories, and their complementary properties

Adapted from: (Chen 1996)

As shown in Figure 6-2, the first way of Chinese elders’ maintaining health was through being in balance with nature. Being open and interacting with nature, adjusting oneself to harmonize with nature, as well as generating a lifestyle integrated with American values were three main approaches. “Following bliss” was the second way of Chinese elders’ being healthy. In Chen’s (1996) work, she explained that elders attempted to do things that made them happy whilst avoiding unhappy situations. Keeping optimistic and having self respect, as well as re-creating a new life after retirement, were key points for elders finding ideal happiness in life. By so doing, elders believed that having a good psychological state made them healthy physically. The last category, listening to
heaven, presented a connection with the divine among elders’ and the spiritual world was considered as the ultimate goal of well-being.

Despite the fact that all participants were from Taiwan, the description of being healthy in Chen’s (1996) work shares many similarities when compared with the theory presented in this study. Conformity with nature as the main core in Chen’s theory could be considered as another version of keeping harmony or balance entirely (such as people, society, and natural environment), and every detail in daily life (routines in lifestyle). Only one point differed with the findings of this present study and this was that the emphasis on “supreme nature” found in Chen’s (1996) work. Although Chinese elders participating in this study also mentioned spiritual issues and how they impacted on their physical well-being, most of them referred these spiritual issues to emotional adjustment (being anxiety free, avoiding emotional fluctuation) rather than a religious stance. The data in this current study showed that they did not emphasise the power of a supreme nature or being. The target populations in these two studies may explain this difference since people from Taiwan were reported as being more enthusiastic and spiritual about religion than people from mainland China (Chen 2007). This slight distinction may lead to the different health related behaviours between Chinese elders and Taiwanese elders. Though sharing similar traditional Chinese notions, different thinking patterns of managing health issues may lead to divergent behavioural patterns between these two groups. However, since no further research on help seeking behaviour of those Taiwanese elders was conducted in Chen’s (1996) study (i.e. the aim was to investigate beliefs and behaviours regarding health promotion and illness prevention rather than the dynamic health behaviours) how the thought patterns influencing Taiwanese elders’ health related behaviours, particular help seeking behaviour remained unknown. On the contrary, the theory of being healthy in this current study presented a dynamic process which comprehensively included Chinese elders’ behavioural pattern when facing health related events.

In summary, despite the depth and breadth of evidence supporting the uniqueness and importance of the traditional notions of health among Chinese people, using the terms “harmony” and “balance”, few identified studies specifically related this view with the process of help seeking behaviour. Structured models or concepts without densely empirical evidence are likely to be esoteric and disconnected from the reality of practice. In contrast, the researcher in this current study added to the body of literature solid
evidence on how the representation of health and illness impacted Chinese elders’ health related behaviours. In the following section, the literature review relating to the process of help seeking will be discussed with its facilitators and barriers.

6.4.3. Help seeking behaviour among overseas Chinese

There are an abundance of studies on the topic of health seeking behaviour, demonstrating the complexity of influences on an individual’s behaviour when facing health related events at a given time and place (MacKian 2001). After reviewing a number of papers exploring what influenced people to behave differently in relation to their health, MacKian (2001) divided these works into two types, firstly studies which emphasised the end point (health care seeking behaviour) and secondly those which stressed the process (help seeking behaviour). The former focused on the barriers or determinants of utilisation of health services and the pathways to certain care models. The latter looked in a general way, rooted in actors’ everyday life as well as health care seeking, drawing out psychological decision-making during this whole process (MacKian 2001). This present work was a Grounded Theory study which emphasised the social process with certain abstract problems related to Chinese elders’ health behaviours. Thus, it did not only examine the barriers to the use of health service, but also investigated and highlighted elders’ psychological transformation when facing certain health related decision-making. In this way, existing evidence regarding both the end point of help seeking and the process of general health behaviours among overseas Chinese people was identified in this part of the literature review. Furthermore, according to the health behaviour approach, the secondary literature review about Chinese immigrants’ health seeking behaviour is presented under the major concepts identified in this current study.

Self management and normalising/minimising

Self management and normalising/minimising were the first two of the four main sub-core categories that had emerged from this study. Chinese elders reported their preference for self care when facing any health issues, before, during and after seeking medical help. Practically, they primarily relied on subjective judgements to guide their activities, such as their recognition of health problems, their previous experiences, and their knowledge of health promotion. Psychologically, elders were likely to keep their
mind in a peaceful state which, from their understanding, improved their physical health situation. This was also an important part of self care from elders’ perception.

Ma (1999) described similar strategies of managing health events in American Chinese people. There was a high rate of self-treatment and home remedies (balanced diets and other alternative medicines) when these Chinese immigrants faced health problems. Another more recent study (Pang et al. 2003) also undertaken in the US came to similar conclusions. In their study of Chinese elders’ approaches to help seeking, the focus was on exploring the influence of family networks during the process of using health resources (Pang et al. 2003). In addition, qualitative analysis of focus group interviews with 25 Chinese elders reported a pathway to health care. Elders took care of themselves first. They actively employed various measures to self manage according to their experiences and knowledge. Individuals determined what their health problem was by searching for information from various sources, including cultural, interpersonal, scientific, folk, and religious sources. Then they judged and linked the information with their own physical experience and tried self-care initially. These findings also echoed a Grounded Theory study carried out by King et al. (2007) in Canada. Semi-structured interviews were conducted among ten Chinese males and five Chinese females who self-identified as having cardiovascular disease (CVD) and aimed to “explain how ethnocultural affiliation and gender influenced the process that cardiac patients go through when faced with making behaviour changes associated with reducing their CVD risk” (King et al. 2007, p 804). King and her colleagues (2007) stated that the most ethno culturally salient findings were the manner in which elders took control over their health problems themselves. To explain further, Chinese elders were extremely diligent in seeking information, obtaining care, and learning about CVD. Though the target population was CVD patients, this identification of taking control of their disease could be compared with the major theme identified in Ma’s (1999) and Pang et al.’s (2003) studies as well as the current study – self management during the help seeking process among Chinese elders. Furthermore, these Chinese people with CVD were found to actively and meticulously seek resources to assist them to manage their problems. This resulted in Chinese people being extraordinarily concerned about their health, consistent with the main core of the theory of being healthy, implying that Chinese people put a high premium on health regardless of what perceptions they hold and what their health situations were. Self care is one major approach utilised by Chinese elders when dealing with health problems and was also reported in two qualitative Australian studies. Kwok
and Sullivan (2007) and Hsu-Hage et al. (2001) provided further support for self care among Chinese people. These two studies both reported that when facing perceived minor illness, Chinese people had a tendency to attempt self management first before seeing doctors.

This important theme of self management identified in these research papers was highly consistent with the findings in this current study but was not as detailed and/or in as much depth. For example, self management in the current study was identified in various situations before, during and after seeking medical help whilst the latter studies did not provide comprehensive understanding of the behavioural processes in various different situations elders encountered. In addition, rather than only providing a brief explanation of how Chinese people conducted their self care in these relevant studies, the data in this present study illustrated the root reason why Chinese people preferred self management. This reason related to Chinese elders’ psychological cognitions. Chinese people believed that if they still had ability to control their health issues at home, this indicated that they were healthy. In this case, they successfully avoided seeking help in order to keep their mind at peace thereby avoiding anxiety. However this strategy also delayed their help seeking and put them at risk of potential harm. In comparison, those identified studies only stated that the result of self care among Chinese people was that they underutilised health care services. It was reported that Chinese people have relatively less check-ups or professional care when feeling ill compared with the local population (Hsu-Hage et al. 2001; Aroian et al. 2005). No identified studies commented on why Chinese people were extremely diligent in self management based on their desire to maintain a state of psychological balance or peace. This present study added important evidence and insights for understanding Chinese people’s initial help seeking behaviour.

**TCM and WM**

Chinese elders in this study engaged in both TCM and WM approaches when seeking medical help. This situation seemed quite usual in every identified study investigating Chinese people’s health related behaviour.

Similar findings were found in a study carried out in the UK by Green et al. (2006) recently. This qualitative study involved interviews with a nonclinical female population and interpreted approaches of health care seeking pathways among Chinese
women. It was an end-point focused piece of research which presented two alternative ways of health care seeking. Green et al. (2006) found that Chinese people exercised a pragmatic choice when deciding between TCM and WM. This utilisation of therapy relied on which kind of service was more accessible for Chinese people when facing health problems. Seeking alternative treatments did not necessarily represent their rejection of TCM or WM but showed the acceptance of both health care services. The results also illustrated that the use of TCM among Chinese was due in part to the belief in the therapeutic efficacy for certain conditions and diseases, such as indigestion, headaches, rheumatism, pain, lack of energy, being too hot, eye spots, and numbness. Additionally, the perceived inefficiency of WM forced individuals to seek help from TCM on occasions. The data showed even Chinese youths who were highly westernised still sought help from TCM if there was no relief from symptoms. In addition, Chinese people consulted with a GP as the first practitioner approached, explaining that TCM practitioners in England were “not that good and also there was not much choice” and they complained about the high cost of TCM. Drawing on the above pathways, British Chinese people could be seen to trust the advanced WM and had a tendency to consult Western doctors initially. Chinese people were also clearly influenced by Chinese traditions, accepting TCM as an essential approach for health promoting or supplementing WM in a pragmatic overall approach to treatment.

This present study can be compared with Green et al.’s study in relation to the pathways and models for seeking help from both Chinese and Western health care services in the UK. There were similar barriers or determinants which influenced Chinese patients’ use of WM or TCM services, such as poor quality of TCM in the UK and perceived ineffectiveness of WM. However, Green et al. (2006) only focused on these scattered elements which impacted on the end point of Chinese patients’ health care seeking. They did not describe a clear trajectory of help seeking behaviour but simply drew the conclusion that Chinese people had the tendency to consult Western practitioners initially. Furthermore, Green et al. (2006) listed the barriers under certain occasions but did not combine these elements to form a coherent process or description. Thus, the findings could not fully explain a clear, serial approach to help seeking. How those elements interacted with each other and to what extent they influenced Chinese women’s final decision of the utilisation of TCM or WM was unclear. More important, Green and her colleagues (2006) aimed to examine how Chinese migrant women resident in England engaged with Western and Chinese healthcare systems when
seeking treatment. It may be argued there was an inherent assumption that Chinese people had the intention to seek help when facing health problems. However, the data in this study revealed that Chinese elders preferred to use personal activities rather than seeking professionals’ help even when facing health problems. Thus, Green et al.’s study was lacking in the investigation of an essential process when no formal help seeking occurred.

Ma (1999) also examined the use of health care services among the American Chinese and identified much higher rates of utilization of integrated Western and traditional health services (travelling to country of origin for care) than the rates of exclusive utilization of Western or traditional Chinese treatments. One significant finding was that the simultaneous use of Western and traditional Chinese health practices were very common among Chinese immigrants in the US. The majority of the Chinese informants believed that WM was more effective for acute diseases while TCM was useful for the promotion of health and the alleviation of certain symptoms.

Further support was provided by another qualitative study conducted by Aroian and her colleagues in the US, which also only focused on the end point of health care seeking (Aroian et al. 2005). Semi-structured, open-ended face to face interviews were conducted among elders and adult children who took care of elders. The findings showed that Chinese elders generally had faith in both TCM and WM health care services, making choice based on the nature of the health problem. From their perceptions, TCM was considered best for getting to the root of disease, but slower acting and not optimal for a quick response. On the contrary, WM was more effective, but elders also feared the strength and invasive nature of the biomedical approach. In general, if TCM or WM did not yield anticipated results, elders switched and used the alternative type of health care for the same problem.

Though these studies were identified in different contexts (i.e. Ma’s (1999) study and Aroian et al.’s (2005) study were conducted in the context of the US, whilst Green et al.’s (2006) study was in the UK), their analyses illustrated that Chinese people would seek medical help, either TCM or WM or both TCM and WM, and then sought evidence to support the hypothesis. Compared with the findings in this current study, all these processes fitted well with the situation of involvement in both TCM and WM among Chinese elders. However, a limitation was a failure to take account of the
decision making that determined whether or not to seek any type of medical help when facing ailments.

Only one the identified study reported a different situation related to the use of WM and TCM among Chinese people. Chappell and Davidlai (1998) compared health service utilization among Chinese elders with the general elderly population in Canada. The use of TCM among this ethnic group was also examined (Chappell and Lai 1998). Some 830 face-to-face questionnaires were used in the study. Statistical methods were employed to analyse the quantitative data. The results showed that Chinese elders’ utilisation of services was similar to that of other elders, having a strong preference for WM over TCM and for WM trained doctors over TCM practitioners. However, the findings that Chinese elders’ preference for WM over TCM should be accepted with caution. As a quantitative study, which focused on the end point of the service use, there was a lack of explication of the whole process of Chinese elders’ help seeking behaviour. The statistical results revealed an overwhelming preference of WM at the end point of help seeking. However, Chappell and Davidlai (1998) also reported that among the WM trained professionals, the Chinese elders still preferred using services with those professionals who were of Chinese origin, probably because of language problems. The results also revealed that approximately half of Chinese seniors still engaged in TCM for both minor illnesses and serious illnesses. Chappell and Davidlai (1998) only identified that Chinese elders’ distinctive culture was related to their use of TCM, what they have not as yet been able to uncover were the reasons why Chinese elders preferred WM but were still involved in TCM no matter what the diseases were.

Compared with this present study, it was obvious that Chappell and Davidlai (1998) did not consider the health care seeking habits and behaviours among Chinese elders, who delay seeking help until the disease progressed to a serious level. Under these circumstances, elders were likely to use WM which was perceived as an efficient approach for both acute and serious health problems. In particular, the theory of being healthy revealed the detailed basic social process, showing a detailed context when elders used either WM or TCM as well as simultaneous uses of WM and TCM.

**Access WM service**
Access to WM services was the third major theme in this current study. Chinese elders reported that when diseases progressed to a serious level (according to the perceived
severity) and they acknowledged their limits in treating certain conditions, they had a tendency to seek help from WM. However, some external factors, including the influences from the family and/or the barriers from health services, hindered their help seeking behaviour to some extent.

Among the practical barriers, a more frequent problem reported by Green et al. (2006), Ma (1999), Lai and Chau (2007) and Kwok and Sullivan (2007) was the communication barrier with WM staff. This was not only due to English language utilisation but also to conceptual misunderstandings arising from cultural diversity. Even Chinese people who had interpretation help or fluent English speakers’ present, reported communication barriers according to the different linguistic and conceptual communication problems. Lack of cultural sensitivity was the most serious problem hindering communication between the WM practitioners and Chinese people. This culture based communication barrier was a general consensus among the majority of elders who participated in this study. Besides this practical barrier, the findings of this study also showed transportation difficulty and other flaws within health care services delivery systems, including long waiting lists and lack of information about services, which hindered Chinese elders’ help seeking. These barriers were also identified in Ma’s (1999) study and Lai and Chau’s (2007) study.

However, Ma (1999) and Aroian et al. (2005) revealed that a lack of health insurance and the high cost of health services hindered American Chinese’s help seeking from WM. Meanwhile, financial barriers which hindered Chinese people’s utilisation of health services was also identified in Austria (Hsu-Hage et al. 2001). In their studies, issues related to money were factors which played a significant role in help seeking behaviour. Furthermore, to what extent it influenced the health care service use was immeasurable. This implied that help seeking was a behaviour that was not rooted solely in the individual but also in the dynamic, collective, and interactive surroundings and social environment. In this way, the findings of studies conducted in other countries may not apply in the context of the UK directly.

Apart from these practical issues influencing Chinese elders’ utilisation of health care services, family was reported in this study as another main factor that impacted their decision making of initial help seeking. Chinese elders were likely to ask for support and advice first from their family before they sought help from professionals.
Meanwhile, on some occasions, their families acted as a barrier which hindered elders’ help seeking. However, only one study which discussed this point was identified in the relevant literature. Furthermore, it illustrated a diverse approach compared with this current study. Pang et al. (2003) reported that when self management was not effective, Chinese elders turned to their friends or neighbours to seek help rather than family. These particular findings suggested a shift from traditional expectations of family support (particular from the adult children) to more of a dependence on neighbours and friends.

Compared with the support network in this present study which showed that family was the main basis, the findings from Pang’s (2003) study revealed that these elderly Chinese Americans shifted their traditional expectations. Nevertheless, these results should be accepted with caution. It should be noted that all the participants in Pang’s work were community-dwelling elders. Though the term “community-dwelling” was not clearly defined, this specific characteristic of such population obviously influenced the interpretation of data. In this way, the application of the result “shifts in expectation” to other elderly Chinese people overseas should be applied with caution.

**Being cured**

Being cured was the fourth and last major sub-core category of the emerged theory of being healthy in this present study. Because of the cultural diversities, Chinese elders reported their distrust of WM which only cured the superficial symptoms but not the root causes of diseases. They described their dissatisfaction with this type of treatment provided by WM professionals and their fear of the side effects of western medicines. They also complained about a lack of health related information from these professionals.

After conducting a stepwise multiple regression analysis of 2214 face-to-face structured questionnaires, Lai and Chau (2007, p 62) pointed out that “barriers associated with cultural incompatibility, personal attitudes and circumstantial challenges were all related to cultural uniqueness, values, and beliefs” among Canadian Chinese elders in their study. However, service barriers were not solely due to Chinese elders and they suggested that there was lack of further description of how these barriers operated; highlighting cultural issues associated with barriers could be compared with the situation of health care use among British Chinese elders in this present study. The
explanation in Lai and Chau’s (2007) study was strengthened by the findings that interpreted the situation of the use of health service at the end point in this study. Regarding to the fourth category “being cured” in the theory of Being Healthy, the diversities in terms of culture and related notions of health and illness between Chinese elders and WM providers were identified as the main reason used to explain the incompatibility or awkwardness of using health care services from elders’ perspective.

Further support for these findings was provided by two studies conducted among Austrian Chinese people (Tang and Easthope 2000; Hsu-Hage et al. 2001). To explain further, this fourth category of being cured could also be linked to the diverse understanding of illness in this present study. This mismatch of expectations between Chinese patients and WM practitioners was also identified in another Australian study (Tang and Easthope 2000). Tang and Easthope (2000) explained that, on the one hand, Chinese patients criticised WM doctors for not treating the roots of the disease. On the other hand, WM professionals had difficulty in understanding what Chinese patients’ meaning of the root cause meant as used in Chinese culture. It was clear from the study that WM doctors and Chinese patients held different interpretations of the meaning of illness; this inconsistency decreased the trust Chinese patients had in WM professionals and acted as a barrier for the use of health care service among Chinese immigrants.

Besides the diverse representation and understanding of illness which resulted in being cured but not being healthy from Chinese patients’ perception, a lack of health related information gained from these WM professionals was another reason which made Chinese elders’ dissatisfied with the WM doctors and their treatment. Hsu-Hage et al. (2001) came to similar conclusions. They reported that Chinese people wanted to receive various health related information, but sources from medical providers were considered less accessible than other mediums (Hsu-Hage et al. 2001). Though this point was not fully explored in Hsu-Hage et al.’s (2001) study, it supported the findings of this current study. In the fourth category of being cured in the current theory of being healthy, Chinese elders were found to be embarrased when communicating with WM practitioners, especially GPs. Though there were some problems of information delivery related to medical providers, it appeared that Chinese people would also take some responsibility for this interaction. On this point, this fourth category of being cured provided a clear analysis of unique feature among Chinese people, portraying the
picture of lack of health information from WM practitioners from Chinese patients’ perspective.

6.4.4. Summary of comparative literature review

The studies related to help seeking behaviour have been undertaken from a number of perspectives, including studies which emphasised the end point of utilisation of health care and which focused on the general process from illness response to help seeking (Tipping and Segall 1995; MacKian 2001). However, the study of overseas Chinese elders’ help seeking behaviour is still in its infancy. Previous research into issues relevant to help seeking behaviour were mainly derived by using deductive conceptualisations (Chappell and Lai 1998; Lai and Chau 2007) or by using certain specific dialogue between induction and deduction (Jovchelovitch and Gervais 1999; Aroian et al. 2005; Green et al. 2006). Although these kinds of research design have provided useful descriptive frameworks or models, they did not reveal the dynamic and constantly changing process which Chinese people experienced in their daily life. In contrast, this present study established through an inductive process, a general help seeking approach grounded in the Chinese elders’ perspective which could be applied in wider relevant areas. Thus, from a multilevel perspective of theorising, this Grounded Theory study of help seeking behaviour exposed a detailed basic social process as it evolved directly from the empirical data which arose from the participants’ concerns in this substantive area rather than the researcher’s professional concern. It also included a number of sub-processes within various circumstances which elders overcame challenges arising in the progress of a disease.

In sum, in Grounded Theory research, the comparison literature review is not intended to verify the findings but to locate that study within the existing literature and to integrate it to a more general knowledge body. Based on a review of the literature this was the first study to attempt to place Chinese elders’ health related behaviours in the context of the day to day living as well as the relations with their surroundings, particularly the WM services and doctors in the UK, rather than concentrating on any particular aspect such as the usage of health care service (Chappell and Lai 1998; Aroian et al. 2005; Green et al. 2006; King et al. 2007) or representations of health and illness (Jovchelovitch and Gervais 1999). It was the first in-depth study in the UK to explore Chinese elders’ pattern of health related experiences and it revealed how this
group of elderly immigrants manage the main problems they experienced in their daily life. This current study added to the knowledge base of both the categories and properties of different stages of health and illness status and particularly highlighted the factors associated with Chinese elders’ help seeking. The conceptual comparison and integration of concepts emerging from this study with their counterparts in the relevant literature led to a set of even more abstract concepts that could be applied beyond Chinese elders in Manchester at the present time. Such findings may have a broader relevance to Chinese elders in other areas in the UK or even other age groups of Chinese people who face chronic health problems in their life.

6.5. Summary

Within this chapter, the researcher attempted to describe the emerged theory of being healthy in a narrative form and discuss the main themes and stages of help seeking behaviour in relation to the literature.

The theory of being healthy showed the main concern of Chinese elders. It recognised how elders actively managed their health events in their own Chinese world; how they decided to seek help from WM; as well as how they chose to go back to their own world. The decision making strategies were continually changeable and based on the interplay of individual and environmental variables. The theory of being healthy highlights both the personal and contextual nature during Chinese elders’ health related behaviours, particularly their seeking help activities.

The comparative literature review in this chapter compared and contrasted the emergent theory of being healthy with the extant literature. Having set the limits of the literature to areas that were directly relevant to the emerging theory and the core category, the comparison focused on the conception of health from Chinese people’s perceptions, and the help seeking process with the contextual situation. Though the comparison showed that the findings of most studies fit with elements or processes in the emergent theory of being healthy, the emergent theory of being healthy added to the understanding of contextual and dynamic behaviour process which recognised the influence of psychological conditions and surrounding context. This was the first study to bring together the different elements related to Chinese elders’ perception of health issues in an attempt to conceptualise the process of dealing with these health events. It was also
an attempt to conceptualise and make explicit the importance of elders’ psychological state in the process since the role of it in decision making of health related behaviours had not been fully explored.
Chapter 7 Discussion and conclusion of this study

7.1. Evaluating the Theory

As Grounded Theory research is concerned with conceptualisation, judgements about a Grounded theory study should focus primarily on the value of its theoretical products (Glaser 1978; Glaser 1998; Kanuha 2000; Glaser 2003). According to Glaser (1978, 1992 & 1998), the criteria of evaluating the emerging theory in a Grounded Theory study are fit, work, relevance, and modifiability. Fit is whether or not the concept adequately expresses the pattern in the data which it purports to conceptualise and is continually refined or refitted by constant comparison (Glaser 1978; Gubrium and Holstein 2001). Work is whether or not the concepts and the way they are related to hypotheses, sufficiently account for the participants’ main concerns in certain substantive area and how this main concern is continually resolved by them (Glaser 1978; Glaser 1998). It is the power of workability that gives a grounded theory the ability to explain or predict basic social processes (Glaser 1978; Glaser 1998). Relevance is whether or not the research deals with the main concerns of the participants involved, in contrast to the pre-conceived issues which could arise from the researcher’s professional interest (Glaser 1978). Modifiability is the potential for change in response to the new data to amend the theory (Glaser 1978). The emergent theory is never right or wrong, nor better or worse, but becomes modified by new data (Glaser 2001). In fact, modification never ends in Grounded Theory research (Glaser 2001). The rigor of emerging theory of being healthy in this study will now be evaluated using Glaser’s four criteria.

7.1.1. Strengths of the theory

The core category being healthy was closely related to Chinese elders’ perceptions of health related issues and accounted for the majority of the data. Analysis of interview data produced hundreds of themes and codes, which were collated into four interrelated key categories and finally subsumed under the core category entitled being healthy. According to Glaser (1978, 1992 & 1998), fit could be interpreted as not only involving how the concepts and theory should fit the data, but that it should also be credible, relevant to and representative of the participants and their experience. This is the result of diligence and competence in the use of Grounded Theory procedures. In this study,
the researcher applied these procedures, including open coding, comparative analysis, memoing, theoretical sampling and selective coding to provide a guarantee of fit. Extensive efforts were continually made to understand these approaches in many rounds of coding, mind-mapping, naming and re-naming concepts and categories. Field notes and theoretical memos provided a trail of the analytic work in order to illustrate not only the concepts but also the analysis procedures. In addition, a fit with the participants’ perceptions was assessed via the informal conversations and emails with some of the elders involved during and after the data collection. Preliminary study findings were verbally checked to avoid the possibility of group pressure, which may prevent those who disagreed from speaking up. The majority of Chinese elders who participated in such feedback discussion agreed that the concepts used in being healthy provided a satisfactory explanation of their perceptions and experiences, and the theory did so in a way that they understood, even if some of the concepts were not directly relevant to them.

That is not to say that controversies did not arise – they did! These were mainly about certain specific findings, for example, one participant disagreed that their family hindered their help seeking, one refuted that her GP was not taking care of her very well but as can be seen from these examples these were issues with elements of the theory rather than the theory as a whole. During these feedback conversations, the vast majority of Chinese elders appeared to be interested in discussing issues raised by the study; indeed some of them commented that the proposed theory had helped them understand the problems they faced with health care services and help seeking. This process has been described by others outside of Grounded Theory research as member checking (Murphy et al. 1998) which is a way of ensuring rigour in qualitative research. In Grounded Theory research it is a way of ensuring the emergent theory is truly “grounded” and is capable of explaining the participants’ experience.

A theory “works” when it is helpful in explaining a phenomenon, predicating and interpreting what is going on in an area of social life (Glaser 1978). In the case of being healthy in the context of Chinese elders’ cognitions of health related events, this theory provided a way of explaining and interpreting a range of situations when they faced issues related to ill health. To a significant extent, this point, which has been discussed in detail in the theory chapter, led to a greater level of understanding of elders’ behaviours in their daily life based around their perceptions of being healthy, including
their normal and ordinary aspects of living (i.e. sleep, diet, exercise) and the dynamics of involvement in the WM when elders experienced health problems. This basic social process highlighted the elders’ ongoing interactions within themselves and their surroundings in the context of a WM dominant world. Furthermore, the current theory of being healthy seemed to offer an understanding of some quite particular issues in the context of being healthy in the UK. These included how elders came to recognise themselves as being severely ill, and also how dissatisfied elders were with their interactions with WM practitioners. The sub categories of self-management, normalising/minimising to be healthy, access to healthcare and being cured provide a possibility for understanding Chinese peoples’ concerns through their pattern of being healthy when they presented with health problems in a WM dominated world.

If a theory is to “work” then it should be relevant (Glaser 1978). Glaser (1994) states that work and relevance relate to the applicability of the core category to the data and they also refer to the extent of the closeness of the connection between the properties (sub categories) and the core category (Glaser 1994). In this study the core category being healthy applied to the majority of the data, and accounted for and helped explain the four sub categories. The theme being healthy has tight interconnections with the four key categories and is compatible with them; their proposed relationships are integral and this was explained in the previous chapter. It provides a broad perspective that makes sense of a range of situations and actions related to Chinese people’s health behaviours. Furthermore, Glaser (1992) claims that the high-level categories or concepts should be highly conceptualised and that they should cover as many concepts as possible to explain and account for the maximum variation in the data (Glaser 1992b). In this proposed theory, there were several extensive concepts which offered a richness of perspective, such as self management. It attested to the varied ways in which Chinese elders handled every aspect of their daily life in order to achieve health. It sufficiently explained the interrelated and heterogeneous nature of Chinese elders’ perceptions of health related issues, including their health related psychological process and their practical behaviours either on a daily basis or when they were in the illness state.

Modifiability means the flexibility around the core variable as well as the ability to respond to new data (Glaser 1978; Glaser 1992b), which the proposed theory of being healthy does appear to hold. The concepts and relationships within the theory of being healthy are not restricted in their application to Chinese elders in the Manchester. For
example, after comparing the findings of this study with the existing evidence and relevant studies conducted in different settings (i.e. other countries) and different populations (general group of Chinese people or Chinese people with chronic symptoms), they could be relevant and readily applied to Chinese immigrants in various health related situations and with different condition. So whilst no claim has been made for the generalisability of the theory of being healthy there is the potential that the concepts would have explanatory power in many contexts in which Chinese people experience health events in host societies. This is evident from the similarities with the limited, but never-the-less generally confirming findings presented in the comparative literature review. It is clear that these connections need testing further through further research and investigation.

7.1.2. Weaknesses of the theory

Glaser (1978, 1992, and 1998) emphasised that rather than generating findings, Grounded Theory should be regarded as a set of integrated hypotheses. However, as the hypotheses are generated, the confusion is whether the Grounded Theory should be verified and how (Dey 1999)? A supplementary illustration here was that some qualitative researchers warn that participant validation is problematic in checking findings. Different interests, meanings and significance over time may result in a different interpretation by participants, therefore making confirmation impossible (Sandelowski 1993; Murphy et al. 1998). However, this was not problematic in this Grounded Theory study. As the focus of Grounded Theory is an abstract pattern derived from a description of the data and as such, the conceptual nature of Grounded Theory makes it easily modifiable by new data in further research to continually refine its fit, work and relevance (Glaser 2001; Glaser 2002). The question here and indeed the upshot of this research is whether the theory is testable using other rigorous verifying methods to test, adapt and modify the theory. Moreover, the purpose of research is its ability to predict and account for behaviour. Future research testing of the central hypotheses around which the core category is integrated in this study will be needed (Glaser 1992b). Therefore a limitation of this thesis is that the research has been unable as yet to test this theory adequately, using different methods and approaches to research.

That being said, the assessment of the theory of being healthy revealed that it was an empirically based substantive theory that was generated inductively from primary data.
provided by the Chinese elders involved in this study. Being healthy has proven to be a useful explanatory tool in understanding the data that arose during this study. Many hypotheses have been generated which could be developed in future research either qualitative or quantitative in orientation.

7.1.3. Application of the theory to models of health psychology

The proposed theory of being healthy identified new theoretical constructs, including being healthy itself, as well as the four key categories: self management, normalising/minimising to be healthy, access health service and being cured. So far, this emerged theory has been integrated into the substantive Chinese immigrants’ health literature. The majority of the component categories and the theoretical constructs have an evidence base that broadly supports their existence. In this section the researcher will locate this theory in the broader body of knowledge provided by other theories of human’s health related behaviour. It is hoped to draw together the theory development and complete the circle of knowledge by relating this theory to established theories relating to helping seeking and behaviour change.

In terms of theoretical contribution, endorsement was identified from several social cognition models (SCMs) which can apply to many general health care situations. These SCMs are the most widely used health psychology models employed to predict the performance of health behaviours. All of them start from the assumption that an individual’s behaviour is best understood in terms of her/his perceptions of the social environment (Conner and Norman 2005). Among them, some elements in Protection motivation theory (PMT) and Social cognition theory (SCT) have some ability to explain Chinese elders’ help seeking behaviour in this present study; these two will be discussed first. The Health Belief Model (HBM) will be highlighted later as it is capable of predicting health related behaviours associated with Chinese elders’ help seeking behaviour in this study, though it does not contain the culturally sensitive elements which were found essential for Chinese elders’ help seeking behaviour but would seem to be the best fit.

Protection motivation theory (PMT)

The PMT was developed by Rogers (1975) as a framework for understanding the cognitive response resulting from fear appeals. It focuses on two independent appraisal
processes: threat and coping appraisal, which are initiated by various variables (Norman et al. 2005). Linking the PMT to this present study of Chinese elders’ help seeking behaviour, PMT, as a social cognition model, may provide a partial framework to understand a general health care seeking behaviour among this group of elders. However, the most important points that occurred in the data were Chinese elders’ unique self management processes and their psychological state of normalising to be healthy. In only using PMT to explain Chinese elders’ behaviour of being healthy, all these crucial factors were simplified into intrinsic and extrinsic rewards. The theory of being healthy suggested that PMT was unable to explain what was really going on among Chinese elders when they facing health related issues. PMT might be modified by specifically adding these exclusive factors in the construct of intrinsic and extrinsic rewards, highlighting Chinese elders’ traditional thinking and behaviours in their daily life.

Social cognition theory (SCT)
Compared with PMT which was specifically developed in the health domain, SCT was developed and modified by Bandura (1977, 1992 & 2000) in the discipline of social psychology. According to the illustration of SCT, the component of self-efficacy is the most powerful single recourse construct in predicting the behaviour (Luszczynska and Schwarzer 2005). However, associating it with the data in this present study, self-efficacy could not explain all the dynamic personal behaviours among the Chinese elders. As the data showed that these elders lived in certain Chinese communities in the UK, they had a relatively isolated life within the western world but sharing various unique Chinese traditions with each other in their own communities. Some other powerful components, such as health information from trusted people, peer pressure as well as traditional norms and influences, were crucial determinants which changed elders’ help seeking behaviour. In this way, these factors might be confounded with self-efficacy to modify the SCT when using it to understand Chinese elders’ help seeking behaviour in the UK.

Health Belief Model (HBM)
The HBM was first formulated in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels. The HBM is a psychological model developed in the health domain to explain and predict health behaviours, focusing on the attitudes and beliefs of individuals (Abraham and Sheeran 2005). Four major constructs, susceptibility, severity,
benefits and barriers, are used to predict the likelihood of successfully attaining the behaviour. Additionally, it is notable that, cues to action and health motivation are relatively neglected in empirical studies because of a lack of clarity in the definitions of these constructs (Abraham and Sheeran 2005). Cues to action could include many experiences that trigger or initiate the stimulus-response sequence (Maiman and Becher 1974; Abraham and Sheeran 2005). The HBM assumes that motivation is a necessary condition for action, usually expressing general concerns about health (Abraham and Sheeran 2005). Meanwhile, these motivations are influenced by the surroundings and selectively shape an individual’s perceptions (Maiman and Becher 1974). Furthermore, motives are viewed as tendencies within the individual to approach positive incentives, and it is postulated that the desire to attain or maintain a positive state of health is a dimension of health motivation (Maiman and Becher 1974; Abraham and Sheeran 2005). Through some five decades, the HBM has been adapted to explore a variety of long- and short-term health behaviours, including preventive health behaviour, sick role behaviour and the use of clinical services (Abraham and Sheeran 2005). As shown, Figure 7-1 illustrates the components in HBM:

Despite the impressive usage of HBM in health research, there are still numerous limitations. From the figure there are no clear guidelines on how to operationalise the links between these components (Abraham and Sheeran 2005). In this way, it can be said to lack the ability to illustrate the behaviour in a context specific, small scale and detailed setting.
When applying the HBM to predict Chinese elders’ help seeking behaviour which was found in this study, all the aspects of this model would predict the Chinese population would not seek help! It was clear that the main concern among Chinese elders was to be healthy and had a high health motivation. Elders were all motivated. They had a general orientation to maintain health but not in the way the WM would accommodate. The first motivation for them was to stay in their own Chinese world to gain a healthy state, via self management and TCM and sometimes TCM integrated with some WM remedies. They preferred these strategies which, from elders’ perception, treated them holistically. Elders were only motivated to action and approached WM services when they felt their health problem was severe enough or very acute in presentation and the situation was out of their control. It should be noted that if the situation got better they were likely to go back to their Chinese way again as soon as possible. The contradiction here was that the elders were highly motivated to maintain health, balance and to reduce anxiety but were unmotivated to accept a diagnosis, follow advice about disease management and were also less motivated to seek help which may disturb their balance and cause anxiety. Regarding perceived susceptibility, Chinese elders did not see themselves as being susceptible. They did not perceive themselves as necessarily in need of help since partially they held cognitions of being healthy people and partially they believed that their self management can make everything better and stop them getting ill. Thus the perceived susceptibility was low from elders’ perceptions and the likelihood of seeking help was reduced. Furthermore, in their daily life, Chinese elders’ perceived severity was quite low as well. They thought/believed that they could promote their health and control the minor ailments via their self management, such as diet therapy, exercise, sleep/rest, and TCM, therefore hindering their help seeking from WM. Further, they were likely not to see a doctor because they wanted to be anxiety free which, from the elders’ perspective would help them gain physical wellness. This self-comforting or anxiety reducing cognition also led them to believe that their condition were not severe. At other times, when elders did recognize severity (i.e. unbearable pain, uncontrollable symptoms), they sought help from WM. However, they then thought they got cured and went back to their Chinese world to continue their often poor self management. Severity for them was very temporal. As discussed, when they planned to contact WM, there were various perceived and actual barriers for these elders to get health care, including many practical barriers related to their families and also healthcare services. Though the family often supported elders, sometimes the family acted as a barrier hindering elders’
help seeking by providing inappropriate information or making incorrect decisions or choices on their behalf. With reference to healthcare services, there were many barriers for elders to seek help, such as language problem, long waiting time; however, the greatest obstacle was that elders did not think they could achieve their desired state of health from the WM practitioners (i.e. only being cured, no sufficient information). This was because of a lack of cultural sensitivity between WM professionals and Chinese elders. Elders did not think WM doctors knew what they wanted and therefore would meet their needs. This was not only related to the interpretation service, but also had relationship with the traditional Chinese notions and TCM. In this way, because of various barriers, elders did not seek help from WM until the situation was out of their control. In addition, elders did not see many benefits in WM. They only saw benefits from the big hospital in terms of treatments that may help them control the serious symptoms or acute disease (e.g. surgery). Otherwise, elders were not likely to involve in the WM because they believed that western medicines prescribed by the doctors only controlled their symptoms and to some extent, they held a conception that much WM treatment approaches were as harmful as they were beneficial. Further, they also had complaints about WM practitioners. Elders thought that the WM doctors did not treat them holistically. Consequently, because of barriers and a lack of benefits, they did not seek help unless the disease progressed to a serious level. Chinese elders were likely to avoid being involved in WM as much as possible. Even when they had contacted WM, they wanted to be away from it (i.e. a lack of follow-ups) and went back to their Chinese world. This was because, from their perception, a peaceful mind would help them to gain physical wellness. In this way, obviously there were a lot of cues to non help seeking. Therefore, the consequence of elders’ behaviours (action) was that they did not seek help or contact WM service until very necessary. Furthermore, even after some interactions with WM, they still wanted to go back to their own world as quickly as possible.

It is interesting to note that there was an underpinning assumption that not seeking help from WM was the final action when using HBM to predict Chinese elders’ help seeking behaviour. Data in this study revealed that Chinese elders did not have the same value with western world, and seeking WM help was not their dominant approach to resolve their health problems. The findings of this study showed a persistent concern with being healthy in elders which permeated every aspect of their later life. However, this motivation was located in their Chinese world not the UK health context. In this way,
no matter how strong the health motivation was, Chinese elders did not consider the utilisation of WM initially. In fact, Chinese elders had various means to gain their pervasive goal of being healthy. Consequently, HBM does generally predict that elders will not contact WM services, due to the very reasons offered. Furthermore, this means that HBM not only has explanatory potential, but more importantly has the ability to provide the possibility of strategies which may lead to inventions to help change Chinese elders’ help seeking behaviour. How the interventions can benefit elders’ health will be discussed in the section of implications.

However, it should be noticed that self treatment was the key approach to handling the health issues for elders and this may be related to Chinese culture and may be compounded by socio-psychological factors. The HBM is generally criticised for failing to explain the significance of cultural factors which were clearly very important in Chinese elders’ world because the model is very general rather than culture specific (Abraham and Sheeran 2005). It could be modified by the specific culture factors, such as Chinese traditions. Furthermore, even in the process of Chinese elders’ seeking help from WM, the HBM could not explain the issues related to certain unique Chinese cognitions, such as the misunderstanding of the cure, which was one of the most important aspects influencing Chinese elders’ use of health services. In comparison, the theory of being healthy is a contemporary, grounded, substantive theory that is context specific, and was derived from empirical evidence from Chinese elders in the UK. It has the ability to explain the phenomenon among this unique group of people. The HBM seems to fit the data best in a negative way by highlighting the many factors that may mitigate against help seeking. Importantly, the HMB may provide a structured and rigorous framework to test interventions that may improve help seeking behaviours.

Summary

In sum, justification for these three social cognition models is based on a major understanding that all of them have originated from and been developed in industrialised countries where WM predominates. In terms of the prediction of help seeking behaviour, these models are used to explain the WM health care usage. To detail this, using these models in exploring help seeking behaviour among people, there is assumption that when facing health problems, people perceive the use of WM as the final stage of help seeking. In this way, it is evident that seeking help from WM health service is the main approach for them.
However, when investigating help seeking behaviour among certain ethnic groups, such as the Chinese elders in this study, these models were unable to completely account for and explain their actions. It was because Chinese people held their own unique set of traditions and norms even when their living surroundings which were very different to their home society, where for example, WM and TCM are often prescribed simultaneously. From their perception, seeking help from WM was not the only way to manage or cope with help problems. When exploring the health related behaviours among Chinese ethnic groups, these social cognition models could be compounded with the ingrained Chinese characteristics, including cultures, norms and traditions (e.g. PMT and SCT) or modified or utilised to predict the non help seeking behaviour (e.g. HBM). Whereas, the proposed theory of being healthy generated in this study extended, developed and applied the existing broad theoretical understanding of health related actions in this Chinese sub-group, containing the psychological and behavioural features of Chinese elders and addressing the complexities of social actions and interactions in their everyday life in the specific context of the UK. The application of models, particularly the HBM leading to interventions is an interesting area for further study generated by this research.

7.2. Evaluating the Research Process
7.2.1. Strengths of the research process

Grounded Theory researchers should remember that the theoretical and philosophical foundation of Grounded Theory is influenced by symbolic interactionism (SI). Additionally, in the domain of nursing research, SI is the most popular paradigm underpinning the use of Grounded Theory to investigate behaviour patterns which provides the researcher with a sensitizing perspective (Glaser 2005). With reference to this study, the researcher has taken great care to ensure theoretical consistency between the epistemological, ontological and methodological aspects of the study. The researcher followed SI perspective and believed that using SI as a filter to analyse elders’ actions and interactions helped to generate a theory which explained the problem and the process by which it was resolved. However, there is one criticism of SI. That is it concentrates on the micro life and it is a micro theory. Therefore it ignores the structural issues of the macro society. This could be seen as the tension between micro sociology of SI and macro sociology of Grounded Theory. Regarding this study, the
The researcher was also trying to establish part of a micro framework (substantive theory in a substantive area by integrating the macro and micro levels of social action). Though addressing this criticism of SI when conducting this study, the researcher did not attempt to ask anything about participants’ structural representation initially. As Glaser (2005) claimed that “there would be no threat to SI if its advocates allow other types of data (structural, cultural, system, organizational, etc.) to be used” (Glaser 2005, p 158). The researcher chose to follow the main principle of Grounded Theory, theoretical sampling and data leading, to collect data. Thus, the researcher wasn’t stultified by the criticism of SI. In sum, the use of a single Grounded Theory approach (Glaserian version) added credibility to the study. The clear analytic framework, consistent with SI, meant that rigour in the whole process could be maintained.

Moving on from the benefits of the chosen methods in this study, it is important to highlight the advantages of selecting the interviews for data generation purposes due to their perceived ease in the acquisition of data (Gubrium and Holstein 2001; Gillham 2005). Furthermore, the strength of the data generation procedures in this study is that meticulous preparation and planning was undertaken by the researcher in the interview phase of the study and measures were used to encourage the elders to speak. These interviews followed the principles of Grounded Theory (Glaser 1978; Glaser 1998), such as in-depth interviews without a pre-conceived structure, enabled the elders to speak about any issues on health issues. From the data, it is clear that the elders did not restrict their dialogue to positive aspects of WM health service (these elders were likely to give positive appraisal and usually seldom criticized others). This suggests that they felt safe and secure in the interviews. Moreover, during the interview, the researcher’s personal biography, insights and understanding of Chinese culture enabled her to develop a close and respectful relationship with the participants. This has added to the trustworthiness of data and automatically the findings. Consequently, this generated high quality, rich and descriptive data on which the theory was built.

In addition, the benefits of Grounded Theory method lies in the way in which the methods allow for assumptions and findings to be checked with participants. Throughout the research process the researcher was able to check the previous concepts with the participants because of the simultaneous data collection in the field and analysis. This added trustworthiness to the findings and ensued that the findings of this study as the findings were as grounded in the data as the researcher could possibly
achieve (Glaser 1998). Moreover, although it is widely accepted that data collection and analysis occur simultaneously, the researcher went to considerable lengths to ensure that the analysis informed ongoing data collection and therefore the development of concepts and themes.

From a position of data analysis and presentation, systematic line by line analysis of the findings and the fact that the researcher went back to the data on numerous occasions to recode earlier analysis added to the rigour of the study. This ensures that an open and transparent approach was taken in the generation of theory. Furthermore, there is a clear audit trail in the working methods section which informs the reader of the decision making process in this study. This ensures that the reader can judge the quality of the thesis. As far as is possible, contextual data (taken from detailed field notes and memos) has been presented alongside the data presented in this study. Once again this allows the reader to assess the conformability of the theory. To further facilitate the judgement of how trustworthy the data in this study are, the extracts from the detailed data set were purposively included in the text as the publications of detailed extracts from the data enable the reader of the text to assess whether the story presented in this thesis is a plausible interpretation of the data. It should also allow the reader to think and develop other interpretations of the text and therefore stimulate debate and even further research. The fact that the theory seems to have resonance with the existing, albeit limited, research suggests that the findings and theory have credibility.

Finally, the use of supervision, consultation with Grounded Theory experts (three Grounded Theory troubleshooting seminars facilitated by Glaser and his experienced research fellows in the beginning of data collection, the final phase of data collection and analysis, as well as the closing stage of this study – November 2008, July 2009 and October 2010) and ongoing reflection ensued that personal bias was kept to as minimal a level as possible.

7.2.2. Weaknesses of the research process

The findings from this exploratory Grounded Theory study need to be considered in terms of the limitations imposed by the study design at the very beginning and the sampling strategies during data collection. The proposed theory of being healthy and its four categories were constructed directly from responses provided by Chinese elders
participating in this study, thus the findings were subject to influence by the researcher’s presence, sampling decisions, and interview questions as well as the accuracy of the participants’ recall and their descriptions. However, the influences from these issues to the emerged theory are reduced to a large extent by adopting the methodology of Grounded Theory. As Glaser (1978, 1992, and 1998) kept emphasising, there is no worrisome accuracy problem in Grounded Theory study because of the conceptualisation feature.

Regarding the data collection, as discussed, this study was unable to identify a location to do observation. In this way, data collection was conducted via interviews. Some have criticised the use of interviews as the sole approach in qualitative data collection, arguing that interviews have been faulted as only providing narrow and brief information without full reality which may triangulate or corroborate interview data (Silverman 2000; Sandelowski 2002). One major critique here is that during the interview, participants may talk about what they feel they are supposed to say and therefore they may fail to disclose their own opinion. Glaser (1998) termed this kind of data as “proper line data”. However, as the core of Grounded Theory is about the conceptualisation rather than worrisome accuracy (Glaser and Strauss 1967; Glaser 1978; Glaser 2001), Glaser (1998, p 8) argued that Grounded Theory researchers “need only to see what incidents come as more data to constantly compare, to generate concepts and to induce the patterns involved”. Regarding this current study, though to what extent the data were truthful was unknown (despite the efforts to encourage Chinese elders to speak freely), the emerged theory of being healthy at a conceptual level did provide a greater insight into factors that affected Chinese elders’ health related behaviours and their belief about health and importantly were generally confirmed by them.

This study was conducted at a particular time (2008-2009), within a particular context (Greater Manchester). The selection of study sites of Chinese communities and samples, it may be argued, has introduced influence and bias. These sites were selected on the basis of criteria designed to maximise variation, no claim is made that they were representative of all or other Chinese communities in the UK. Influence and bias could also have been introduced through the collection of data from a single source, Chinese elders, who volunteered or agreed to participate at the time of the study.
Sampling strategies (theoretical sampling) used to select participants might influence the findings. The researcher accepts this perceived criticism that there is no way of knowing whether the sample was representative of the population or indeed other populations of Chinese elders living elsewhere. The researcher attempted to ensure that samples included members of multiple backgrounds in an attempt to portray a comprehensive picture of the phenomenon under study and the range of views were assessed. Taking the argument of representativeness to its conclusion, whilst this study may or may not be representative of other populations, it presents the perspectives of these elders which is a worthy enterprise in itself. If these data have resonance with other groups (which the secondary literature reviews suggests it has) then this confirms some elements of the rigour of the research process.

Though the themes and frameworks emerging from the data met with varying degrees of success and some difficulties, it should be remembered that Grounded Theory is not intended to indulge in extensive data description but rather conceptualisation (Glaser 1998). As Glaser (1998 & 2001) stated that the most important property of conceptualisation for Grounded Theory is its abstraction of time, place and people. After this abstraction, the researcher could arrive at a theory based on a core variable which can be applied to any relevant areas (Glaser 2001). Glaser (1998) also suggested that researchers should generate hypothesis to test elements of theory and consider a range of data sources where testing can take place. Through the constant comparison of the incoming data with the themes and concepts in hand for fit, the substantive theory could be refined (Glaser 2001). Within this study, it would have been useful for example to explore more fully the different health behaviours between:

- Mandarin and Cantonese speakers
- Mobile and less mobile elders
- The variations between male and female elders
- The community-dwelling elders

These potential hypothetical developments may help the further development and refining of the existing theory by illustrating where the gaps are and how they could be filled. Meanwhile, besides exploring the theory of being healthy in elderly groups, its fit and relevance could be assessed elsewhere. For example, it would be interesting to analyse this behaviour pattern among Chinese people who are experiencing chronic diseases in the UK or even a wider healthy Chinese population. So pragmatically, as
Glaser would argue (1978 & 1992), the Grounded Theory is the beginning and not the end of the research process. It could be refined using either further inductive or indeed deductive methods to test the hypotheses generated in the study.

It is usual when beginning a research career to develop embryonic skills and methodological awareness. It is inevitable that a lack of ability in probing, prompting and clarifying the theoretical ideas to some extent as well as varying levels of sensitivity to some themes encountered during the interview, may have affected the data in the early stages of the study. As the accuracy of the data provided by elders could not be completely authenticated and the researcher’s understanding of what the elders said could not be totally accurate, some validations were employed at various stages of the study to address these potential problems. However, few elders (including elders who participated in this study and some other elders) provided feedback about the summary of the preliminary findings during the informal discussion with the researcher. There was no substantive disagreement. In order to overcome these problems there was close supervision (by the study supervisors) during the early stages, joint coding of the data and reflexivity both in the early stages and at later points when early coding was amended, all helped to go some way to resolve these potential problems.

Though the study findings are based on empirical data gathered using as rigorous a Grounded Theory methodology as possible and with support and guidance by two expert and experienced supervisors, the researcher’s background, perspectives, pre-existing knowledge and prejudices could have also affected the data collection, analysis and interpretation. Moreover, this study was conducted by a single researcher undertaking a PhD programme and this was the first time for the researcher used Grounded Theory. With regard to theory development in this Grounded Theory study, the related literature was complicated and confusing for an inexperienced researcher. It was inevitable that the analytical abilities varied during the course of the study. The researcher’s knowledge about Grounded Theory approach influenced the whole study. Therefore, researchers from a pure western background or with an expert Grounded Theory experience may have led to having other ideas about the data. These limitations of the current study are identified by the study design and methods, which may provide recommendations for future research. As there has been a substantial increase in “insider” research in nursing (Kanuha 2000; Gerrish and Lacey 2010), Grounded Theory may challenge these insiders to develop strategies to decrease bias and increase
sensitivity in order to produce trustworthy studies (Backman and Kynngas 1999). However, as maintained by Glaser (1998 & 2002), the repeated pattern and participants’ main concern will emerge from the data by following the complete and rigorous Grounded Theory procedures, such as constant comparison. With an experience involving in Grounded Theory research, the insider’s perspective will be decreased to a great extent.

7.3. Implications for health and social care services

Supporting self care
Self care is highlighted in the NHS Plan as one of the key elements for a patient-centred health service, particularly for supporting people with long term conditions (Department of Health 2005; Department of Health 2007b). One NHS document provides an evidence base which explores 160 systematic reviews, 240 primary research studies and surveys covering the different types of self care support interventions among the general population to show the effectiveness of self care (Department of Health 2007b). According to the findings, there is a body of evidence which suggests that supporting self care can improve health outcomes and increase patient satisfaction (Department of Health 2007b). Furthermore, self care support can also result in an effective and efficient healthcare system usage (with fewer primary care consultations, reduction in visits to outpatients and A&E, and decrease in use of hospital resources) throughout the country (Department of Health 2005; Department of Health 2007b). According to Department of Health, self care is a part of daily living and the aim is for patients to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital (Department of Health 2005). It is the care taken by individuals towards their own health and well being, and includes the care extended to their children, family, friends and others in neighbourhoods and local communities (Department of Health 2005). Though self care is a big theme in the NHS plan, there is less evidence for the effectiveness of these strategies among ethnic minority groups. As discussed, among the Department of Health document (Department of Health 2007b) which explores 160 systematic reviews, 240 primary research studies, only two research studies focused on the self care interventions among ethnic minorities (however, none of the articles included Chinese population) (Humphreys et al. 1994; Eakin et al. 2002). It is obvious
that this lack of data on ethnicity hinders the promotion of self care among ethnic populations.

According to the findings of this study, self management is the main strategy for Chinese elders handling their health events, including production, maintenance and reproduction of being healthy. Furthermore, Chinese elders seem have a comprehensive self care strategy which is affected mainly by the cultural traditions and notions among Chinese elders. These notions organised the system of everyday knowledge of health related issues and the definitions of health and illness. Based on these traditions, Chinese elders explained the aetiology of disease as well as an established therapeutic procedure to prevent and cure the ailments from their perception. Generally, Chinese elders have a high motivation to maintain health via self management and define themselves as healthy persons naturally. This finding is quite similar to the data provided by Department of Health (2010). The Equality and Human Rights Commission shows that Chinese men and women are most likely to report good health at most ages than local British people and other ethnic minorities in the UK (Equality and Human Rights Commission 2010). However, the commission also claims that this result should be accepted with caution and interpreted carefully (Equality and Human Rights Commission 2010) as subjective measures (a set of options such as “fair” or “bad”) are used among all population groups without taking account of any differences, more specific information is needed to compare the capabilities of different groups to achieve their health potential (Equality and Human Rights Commission 2010).

Regarding the findings in this current study, it is clear that Chinese elders’ health situations is discomforting. Chinese elders’ self care is often not positive or helpful, for example the denial of health problems to avoid psychological anxiety, and the late presentation at WM services when they perceive their condition to be severe. Unfortunately, Chinese elders’ concern with self management often excludes or precludes WM. As shown in the diagram of the theory which emerged in this study, the two circles (Chinese world – self management and UK world – WM), showed an overwhelming tendency towards using self care in the Chinese world among the elders. This is what is happening at the moment. However, it is hoped that a balance of self care and the use of WM can be established in the future. Alongside further qualitative investigations, intervention studies perhaps using the HBM as a guide, could examine how Chinese people may be helped to appreciate the role that WM can play in
improving their health. Testing educational interventions such symptom recognition, an understanding of susceptibility and even severity of illness may help to promote health care utilisation and help seeking behaviour. It is clear from this study that significant appreciation of the current cultural factors and practices within the Chinese community will need to be considered in the plan of intervention studies. It is also clear that from the data presented here that if the needs of this ethnic group are to be met in line with policy directives (Department of Health 2008; Marmot 2010) then this should be a priority as this is an ageing population who are set to face many health care problems in the near future.

In addition, Chinese people habitually labelled themselves as self sufficient or self dependent in this study mainly because of their cultural characteristics (i.e. health issues are self affairs). According to the data, Chinese elders did not see themselves as being susceptible or at risk. The phenomenon discovered in this study (self management in their Chinese world and going back to self care as soon as possible after seeing doctor and a lack of follow up) may result in a misplaced view that Chinese people are a problem-free ethnic minority group. However this is a false premise according to the findings of this study. In fact, Chinese elders lacked knowledge of common health conditions or held incorrect health information when facing their health related events. This led to deficient perceptions and measures of their diseases. Clearly, low perceived susceptibility and risk hindered elders’ help seeking and these facts might result in worrying and ongoing problems for both patients themselves and the health service delivery system. For example, according to the findings, elders were likely to attribute their chronic symptoms to other factors such as old age, or a lack of rest, as opposed to the disease itself. This was partially because of the psychological desire to be healthy, but also partially due to the lack of basic knowledge of disease. As a result, elders may place themselves at risk because of the delayed help seeking. This indicated a need for urgent action by healthcare organisations to provide education of some common chronic diseases and dissemination the correct information to Chinese communities.

Some agencies had produced pamphlets and publications or given health related lectures in Chinese communities with their intention to promote Chinese people’s knowledge of health and illness. However, the services seemed piecemeal and patchy and the benefits from these activities seemed relatively minor. This was supported by the data in this current study. The elderly participants complained that some letters or pamphlets were
too professional to understand or follow even in a Chinese version. In this way, health and social work interventions used in supporting self care should strengthen the support and resources for this vulnerable group using information appropriate to Chinese elders’ cultural needs. For example, training on lifestyle issues to change behaviours and promote wellness and prevent illness should be highlighted (Department of Health 2005); the right support can also be given to the care of long-term conditions in order to achieve a better quality of life (Department of Health 2006a); multi-media multi-lingual self care facilities and information materials should be provided in Chinese communities (Department of Health 2005). In the long term, health education and self care skill training should be conducted among family and the community in order to improve the health related conceptual framework among Chinese elders as well as their family. Therefore, by educating Elders about western concepts of health, Chinese people’s health beliefs and competence may be improved. Furthermore, the Chinese communities could be encouraged to more purposefully participate in WM health service within a more appropriate time frame.

In sum, as claimed by Department of health (2006), support may be particularly useful to people from ethnic minority communities, where language and culture can be a real barrier to self care (Department of Health 2006a). To enable Chinese minorities to access health information and guidance, plus increase understanding and awareness of self care, social care providers should adjust service delivery to better serve elders who still maintain strong Chinese cultural values and beliefs. Furthermore, understanding general health needs and experiences with health service utilisation by community groups can be used to enhance cost-effective service delivery planning. The findings of this study have important implications for designing and implementing health promotions oriented towards Chinese ethnic communities.

Better information
The role of information and knowledge about health issues as an important resource in mediating individuals’ decisions to seek health care and their help-seeking behaviour is demonstrated in many government documents and reports (Department of Health 2004b; Woods et al. 2005; Department of Health 2008; Department of Health 2010). Furthermore, information, combined with the right support, is central to better care, better interactions between professionals and patients, better outcomes and reduced costs (Department of Health 2010). This is because information helps knowledge and
understanding and gives patients the power and confidence to engage as partners with the NHS (Department of Health 2004b). With particular reference to long-term conditions, patient involvement in decision-making within appropriate information increases not just patients’ knowledge and understanding of the management but also their adherence to a chosen treatment (Department of Health 2010).

However, among ethnic groups, because of a lack of appropriate information, it is reported that there are more difficulties to access of GP services than white populations and also that satisfaction is lower than that for white populations (Department of Health 2008). The main problems are firstly, a substantial communication problem between patients and practices caused by language and culture barriers and secondly the expectations of ethnic minority patients (Department of Health 2008). Furthermore, they are afraid to complain about poor services and the healthcare and information they need but a clearly not getting (Department of Health 2008). Therefore, an urgent need to build trust should be established between ethnic minorities and health professionals by providing accessible and available information for these marginalised groups (Department of Health 2004b; Department of Health 2008).

The findings in this study have many similarities with the latter points. When Chinese elders perceived the severity of diseases was out of their control, they would consider seeking help from WM service. However, there were various actual barriers for these elders to approach to health care. The greatest obstacle made elders believe that they could not get holistic health gains from the WM practitioners because they only got some tablets and, from their perspective poor quality information. In this way, elders experienced many barriers and did not see many benefits in seeking help from WM. Chinese elders complained that the information gained from WM professionals was quite poor though elders reported their strong desire to communicate with health practitioners. The theme “avoiding bothering doctors unnecessarily” is an example illustrating Chinese elders’ consideration of communicating with WM professionals. In the light of the findings, Chinese elders hold the principle of keeping harmony as the guidance to deal with people and things surroundings. They tended to be reluctant to seek help or to voice their problems to health practitioners. They did not want to bring any troubles or inconvenience to the practitioners; they never argued with health practitioners even when they disagreed. This was partly because of traditional Chinese culture and partly because of the inappropriate nature of services the WM offered. In
this way, the general Chinese norms should be understood by health practitioners in
order to support a culturally understandable communication with these elders. Prac-
titioners need to be patient and sometimes encourage elders to express and offer
detailed information to these elders. In this situation, supporting self care should be
provided by appropriate and accessible advice and information (Department of Health
2005). The information should include individual care plan, self-diagnostic tools, and
self-monitoring devices (Department of Health 2004b; Department of Health 2005;
Department of Health 2008). Thus, the gap may be closed and effective consultations
may be developed for Chinese patients. Furthermore, follow up self care is supported by
the professionals and Chinese patients could conduct a more effective and appropriate
self management whilst staying in their Chinese world.

In sum, doctors and nurses can use the findings of this study to enhance their practice
and give them confidence in their interaction with Chinese patients on the basis of how
they think and behave in relation to help seeking. By doing so, the effectiveness of help
seeking may be improved for Chinese patients.

7.4. Implications for Policy in the UK and beyond

As the NHS provides expert health advice and delivers health services to the lives of
people in the UK it is well known that older people are the main users of health and
social care services in the UK and the provision of services for older people is a priority
for policy makers in the UK (Harari et al. 2008). This situation is very much
complicated with regard to the ethnic minority groups (Department of Health 2009). As
reported, there is a complex interplay of factors affecting ethnic health and their use of
healthcare services, such as socio-economic status, the impact of migration, racism,
culturally different lifestyle, the biological susceptibility and poor delivery of health
care (Harriss 2007; Marmot 2010). All of these factors are affected by the political and
cultural and social context in which the ethnic groups sit (Marmot 2010). With reference
to policy, reducing health inequalities is a matter of fairness and social justice and the
fair distribution of health, well-being and sustainability are important social goals in
England (Marmot 2010). There will be lots of benefits if health inequalities are reduced.
For example, it will have economic benefits in reducing losses from illness associated
with health inequalities, including productivity losses, tax revenue, higher welfare
payments and treatment costs (Marmot 2010).
In 1998, Sir Donald Acheson’s Independent Inquiry into Inequalities in Health firstly placed health inequalities onto the policy agenda. The Acheson Inquiry made three main recommendations for reducing ethnic health inequalities (policies on reducing socio-economic inequalities should consider the needs of black and minority ethnic groups (BME) groups, services should be sensitive to the needs of BME groups and promote awareness of their health risks and the needs of BME groups should be specifically considered in planning and providing health care) (Harriss 2007). Recently, a number of policy developments have aimed to tackle ethnic health inequalities, such as Health Survey for England – Minority Ethnic Groups (Sproston and Mindell 2006), Health Challenge England (Department of Health 2006b) and Tackling Health Inequalities: A Programme for Action (Department of Health 2002). One of the main targets of these policies is to ensure that people of all backgrounds have access to information and high quality services (Rawlinson 2008; Marmot 2010). Regarding older people from BME groups, the greatest variation by ethnicity is seen among this age group (Harriss 2007). In addition, as minority ethnic older people are a more vulnerable group, they need to gain more consideration according to the NHS Direct Equality Scheme (Rawlinson 2008; Marmot 2010).

In order to narrow the inequality among the minority elders, the NHS needs to make the services culturally sensitive, relevant and accessible to meet the needs of those patients (Rawlinson 2008). However, one of the major factors which hinders the likelihood of action on ethnic health inequalities is the availability of data on ethnicity (Woods et al. 2005; Harriss 2007). There remains an urgent need to improve data collection relating to ethnic monitoring so that the reality and the scale of the challenge in reducing health inequalities are clearly understood (Randhawa 2007).

In terms of the elderly Chinese immigrants living in the UK, the dearth of reliable and valid quality empirical studies about their general health needs and experiences makes it difficult to increase the service quality for this sub group (Netto et al. 2008). This indicates a need for more research and development of existing knowledge in this area. By doing so, organisations could understand Chinese immigrants’ characteristics of health related behaviours.
In terms of the findings in this present study, Chinese elders perceived that the quality of health care service was regularly not as high as it should be, describing it as unsatisfactory and to some extent discussing the unacceptably low level service they had experienced. More importantly, Chinese elders participating in this study described their self management in their everyday life. It indicated, from another point of view, that they had alternative approaches in their health maintenance and were unwilling to seek help from WM health service if they felt it was unnecessary. The lack of help seeking may be improved if an understanding of the unique Chinese traditions and norms are available and WM practitioners appreciate this knowledge. The theme “being cured” in the theory was a typical example. Lots of Chinese elders went to the WM and they got the treatment but after the symptoms had gone, elders stop taking the tablets because they used self management to get rid of their perceived root cause of the problem which, they thought, WM could not achieve. The data analysis suggested that WM practitioners thought they treated Chinese elders. But in fact, elders sometimes did not carry on with the treatments. This is because there is a mismatch of expectations between Chinese elders and WM providers. These important findings indicated some worrying problems, including communication problems between Chinese patients and health providers, as well as mutual misunderstandings arising from their different backgrounds. Action needs to be taken to reduce the negative factors that influence the interactions between WM practitioners and Chinese patients. By doing so, the risks to patient safety could be reduced and the well-being among this minority group could be improved. A more patient-focused service may result.

7.5. Recommendation for future research

This research was designed as an exploratory study because of the lack of existing knowledge and evidence relating to Chinese elders’ perceptions of health seeking in the UK. As this was the first in-depth study to explore Chinese elders’ experiences of health related behaviour patterns in the UK that can be located, it identified a number of findings that warrant further investigation, as well as assessment of these findings using other methodologies in larger and more varied samples.

In relation to the theory of being healthy, further research is recommended. Using a more representative sample in different populations in various settings, in order to display its modifiability and ascertain its applicability. In this way, it may be generated
to explain overseas Chinese people’s help seeking behaviour that may have resonance for other communities not based in the UK.

In addition, further study might focus on certain themes emerging from this study to conduct investigation in more depth. Self management, normalising/minimising to be healthy as well as other alternative approaches, including seeking help from TCM or family members which were identified as critical factors for Chinese elders’ being healthy. Further research could conduct more exploration of this area as opposed to help seeking from WM health services. The sampling could also contain the adult children who take care of Chinese elders or the TCM practitioners in the UK. Thus, the data could be analysed for reliability, validity and comprehensiveness in a more focused manner and would probably warrant a further quantitatively oriented study. On the other hand, further research could focus on the WM health service usage among Chinese elders in the UK. Further investigations could concentrate on the interactions between Chinese elders and the WM professionals. The elements, their relationship and the proposed theoretical framework are provisional and require verification, further development and refinement through research. Thus, the sampling could also include the WM professionals, exploring their perceptions of elderly Chinese patients.

In addition, with reference to the application to the HBM, as discussed, all the aspects of HBM would predict that the Chinese population would not seek help unless they faced extreme situations. Because Chinese elders hold population-specific health beliefs, and the external environment of their living and help seeking is a host society, their health related behaviours need to be specified. Therefore, the evidence-based findings in this study could enhance the precision and explanatory power of the behavioural model. By doing so, it provides the possibilities for researchers to move forward and to conduct some quantitative studies. These may test some elements of the HBM and introduce certain interventions to improve Chinese elders’ health related behaviours. For instance, these actions could include guides which can increase the cues to action, such as increasing their understanding of severity and susceptibility of illness symptoms, helping them to see the benefits in WM services. These interventions should been done in a way which would let these ideas be easily accepted by the Chinese elders. In order to achieve this goal, reference to the characteristics described in this study could be very helpful. Hence, these quantitatively oriented studies could be useful in improving the
health situation among Chinese population significantly and promote appropriate service use.

Though it is proposed that all the elements and relationships in the emerging theory of being healthy require verification in future research, the outcome of this study is congruent with the adoption of a qualitative exploratory approach and provides the basis of a programme of continuing work.

7.6. Conclusions

The purpose of this study was to explore Chinese elders’ perceptions of health related behaviours, including their help seeking behaviour. Analysis of data collected by semi-structured interviews from 33 Chinese elders living in Great Manchester revealed four key categories which were used to generate a theory of being healthy. The four categories emerging from the findings of this study were: self management, normalising/minimising to be healthy, access health services and being cured. These emerging themes are congruent with and supported by the literature, the majority of which were evidence based. This exploratory study has advanced the understanding of the health related behaviours among Chinese elders living in the UK. The results in this study clearly demonstrate how Chinese elders deal with their health related events routinely and their health seeking pathways when facing health problems. This Grounded Theory is generated to clarify a care trajectory, from their self care to their initial help seeking. This is emerged as very important in the final theory.

The study made a unique theoretical contribution because it was the first time that a theory accounting for how Chinese elders managed their health events themselves and interacted with others in a host society, including medical professionals when the health problems progressed to a perceived serious level. As evident from the literature reviewed, studies to date were intent on describing how Chinese immigrants sought help from medical practitioners. No previous study had investigated how self management influenced their initial help seeking behaviour or on the implications of this in making a hindrance to their help seeking. Most concepts generated from the study were also unique. The theory focused on the complexity of psychological changes and adjustments in terms of the progression of physical problems as well as the related activities Chinese elders took based on their decision.
It is hoped that this proposed theory could contribute to nurses’ and other professionals’ knowledge and understanding of how elderly Chinese patients are thinking and behaving in this context and therefore, the findings have the potential to inform and enhance the support received by Chinese patients in the future. It is also hoped that this study can be a reference point for policy makers assessing the health related needs of Chinese elders living in the UK.
References


Appendix 2-1 Summary of literature (pre-field literature review)

<table>
<thead>
<tr>
<th>First author and date of publication</th>
<th>Nature of evidence</th>
<th>Theme</th>
<th>Location and date of field work</th>
<th>Source of sample</th>
<th>Definition of ethnicity</th>
<th>No. of participants and age group</th>
<th>Methods for translation, adaptation</th>
<th>Back translation</th>
<th>Reported outcomes</th>
<th>Quality score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chappell, 1998</td>
<td>Face-to-face interview</td>
<td>To assess whether the same factors are predictive of health service utilization among Chinese ethnic group as the general population of seniors.</td>
<td>Victoria and greater Vancouver areas of the province of British Columbia, Canada</td>
<td>The name listed in provincial government</td>
<td>Individual self-identified as Chinese origin</td>
<td>830 participants with the median age of 76 (a range of 65 to 102)</td>
<td>an expert steering committee consisting of individuals from the Chinese communities</td>
<td>Yes, back translated and revised</td>
<td>Religious beliefs and a preference for traditional Chinese medicine are strongly predictive of the use of traditional care. They prefer use services with Chinese staff, probably because of language.</td>
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<tr>
<td>King, 2007</td>
<td>semi-structured interviews</td>
<td>To explain the influence of Chinese culture and gender</td>
<td>Canada</td>
<td>Chinese community</td>
<td>Interviewer assessment of the characteristics (country of birth, etc.),</td>
<td>10 men, aged from 53-83; 5 women, aged from 68-79</td>
<td>One of the researchers and staff working in the community</td>
<td>NR</td>
<td>The challenge (or not) of managing CVD risk was influenced by intrapersonal (the predominant</td>
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<td>Year</td>
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<td>Study Design</td>
<td>Participants</td>
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<td>Data Analysis</td>
<td>Response Rate</td>
<td>Study Key Findings</td>
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<td>Lai, 2007</td>
<td>Face-to-face questionnaire</td>
<td>To examine access barriers to health services faced by older Chinese immigrants.</td>
<td>Seven cities with 89% of all Chinese people in Canada reside</td>
<td>Randomly selected from telephone directories</td>
<td>Individual self-identified as Chinese origin</td>
<td>2272 participants consent (response rate 77%) and 2214 Chinese immigrants were included</td>
<td>Member of research team available to translate</td>
<td>Yes, back translated to ensure consistency</td>
<td>Barriers associated with cultural incompatibility, personal attitudes were associated with cultural uniqueness; service barriers were related to administrative problems.</td>
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<td>Ma, 1999</td>
<td>Qualitative: participant-observation; face-to-face</td>
<td>Examine the use of TCM and western medicine in Chinese communities</td>
<td>Houston and Los Angeles, US; Chinese communities</td>
<td>Country of birth</td>
<td>75 Chinese consumers and 30 Chinese</td>
<td>NR</td>
<td>NR</td>
<td>High rates of self-treatment and home remedies, medium rate of</td>
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<td>Methodology</td>
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<td>Setting</td>
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<tr>
<td>Pang, 2003</td>
<td>Focus group interview and survey questionnaire</td>
<td>The values and immigrant experiences and role of family and friends related to utilization of health care services</td>
<td>25 Chinese immigrants (11 men and 14 women) aged 60 and older (the average age 72)</td>
<td>Los Angeles, US; Chinatown Services Centre</td>
<td>Interviewer assessment of country of birth and first language</td>
<td>A shift from traditional expectations of filial piety to more dependence on neighbours and friends and an adaptability to combining Eastern and Western health care modalities.</td>
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Abbreviations: NR, not reported; TCM, traditional Chinese Medicine; CVD, cardiovascular disease
Appendix 2-2 Assessment elements

<table>
<thead>
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<tr>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Very poor</th>
<th>Comment</th>
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1. Abstract and title

2. Introduction and aims

3. Method and data

4. Sampling

5. Data analysis

6. Ethics and bias

7. Findings/results

8. Transferability/generalizability

9. Implications and usefulness

Total

Source: (Hawker et al. 2002, p 1295)
Appendix 2-3 Assessment criteria

1. Abstract and title: Did they provide a clear description of the study?
   - **Good**: Structured abstract with full information and clear title.
   - **Fair**: Abstract with most of the information.
   - **Poor**: Inadequate abstract
   - **Very Poor**: No abstract

2. Introduction and aims: Was there a good background and clear statement of the aims of the research?
   - **Good**: Full but concise background to discussion/study containing up-to-date literature review and highlighting gaps in knowledge. Clear statement of aim AND objectives including research questions
   - **Fair**: Some background and literature review. Research questions outlined.
   - **Poor**: Some background but no aim/objectives/questions, OR Aims/objectives but inadequate background
   - **Very Poor**: No mention of aims/objectives No background or literature review.

3. Method and data: Is the method appropriate and clearly explained?
   - **Good**: Method is appropriate and described clearly. Clear details of the data collection and recording
   - **Fair**: Method appropriate, description could be better. Data described.
   - **Poor**: Questionable whether method is appropriate Method described inadequately. Little description of data
   - **Very Poor**: No mention of method, AND/OR Method inappropriate, AND/OR No details of data.

4. Sampling: Was the sampling strategy appropriate to address the aims?
   - **Good**: Details (age/gender/race/context) of who was studied and how they were recruited. Why this group was targeted. The sample size was justified for the study. Response rates shown and explained
   - **Fair**: Sample size justified. Most information given, but some missing
   - **Poor**: Sampling mentioned but few descriptive details.
   - **Very Poor**: No details of sample

5. Data analysis: Was the description of the data analysis sufficiently rigorous?
   - **Good**: Clear description of how analysis was done. Qualitative studies: Description of how themes derived/respondent validation or triangulation. Quantitative studies: Reasons for tests selected hypothesis driven/numbers add up/statistical significance discussed.
   - **Fair**: Qualitative: Descriptive discussion of analysis. Quantitative
   - **Poor**: Minimal details about analysis
   - **Very Poor**: No discussion of analysis
6. Ethics and bias: Have ethical issues been addressed, and what has necessary ethical approval gained? Has the relationship between researchers and participants been adequately considered?

**Good**
- Ethics: Where necessary issues of confidentiality, sensitivity, and consent were addressed.
- Bias: Researcher was reflexive and/or aware of own bias.

**Fair**
- Lip service was paid to above

**Poor**
- Brief mention of issues

**Very Poor**
- No mention of issues

7. Results: Is there a clear statement of the findings?

**Good**
- Findings explicit, easy to understand, and in logical progression.
- Tables, if present, are explained in text.
- Results relate directly to aims.
- Sufficient data are presented to support findings.

**Fair**
- Findings mentioned but more explanation could be given.
- Data presented relate directly to results.

**Poor**
- Findings presented haphazardly, not explained, and do not progress logically from results.

**Very Poor**
- Findings not mentioned or do not relate to aims.

8. Transferability or generalizability: Are the findings of this study transferable to a wider population?

**Good**
- Context and setting of the study is described sufficiently to allow comparison with other contexts and settings, plus high score in Question 4 (sampling).

**Fair**
- Some context and setting described, but more needed to replicate or compare the study with others, PLUS fair score or higher in Question 4.

**Poor**
- Minimal description of context/setting

**Very Poor**
- No description of context/setting

9. Implications and usefulness: How important are these findings to policy and practice?

**Good**
- Contributes something new and/or different in terms of understanding/insight or perspective.
- Suggests ideas for further research
- Suggests implications for policy and/or practice

**Fair**
- Two of the above (state what is missing in comments).

**Poor**
- Only one of the above

**Very Poor**
- None of the above

Source: (Hawker et al. 2002, p 1296-1297)
## Appendix 2-4 Quality of included literature

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Chappell</th>
<th>King</th>
<th>Lai</th>
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<td>4. Sampling</td>
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<td>5. Data analysis</td>
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<td>8. Transferability/generalizability</td>
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<td>3</td>
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<tr>
<td>9. Implications and usefulness</td>
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</table>
Appendix 4-1 Interview guide

Appendix 4-1-1 Interview guide at initial stage

Demographic questions

- Could you please tell me your age?
- How long have you been living in the UK?
- Can you tell me your marital status? (married/married though residing apart/widowed)
- Can you tell me who do you share your house with? (alone/with spouse/ with spouse and unmarried children and/or grandchildren/with spouse and son or daughter’s family)
- What is your first language?
- What is your education situation? (none/elementary school/junior high school/high school/college or university or graduate studies)
- Do you have an occupation? (full-time work/ part-time work/unable to work/retired)

General questions

- What is it like to be a Chinese person living in the UK?
- How do you feel about the health services in the UK?
- Could you please tell me about your health in general?
- What sort of things do you worry about in relation to your wellbeing?
- What would make you go to the doctor for help?
- How do you feel about western medicine, compared with traditional medicine?

Beliefs of CHD

- What do you know about diseases which affect the heart?
- If you felt worried about your heart, what would you do about it?
- Can you tell me what comes to mind when you think of CHD?
- Could you describe what you think CHD is and give me information that you know about CHD?
- Can you tell me what other Chinese people you know (family or/ and friends) think about CHD?

Help seeking experiences

- X is a 60 year old Chinese woman who has lived in the UK for 20 years who does not smoke. She lives in a second floor flat in Manchester. Over the last year she has noticed that she gets out of breath when she is carrying shopping up to her flat. She also notices that she has a twinge in the upper part of her chest sometimes when she does vigorous housework. If this was you, what would you think?
- Last week, a Chinese man told me that he preferred to Chinese traditional therapy but in Manchester it was much more expensive than western medicine, so he did not want to seek any help if there was no acute disease. What do you think about it?
- Can you give me an example of a health problem you have had in the past and what did you do about this?
- Can you tell me your experience about the process of handling the health problem in detail?

Comments

- Are there any other comments you would like to make?
Appendix 4-1-2 Modified topic guide in the middle project

Demographic questions

Broad questions:
- Tell about your life here now?
- How things going on when you get older?
- How do you manage your health problems?
- What do you mean by health?
- What you worry about and what you concern about your health?
- Does anything bother your health?

Understanding of condition
- Can you describe what your general state of health is like? (If the participant thinks that he/she is healthy, probe why.)
- Do you do anything specific to stay health? (Exercise, diet or others)
- Could you tell me about other medical problems that you have?

Health seeking process (only ask these questions those people who have had previous disease, particularly heart disease)
- Have you had some experiences in the past and how you managed them?
- The story will come at the end. You can test their knowledge and ask directly about heart disease.
- Did you ever think that you would have a problem with your heart?
- What do you think influence your heart condition?
- Can you tell me about your disease? What happened? How did you find out?
- Did you use interpreters? (Hospital staff or family member)
- Did you feel that you were able to discuss all issues you were concerned about?
- Since you came out of hospital have you had any concerns about your problem?
Appendix 4-1-3 Topic guide towards the end of data collection

Being cured

- Do you want to have some health related information?
- Why not asking professionals?
- What kind of services did the doctor provide to you?
- How did you feel about the service?
Appendix 4-2 Example of open coding

Interview 3 (July 2008): this excerpt from the transcript of Interview 3 was permitted to be presented here by the interviewee.

A: Do you have any other health problems except those you have mentioned?
P: Yes, there is something wrong with my heart… My cardiogram was abnormal, ST segment depressed. They (Chinese doctors) prescribed “Su Xiao Jiu Xin Wan” (a kind of TCMPP made from Dryobalanops aromatica Gaertn. f. (this is made from Blumea balsamifera DC.) and Ligusticum chuanxiong Hort.; this TCMPP is used for amending blood shortage in cardiac muscle, it is one kind of calcium channel blocker) for me at that time. I have not mentioned this problem to the doctor here. This is because that my son told me there is no symptom of my heart, and hence the doctor won’t check it for me. In these situations I took “Su Xiao Jiu Xin Wan” immediately.

A: Why didn’t you go to the doctor?
P: I don’t actually know as well. Though my son said it can only be checked out when I have symptom, I don’t completely agree with him. You know I had full scale body check in China every year, and the abnormality of my cardiogram had been noticed while I was not having any symptom. Sometimes I feel that I troubled my son for asking him to accompany me. However, due to my language obstacle, I am lack of the confidence and ability. Anyways, the working time of my son is relatively flexible, so generally the situation is good.

A: So will you try to get some information about health and understand it in your peace time?
P: Yes, I will. I hope I am able to understand about the health problem. When I receive the letters from hospitals, I hope I am able to understand them. For using the health service, I will read the manual of the medicine prescribed by the doctor. I want to know in detail. Things like these written materials, I will try to read. I read by myself. However, I am not able to communicate with doctors. I really hope to communicate with them, but due to the language barrier, it’s very hard for me to make it. I have to ask my son for help.

A: Did your son explain in detail?
P: No idea. Maybe just simply explain it for me. Because of this I am eager to understand all things by myself. Before I see doctor, I will always tell my son which part on me is uncomfortable, and my son will tell the doctor.

A: So in what situation you would feel that your heart is not alright?
P: Such as chest pain, faintness, uneasy breaths I think, things related to blood supply. Then I will take “Su Xiao Jiu Xin Wan”, however, I don’t take it often. I know it’s not good to take it too often.

A: What will make you to see doctor?
P: I think aging is a consequence of natural process and development. Your eyes can’t see as clear as before, your hands shaking… etc. You can’t change these.
Appendix 4-3 Elements development via concurrent analysis

Appendix 4-3-1 Structure after the first and second interview

Demographic variables
Age

Disease itself

Social structure variables
Education
Life style
Family support (trouble family)
Social support
Chinese culture (destiny)
Religion
Discordant language
Communication
Translation
Transportation

Health beliefs and attitudes
Beliefs about drugs
Values concerning health and illness
Social identity of old age
Knowledge about disease
None utilization of traditional Chinese medicine

Inappropriate perceived illness
Incorrect information for health
Inappropriate perceived cause

Personal health practices
Self-treatment and remedies

Health care system
Health system benefit
Referral system
Consultancy appointments and waiting time
Printed materials and other media forms
Hospital translation
Scare of ambulance
Health motivation
Values/beliefs about health
Traditional Chinese lifestyle
Good air quality
Diet therapy
Outdoor exercise
Indoor exercise
Good sleep
Good mood
TCM promoting health

Disease concern
Lack of balance

Private affair
Self cognition as health
Wish to know

Self management
Making judgements
Feeling of pain
Only consider severe pain as disease
Perceived disease causes
Experiencing unbearable pain
Hopelessness (disease)

Normalising/minimising
Social identity of older age
Attributing to old age
Denying symptoms
Attributing to tiredness
Minimising the severity

Self treatment
Trust own capability
TCMPP self-management
Beliefs of TCM
TCM infusion
Bear slight pain
Comfort self
Avoiding talking heart problem
Keeping positive thinking
Concentrating on today

Knowledge
Lack of knowledge
Narrow understanding
Incorrect knowledge

Access to health services
Overall satisfy with WM
Health system benefit
Trust big hospital
Trust WM drugs
Expensive TCM vs. free WM

Obstacles of seeking help
Referral system
Consultancy appointment
Waiting time
Language barrier
Interpretation service
Beliefs about drugs
Painkiller
Printed materials
Scare of ambulance
Chinese treatment pattern
Translation problem
Helplessness
Translation/interpretation

WM doctor
Blind adherence
Rely on doctor
Satisfy with WM provider

Family
Family support
Rely on family
Filial piety
Family hinders help seeking
Transportation
Small social circle

Symptom – pain
Degrees of pain
Pain as indicator
Pain as motivator

Lack of trust in TCM in the UK
Appendix 4-3-3 Structure towards the end of the analysis

Category 1 Self management

- **Self-reliance & Self-believing**
  - Chinese culture influence (health related)
    - Self-reliance and self-sufficiency
  - Health is private issue and one’s own affair
  - Trust own ability & Attempting to take control
  - Keeping an undisturbed peaceful life
    - “Peaceful” treatment preference
    - Treatment of illness is troublesome both to one’s self and doctor
    - Bearing pain without treatment
  - To avoid seeing doctor so as to conceal one’s illness for fear of criticism/worry
  - Predominantly secular but religious faith is regarded as a support (Bad deeds, as well as good, may rebound upon the doer.)

- **Personalised self-care (selecting different methods of health keeping by one’s own)**
  - Self-judgement of health condition
    - Self cognition of health (nothing need to worry about)
    - Using own feeling (e.g. pain) to measure degree of disease/illness
    - No pain = no disease
    - Self definition of minor illness (e.g. coughing/cold /fever/headache/stomach-ache)
  - Mental adjustment
    - Mind & body relationship: mind affects body to some extent (e.g. good mood & positive things promote health)
    - Ignore dim future & concentrate on today

- **Unsupervised self treatment**
  - Home remedies
  - Using TCMPP for minor illness, or as supplement to WM
  - Examples: Taking own ways of heart protections; Rest & do minor exercises to recover breathe; Innovative action to resist chest pain: crouching

- **TCM in self management**
  - Most participants believe in TCM
  - TCM cure the root/foundation of the disease
  - TCM in the UK
    - Lack of trust in/Being unsure about TCM service/quality in the UK
    - High price of TCM service in the UK
    - Limited herb varieties
    - Different treatment style
    - Non-engaged in TCM in the UK
  - TCM has no instant result as an advantage
  - TCM optimising health status
  - TCMPP for “minor” diseases
Category 2 normalising/minimising symptoms: trying to be healthy

- **Knowledge about heart disease**
  - Not well informed about heart disease
    - Considering CHD or heart problem as MI
    - Inappropriate perceived cause for heart problem (heard work, lack of rest)
    - Thinking heart is well protected (in their own methods)
  - Considering feeling of breathe/chest pain are related to heart condition
  - Equalling blood pressure to heart disease
  - Narrowing understanding
  - Inappropriate information
  - Appearing to concern heart a lot
    - Taking own ways of heart protections
    - Fearing death caused by heart attack
    - Firmly believing heart crisis in the future (without proof)
  - Acknowledging heart disease as a life threatening disease
  - Heart disease cannot be diagnosed when there is no symptom

- **Self-cognition/Making self-judgement**

- **Experienced unbearable/escalating pain**
  - Being frightened during pain

- **Normalising symptoms to comfort oneself**
  - Considering heart disease as a geriatric disease (avoid self being that old)
  - Interpreting own symptoms
  - Denying symptoms
  - Normalising pain as a usual thing related to old age
  - Normalising chest pain as normal pain
  - Feeling satisfied with being able to handle everything without troubling others

- **Emotional stoicism and reserve**
  - Avoid bad/negative things
  - Ignore dim future & concentrate on today
    - Being unable to control the heart problem/foreseeing crisis
    - Seeing risk of losing control
    - Hopelessness of the crisis in the future
    - Being unable to control pain and hale state (in the future)
  - A taboo about the discussion of heart disease
    - Avoiding mention/disclosure of disease
  - Heart problems are tightly related to psychological things

- **Lack of real concern about illness**

- **Bear slight pain**

- **Health keeping means**
  - TCMPP to protect heart
  - Food and exercises
  - Innovative action to resist aliments
Category 3 Access health services

- UK health care system
  - Health system characteristics in the UK
    - Overall satisfied with NHS (benefit)
    - Particularly good service to elder
    - Free as the most important advantage
    - Hospital interpreter
  - Inconvenient points of health service in the UK
    - Not as good as Chinese health service whilst it is free too
    - Long waiting time
    - Minor illness not worth waiting for GP service
    - Consultancy appointment
    - Tend to seek immediate care rather than GP
    - Anxious about ambulance

- Practical difficulty – communication
  - Language barrier
    - Desire to cope with language barrier but difficult
    - Only basic descriptions
  - Printed materials (from hospitals)
    - Needing information in Chinese
  - Better educated elders received more information from books/videos
  - Information from friends
  - Vague interpretation by family members
  - Desire for detailed information
  - Inappropriate information not corrected
  - Some extent anti socialisation

- Roles of family
  - Rely on family
    - Importance of family relationships
      - Very close family relationship, family ties: responsibility/obligation
        (no troublesome to trouble children)
      - Children dependence
      - Filial piety/family duty
    - Friend network from family
    - Expectations of family support in illness
    - Decision making sharing with family (familial rather than individual decision making)
    - Turn to family to seek for help first
    - Support from family
      - Provision of psychological and emotional support from family (not expected from professionals)
      - Emotional reliance (not being worried or nervous)
      - Transportation service
      - Family as information source
      - Family members as interpreters (better than hospital interpretation)
  - Valuing self/family reliance &achievement of goals despite life experience
  - Family conception
    - Peaceful/private place
    - Family compared to huge
    - Caring for elders/ill family member is private family affair
    - Parents consider children as their whole life
  - Family hinders help seeking
    - Comforting elders
    - Supporting incorrect ideas
    - Blind adherence to family
    - Delaying informing family (worrying about bothering family in case of a false alarm)
  - Concerning others a lot
  - Being burden to family
Category 4 being cured (different criteria for need)

- **Influences of health service in China**
  - Hospital is held high esteem (hospital medical care high valued, trusting big hospital)
  - Having no health care choices; passive and compliance acceptance
  - Huge respect to doctors and other health professionals (in traditional Chinese social system, doctors afford a high status and not to be challenged)
  - Direct hospital service
  - WM service combined with TCM
  - Trust and have more faith in big hospital
  - OTC TCMPP available in pharmacies
  - Preferring infusion as an effective way of controlling symptoms

- **Roles of doctor**
  - Blind adherence to doctor’s instruction, and accepting doctor as decision maker
  - Rely on doctor passively
  - Trust doctor
  - Troubling both oneself and doctor
  - Impatient doctor
  - Trust western doctor more

- **Beliefs about drugs**
  - Good drugs should make one feel effective
  - Overall trust in western medicine drugs
  - Painkiller
    - Some reject painkiller (never use, fearing drug reliance)
    - Some taking painkiller on *ad hoc* basis
    - Not a treatment at all

- **Different culture backgrounds**
  - Description of disease (in TCM way)
  - Feeling doctor are not able to understand

- **Doctor’s attitude**
  - Polite, nice (superficial)
  - Indifferent (do not care about patients)

- **Western medicines**
  - Believing that Western medicines control symptoms only not the root cause of the diseases
  - Functioning immediately as disadvantage
  - Surgery
  - Not completely trust in WM
Appendix 4-3-4 Final structure

**Category 1: Self management**
Self-reliance and keeping peace
Self-reliance
Keeping a mentally undisturbed peace
Personalised self care and self treatment
Beliefs of TCM in Chinese elders’ mind
Utilisation of TCM in self management
Home remedies

**Category 2: Normalising/minimising to be healthy**
Creating a sense of normality
Knowledge about health issues
Old age and accepting

**Category 3: Access health services**
Roles of family
Filial piety
Shared decision making
Expecting family support
Fear of being a burden
Controversial health care service in the UK
Feeling content with health system in the UK
“Free doesn't mean good quality”

**Category 4: Been cured**
A dual character of Western medicine
Variation in appraisal towards WM practitioners
Ineffective culture related communication
Avoiding bothering doctors unnecessarily
Passive dependency upon doctors
Appendix 4-4: Example of the development of a theoretical memo

**Category 4: “being cured”**

**Sources:** Interview data, field notes, current analysis and informal feedback data

**Getting/picking up ideas:** (Chinese elders perceived concern, dissatisfaction, distrust and fear in relation to the WM services, particularly the professionals)

<table>
<thead>
<tr>
<th>WHO</th>
<th>Majority of participated elders</th>
</tr>
</thead>
</table>
| **WHAT** | Discussing the dual character of western medicines, with its merits and disadvantages  
Though reporting variation in appraisal to the WM practitioner, in fact, showing their unsatisfactory (comparing the situation in China)  
Avoiding bothering doctors, because of their unwilling to help  
Passively following doctors when seeking help |
| **CONTRAST:** | Many elders referred directly or indirectly to defences between the practitioners in China and in the UK, suggesting what should be gained from the professionals in their ideal, and how was not what happened in their real interactions with the UK practitioners. |
| **HOW** | Language, non verbal behaviour indicated a negative attitude and appraisal.  
Privative words – Won’t, not able to, not enough, do not (showing the disapproving emotions about the low services)  
accompanying by negative non-verbal behaviours (sigh, head-shaking)  
Ethical/moral terms – ought to, should to (describing the ideal situation)  
Nature of speech – intense, vehement suggested emotional involvement and their concern |
| **SUMMARY** | Elders were experiencing conflicts and discrepancies between what they thought the practitioners should do and what elders actually gained. |
| **ANALYSIS** | “Being cured” was the term which used frequently by elders discussing the general service they got from the UK practitioners. It described elders’ perceptions of failing to achieve the ideal help they aspire to, and the lower standards they had gained according to their previous experiences. This was not only because of the comparison between the health services provided by doctors in China and the practitioners in the UK; it also derived from traditional Chinese culture, emphasising the holistic treatment. This included the control of symptom as well as the root cause eradication. However, from elders’ perception, the UK doctors only treat their symptoms. In this way, after getting cured, elders did not follow up the treatment but went back their own Chinese world to do self management. Further, as the WM doctors supposed that elders gained healthy (because elders did not seek help any more), they would not take care of these patients any more. In this way, it enhanced the thought of elders that WM practitioners were unwilling to help them. Thus, it became a big barrier to elders’ help seeking. |
## Appendix 4-5: Comparative literature review search in electronic databases

<table>
<thead>
<tr>
<th>Population</th>
<th>Date of search (20/02/2010)</th>
<th>AMED</th>
<th>British Nursing Index and Archive</th>
<th>EMBASE</th>
<th>Global Health</th>
<th>Ovid MEDLINE(R)</th>
<th>PsycINFO</th>
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<tbody>
<tr>
<td>Population 1</td>
<td>Chinese.</td>
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<td>864</td>
<td>14578</td>
<td>10755</td>
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<td>Population 2</td>
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<td>478</td>
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<td>5437</td>
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<td>7534</td>
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<tr>
<td>Population 3</td>
<td>Immigrant {Including Limited Related Terms}</td>
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<td>8273</td>
<td>5647</td>
<td>7122</td>
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<td>Population 4</td>
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<td>0</td>
<td>4</td>
<td>1</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Population 5</td>
<td>1 and 2</td>
<td>10</td>
<td>10</td>
<td>66</td>
<td>20</td>
<td>55</td>
<td>101</td>
</tr>
<tr>
<td>Population 6</td>
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<td>98</td>
<td>113</td>
<td>419</td>
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<tr>
<td>Population 7</td>
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<td>11</td>
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<td>90</td>
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<td>1701</td>
<td>28225</td>
<td>17480</td>
<td>23931</td>
<td>23164</td>
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<td>24</td>
<td>678</td>
<td>299</td>
<td>906</td>
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<td>help seeking</td>
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<td>5540</td>
<td>5603</td>
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<tr>
<td>Phenomenon 11</td>
<td>9 or 10</td>
<td>826</td>
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<td>4394</td>
<td>5540</td>
<td>6178</td>
<td>4149</td>
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<td>Setting 12</td>
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<td>1955</td>
<td>3914</td>
<td>13222</td>
<td>21069</td>
<td>7480</td>
<td>12303</td>
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<td>Result 13</td>
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<td>11</td>
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<td>68</td>
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<td>49</td>
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<td>Result 17</td>
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<td>2</td>
<td>8</td>
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<td>1</td>
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</tr>
</tbody>
</table>
Appendix 4-6 Ethical issues (Participant Information Sheet, Consent Form and Ethical approval)

Appendix 4-6-1 Participant Information Sheets (Simplified/Traditional Chinese version & English version)

English version

**Research study about the help-seeking behaviour**
You are invited to take part in a study about the help-seeking behaviour among senior Chinese immigrants in the North West of England.

**Why have I been contacted?**
We are interested in finding out the views of the Chinese immigrants’ attitude on help seeking behaviour when facing certain health problems. We would like to know what you thought the health service and whether you have any barriers in help-seeking. This information will help us to provide a quality service to patients, based on what patients feel is important to them.

**What is involved?**
We would like to interview you on one occasion about your views. The interview will last about one hour but can be shorter or longer depending on you. During the interview you will be asked a number of questions about your views on local health services, and potential problems in help-seeking. There are no right or wrong answers; your opinions are important to us. A researcher, who is a student of Social Work, will carry out your interview. The researcher will ask what has been helpful to you and what has not been helpful. The interview will take place in your own home or at a place that is convenient for you. We need your written consent to be interviewed and I have enclosed a consent form for you to read and sign if you are willing to be interviewed.

**What if I consent to be involved in the study but change my mind?**
If you consent to an interview you are under no obligation to proceed. You do not have to give a reason for changing your mind and at no time will your care and treatment be affected by your decision to be interviewed or not.

**Will what I say during the interview be treated as confidential?**
Yes, all information you give will be treated as strictly confidential. In order to ensure accuracy, each interview will be recorded with your consent. If you agree to your interview being recorded, you can ask for the recorder to be stopped at any time during the conversation or you can ask for any part of the conversation to be deleted. Your interviews will be transcribed (typed up) and you will be welcome to a copy of your transcript if you want. Another student whose major is public health and I will transcribe recordings and identifying names of individuals and institutions will be removed. All recordings will be destroyed at the end of the study. Only the researcher who carries out your interview (Zhenmi Liu) will be aware of your name. When your recording is sent for transcribing you will be identified by a number, so that you remain anonymous to anyone else. When a report is written about the study we may mention some of your comments but your name will not be mentioned or any other details which might directly identify you.
Do any of my family or friends need to be involved in the interview?
No, your family and friends do not need to be involved in the interview but if they have any questions about the interview then we would be happy to answer them, with your permission. We are interested in your views but if you would like any members of your family or friends to be present at the interview then this will be up to you.

Is there any other information about this research study that I need to consider?
After the interview you may have questions about the interview or the research study that you have been involved in. The researcher will ensure that you have time to ask any questions after the interview. The researcher will also leave her contact number with you for any further assistance. You may wish to keep this information sheet in case you need to ask any questions about the study in the future. Please don’t hesitate to get in touch if you have any questions.

Do I have to be interviewed?
No, your participation in all parts of this study is entirely voluntary. You do not need to give a reason for not wanting to take part.

If I decide to be interviewed, what do I do?
There is a reply slip attached to this sheet, please indicate if you are willing to take part. If you are, please return it to the staff in the community centre and I will contact you in a couple of days; or can contact me directly. If you do not wish to take part, then thank you for reading this, and I will not contact you further.
Thank you for taking the time to read this information sheet

Investigator: Zhenmi.Liu
Telephone: 07895270419
E-mail: zhenmi.liu@student.manchester.ac.uk
邀请函

我们希望您可以加入一项研究，这个研究旨在调查英国西北部年过六十之华人在寻求英国医疗服务机构帮助中遇到的问题。

为什么我们要联系您?
因为我们对年过六十之华人，在就医态度在这个问题上的看法很有兴趣。我们希望了解您是如何看待这里的医疗服务机构的，以及您若要寻求医疗服务，又会有哪些困难。您提供的资料，将会帮助我们为在英华人提供更好的医疗服务，因为您的感受，对医疗服务的提供者是非常重要的。

这个调查包括了些什么?
我们希望可以对您进行一次采访，听取您的看法。我们计划此采访将持续约一小时，但是并没有规定，可长可短，以您的愿望为准。在采访中我们将询问您一些问题，主要是有关您与此地医疗服务机构的联系，以及在寻求医疗服务时可能或者已经遇到的问题等等。这些问题没有标准答案，无所谓对错，您的意见对我们来说是最宝贵的。一位经过培训的研究人员将会完成这个采访，并与您交流。该采访可以在您家中，或者任何您认为合适的地方完成。为了可以完成这个采访，我们需要您的书面知情同意书。我已经将一份知情同意书与此信一起交给您，如果您愿意接受此采访，则请您阅读并在该份知情同意书上签字。

如果我在同意加入该调查后改变了决定会怎么样?
即使您已经同意接受采访，您也没有任何义务继续进行下去。您可以改变决定而不需要给出任何理由，并且，您现在的医疗服务也不会因为您是否接受采访而受到任何影响和有任何改变。

我在接受采访时说的话会被保密吗?
是的。您提供的所有信息都会被严格保密。为了保证调查的精确，所有的采访都会在您的同意下被记录下来。如果您同意我们对采访录音，您在交谈中可以在任何时候要求我们停止录音，也可以要求我们删除任何部分的录音。您的采访记录将会被转录为书面档案，而若您需要，您也可以获得一份。转录工作将会由专业的转录服务人员完成，而您的所有个人资料和相关人员/单位信息都会被消去。仅有完成对您采访的研究人员（刘振谧）可以得知您的名字。当您的录音被送去进行转录时，您的录音将使用数字标记，所以对其他人来说，您是匿名的。在写作关于此研究的报告时，您的发言可能会被提到，但是您的名字或者任何可能泄露您身份的细节都将会被隐去。

我的家人和朋友也需要参加这个采访吗?
该采访，没有对他们加入的要求，但是如果他们对采访有任何疑问的话，在您的许可下我们将很高兴回答。我们更看重的是您的意见，但是是否让您的家人或者朋友也加入采访则取决于您。

关于这个研究还有其他我需要考虑的问题吗?
在完成调查后，您也许会被问及对于此研究及采访的看法。研究人员也会保证在采访后您有充足的时间来提问。研究人员还会留下她的联系方式，以便在将来您需要更多帮助时联系她。您可能会想保留本信，这样将来如果您需要询问有关本研究的问题便可以与她联系。如果您有任何问题，请联系，不要多虑。

**我必须参加采访吗？**
不，对本调查的参与是完全自愿的。您若不愿意参加，不需要给出任何理由。

**如果我决定参加，我应该怎么做？**
随函附有回复单，如果你愿意参加，可以填好回复单交给活动中心负责人，刘振谧将会联系您；您也可以直接与刘振谧联系。如果您不愿意参加，不用作任何回复，刘振谧也不会再联系您。

**谢谢您抽出宝贵的时间来阅读本邀请函**

研究人：刘振谧
电话：07895270419
邮箱：zhenmi.liu@student.manchester.ac.uk

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回复单
题目：英国西北部年过六十之华人在英就医情况调查
我愿意参加访谈：

签名：
日期：
请交还到中心负责人，谢谢。
邀請函

我們希望您可以加入一項研究，這個研究旨在調查英國西北部年過六十之華人在尋求英國醫療服務機構幫助中遇到的問題。

為什麼我們要聯系您?

因為我們對年過六十之華人，在就醫態度在這個問題上的看法很有興趣。我們希望了解您是如何看待這裏的醫療服務機構的，以及您若要尋求醫療服務，又會有哪些困難。您提供的資料，將會幫助我們為在英華人提供更好的醫療服務，因為您的感受，對醫療服務的提供者是非常重要的。

這個調查包括了些什麼?

我們希望可以對您進行一次采訪，聽取您的看法。我們計劃此采訪將持續約一小時，但是並沒有規定，可長可短，以您的願望為準。在采訪中我們將詢問您一些問題，主要是有關您與此地醫療服務機構的聯系，以及在尋求醫療服務時可能或者已經遇到的問題等等。這些問題沒有標準答案，無所謂對錯，您的意見對我們來說是最寶貴的。一位經過培訓的研究人員將會完成這個采訪，並與您交流。該采訪可以在您家中，或者任何您認為合適的地方完成。為了可以完成這個采訪，我們需要您的書面知情同意書。我已經將一份知情同意書與此信一起交給您，如果您願意接受此采訪，則請您閱讀並在該份知情同意書上簽字。

如果我在同意加入該調查後改變了決定會怎麼樣?

即使您已經同意接受采訪，您也沒有任何義務繼續進行下去。您可以改變決定而不需要給出任何理由，並且，您現在的醫療服務也不會因爲您是否接受採訪而受到任何影響和有任何改變。

我在接受採訪時說的話會被保密嗎?

是的。您提供的所有信息都會被嚴格保密。爲了保證調查的精確，所有的采訪都會在您的同意下被記錄下來。如果您同意我們對採訪錄音，您在交談中可以在任何時候要求我們停止錄音，也可以要求我們刪除任何部分的錄音。您的採訪記錄將會被轉錄爲書面檔案，而若您需要，您也可以獲得一份。轉錄工作將會由專業的轉錄服務人員完成，而您的所有個人資料和相關人員/單位信息都會被消去。僅有完成對您採訪的研究人員(劉振謙)可以得知您的名字。當您的錄音被送去進行轉錄時，您的錄音將使用數字標記，所以對其他人來說，您是匿名的。在寫作關于此研究的報告時，您的發言可能會被提到，但是您的名字或者任何可能泄漏您身份的細節都將會被隱去。

我的家人和朋友也需要參加這個采訪嗎?

該采訪，沒有對他們加入的要求，但是如果他們對採訪有任何疑問的话，在您的許可下我們將很高興回答。我們更看重的是您的意見，但是是否讓您的家人或者朋友也加入採訪則取決於您。

關於這個研究還有其他我需要考慮的問題嗎?

在完成調查後，您也許會被問及對於此研究及採訪的看法。研究人員也會保證在採訪後您有充足的时间来提問。研究人員還會留下她的聯繫方式，以便在將來您需要更多幫助。
時聯系她。您可能會想保留本信，這樣將來如果您需要詢問有關本研究的問題便可以與她聯系。如果您有任何問題，請聯系，不要多慮。

我必須參加訪談嗎？
不，對本調查的參與是完全自願的。您若不願意參加，不需要給出任何理由。

如果我決定參加，我應該怎麼做？
隨函附有回覆單，如果你願意參加，可以填好回覆單交給活動中心負責人，劉振謙將會聯系您；您也可以直接與劉振謙聯系。如果您不願意參加，不用作任何回覆，劉振謙也不會再聯系您。

謝謝您抽出寶貴的時間來閱讀本邀請函

研究人：劉振謙
電話：07895270419
郵箱：zhenmi.liu@student.manchester.ac.uk

回覆單
題目：英國西北部年過六十之華人在英就醫情況調查
我願意參加訪談：□

簽名：
日期：
請交還到中心負責處，謝謝。
Appendix 4-6-2 Consent Forms (Simplify/Traditional Chinese version & English version)

**English version**

**Consent Form**

*An investigation into the factors that facilitate early help seeking behaviour for coronary heart disease (CHD) related conditions among Chinese elders in the North West of England*

This consent form is designed to check that you understand the purposes of the study, that you are aware of your rights as a participant and to confirm that you are willing to take part.

<table>
<thead>
<tr>
<th>Please tick as appropriate</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 I have read the information sheet describing the study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 I have received sufficient information about the study for me to decide whether to take part</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 I understand that I am free to refuse to take part if I wish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 I understand that I may withdraw from the study at any point without having to provide a reason</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 I know that I can ask for further information about the study from the research team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 I understand that all information arising from the study will be treated as confidential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 I know that it will not be possible to identify any individual respondent in the study report, including myself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 I agree to take part in the study</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature: Date:  
Name in block letters, please:

I confirm that quotations from the interview can be used in the final research report and other publications. I understand that these will be used anonymously and that no individual respondent will be identified in such report.

Signature: Date:  
Name in block letters, please:

Signature of the researcher: Date:
知情同意书

关于英格兰东北地区年逾六十之华人因冠心病相关体况而寻求医疗服务的情况的调查

本知情同意书是为了确保您已经了解了此研究的目的和您作为参与者的权力。同时也是确认您愿意参加本调查。

请勾选符合条件的回答

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签名: | 日期: |
|---|---|

名字（请用易辨识的字体书写）: 

我确认本采访中的发言可以在最终的研究报告中和其他文献中被引用。我了解这些引用会保持匿名，而且参与者不会因此而暴露身份。

签名: | 日期: |
|---|---|

名字（请用易辨识的字体书写）: 

研究人员签名: | 日期: |
知情同意書

關於英格蘭東北地區年逾六十之華人因冠心病相關體況而尋求醫療服務的情況的調查

本知情同意書是為了確保您已經了解了此研究的目的和您作為參與者的權力。同時也是確認您願意參加本調查。

請勾選符合條件的回應

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日期:  

名字（請用易辨識的字體書寫）:  

我確認本採訪中的發言可以在最終的研究報告中和其他文獻中被引用。我了解這些引用會保持匿名，而且參與者不會因此而暴露身份。

簽名:  
日期:  

名字（請用易辨識的字體書寫）:  

研究人員簽名:  
日期:  
Appendix 4-6-3 Ethical approval

Ms Zhihui Liu
Flat 50 Plymouth Village
208 Plymouth Grove
Manchester
M13 9AS

23 July 2006

Re: An investigation into factors that facilitate early help seeking behaviour for coronary heart disease related conditions among Chinese elders in the North West of England

Proposal Number: 06/1006/NMSW

Dear Ms Liu,

Thank you for the clarifications and amendments to the above study as requested by the Research Ethics Committee.

I am of the opinion that no major concerns or objections are evident of an ethical nature. Therefore on behalf of the Committee I am happy to grant full ethical approval.

During the progress of the study please inform the Committee of any changes or amendments that may be necessary.

On completion of the study would you please provide the Committee with a "Completion of Study Report".

In order to arrange University Insurance Cover please forward the completed Insurance Form (enclosed) along with your Research Proposal and a copy of this letter to the Purchasing Office at the address printed on the form.

Best wishes for your study.

Yours sincerely

Pp.

Howard Shilton
Chair, School Research Ethics Committee

cc. Dr Sean Speed
Professor Keith Beavis
### Appendix 5-1 Demographic information

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<th>Gender</th>
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<th>Marital status</th>
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N = 33, Average age = 71.06 (60 – 84), Female/ Male = 23/10, average year in the UK = 24.6 (1.5 - 54).
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<th>Name of Author (Year) and Journal</th>
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<th>Methods</th>
<th>Findings</th>
<th>Implications/Limitations</th>
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<tr>
<td>S. Jovchelovitch and M.-C. Gervais (1999) <em>Journal of Community &amp; Applied Social Psychology</em></td>
<td>Social Representations of Health and Illness: The Case of the Chinese Community in England (England)</td>
<td>Qualitative methods of data collection and analysis. Interviews with experts (n=6) on the Chinese community, individual interviews (n=12) and focus group (n=24, 4 groups in different age) with lay Chinese people.</td>
<td>The themes addressed from lay members included the experience of being Chinese in England, health beliefs and health-related practices, the relationships between Western and Chinese medicine, experiences of ill-health, and experience of health services in England. Balance and harmony: health as a world view (based on the TCM principles). Food rituals and the transmission of knowledge: constructing representations in everyday life.</td>
<td>Suggests that though different in age and degrees of acculturation, Chinese people in England share a common representational system with respect to health and illness. The representations did not appear as a fully articulated corpus of notions and were often in a patchy and fragmented form. Difficult methodology to follow – lots of areas unclear as to why and what was done.</td>
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<tr>
<td>G. Green, et al. (2006) <em>Social Science &amp; Medicine</em></td>
<td>“We are not completely Westernised”: Dual medical systems and pathways to health care among Chinese migrant women in England (England)</td>
<td>In-depth semi-structured interviews with 42 women of Chinese origin (24 were categorised as ‘mentally distressed’ including 13 with a medically diagnosed and 2 were still receiving treatment). Using ‘Winmax’ software for coding (a standard computer assisted package for the analysis of qualitative data).</td>
<td>Diverse explanatory models (attributing mental problems to a lack of harmony in dietary management). Pathways through Western and Chinese health care Barriers to health care (language, culture based communication). Dualism to overcome barriers (traditional health beliefs and biomedical Western representations).</td>
<td>Chinese women in predominant use of biomedical health care, but also use other forms of treatment to supplement in a pragmatic way to treatment. Suggests that when the Chinese seek complementary care; they normally turn to remedies based upon Chinese understandings of health and illness. There is discrepancy between the understandings and health perceptions of Chinese women and their NHS practitioners. Gives insight the dynamic of seeking help from Chinese perspective. This study does not take into account the reason why</td>
</tr>
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<td>M.-C. Gervais and S. Jovchelovitch (1998) Social Science information</td>
<td>Health and identity: the case of the Chinese community in England (England)</td>
<td>6 individual interviews with experts on the Chinese community, 12 with lay subjects, together with 4 focus groups (22 lay people). The qualitative data were transcribed and coded for detailed analysis.</td>
<td>Chinese community in England: unity and diversity (heterogeneous). Chinese representations of health and illness (the aetiology of disease and the therapeutics to handle it, such as adjusting diet and emotion). Hybrid social representations and strategies of identification.</td>
<td>Difficult to evaluate as the methods are unclear. Fails to incorporate the dynamic way of the transmission and the transformation of a cultural identity. Need to look as the processes and mechanics of Chinese people’s help seeking. Further research needed to be sensitive to such social and psychic dynamics.</td>
</tr>
<tr>
<td>G. X. Ma (1999) Journal of Community Health</td>
<td>Between Two Worlds: The Use of Traditional And Western Health Services by Chinese Immigrants (USA)</td>
<td>Quantitative surveys were conducted with all selected informants (n=105: 75 Chinese consumers and 30 Chinese health professionals including Western physicians and traditional practitioners). Qualitative ethnographic methods used included: (1) participant-observation, (2) face-to-face interview, and (3) case study.</td>
<td>High rates of self-treatment and home remedies (balanced diets and other alternative medicines). Medium rates of utilization of integrated Western and traditional health services, including travel to country of origin for care. Low rates of exclusive utilization of Western or traditional Chinese treatments.</td>
<td>Difficult methodology to follow – lack of explanation of the cooperation of the epistemology of ethnography with the data analysis using Grounded Theory. Show the depth of analysis to some extent – one important factor in determining health care choice for the Chinese is their perceptions of health and illness based on the Chinese traditions. Sensitising health providers to TCM and related alternative healing practices and educating Chinese and other Asian communities in Western concepts of mental and physical health.</td>
</tr>
<tr>
<td>Y. L. Chen (1996) Advanced Nursing Science</td>
<td>Conformity with nature: a theory of Chinese American</td>
<td>Grounded theory methodology was used to generate a substantive</td>
<td>The theory, conformity with nature, emerged. Three interrelated subthemes – harmonizing with the</td>
<td>Conformity with nature is not passive but as doing one’s best. Shows some of the dynamics of</td>
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<tr>
<td><strong>Health-Seeking Behaviours of Elderly Chinese Americans: Shifts in Expectations (USA)</strong></td>
<td>Content analysis was used to obtain themes and key points of focus group interview data (n=25)</td>
<td>A shift from traditional expectations of filial piety to more dependence on neighbours and friends, and a genuine adaptability to combining Eastern and Western health care modalities. Immigration was not proposed by these Chinese elders as an explanation of shifts in expectations for family support or values.</td>
<td>Implications for research, service delivery, and policy making for health care of ethnic elderly persons, particularly in addressing structural and cultural issues in access and compliance. This study only focuses on the community-dwelling Chinese elders; it needs more investigation among the population with diverse backgrounds, to make the results rigorous.</td>
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<td><strong>Health Care and Social Service Use Among Chinese Immigrant Elders (USA)</strong></td>
<td>Interviews were conducted with 27 Chinese immigrant elders, 11 adult care giving children, and 12 health and social service providers. Content analysis of these qualitative data.</td>
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<td>Study Title</td>
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