Sandra Jovchelovitch
Institute of Social Psychology, LSE

# Health and identity: the case of the Chinese community in England[1]

Marie-Claude Gervais and Sandra Jovchelovitch

*Symposium: "Representations, communities and health"*

*Abstract. Social representations of health and illness are deeply intertwined with issues of cultural identity. People think of health and illness in relation to their social environment and cultural background. In this paper, we report findings of a study on representations of health among the Chinese community in England. Using focus groups and in-depth interviews with experts and lay members of the Chinese community, we found a hybrid representation which combines Chinese traditions and western biomedical knowledge. This mixed social representation is paradoxical: it both integrates and draws upon the differences inherent in the two knowledge systems. The contradictory nature of the representation is functional: it enables the community both to sustain/defend its cultural identity and to cope with the challenges posed by the host environment. The findings are discussed in relation to the hybridization of identities in the context of globalization.*

The study reported here was commissioned by the Health Education Authority (HEA) as part of a more extensive and wide-ranging research on the health beliefs, status and needs of the Chinese community in England, The authors are grateful to the HEA for its support at every stage of the research process. The authors also thank their research assistants Melissa Curry, Caroline Howarth and Keng Lee for their coIlaboration. Lastly, the final version of this paper was written while the second author was Directeur d'Etudes Associé at the Maison des Sciences de l'Homme in Paris. She wishes to express her gratitude to Mr Maurice Aymard, the Administrator of the Maison, for having provided such a congenial environment in which to work.

**Introduction**

The present paper is guided by a fundamental question: how to conceptualize the relationships between social representations and identity in a way which is sensitive to changing cultural contexts and social environments. We examine these issues in relation to the social representations of health and illness which are found today among the Chinese community in England. This community affords a critical case to explore the functioning of social representations of health and illness and their relation with both self and collective identity. Indeed, perhaps more than any other ethnic minority group in England, the Chinese can draw upon a long and well established cultural and medical tradition in order to explain health matters and to make health-related decisions. And yet, as any other displaced community, they are exposed to a way of thinking which differs from their own in some important ways, but with which they must nonetheless engage. How do the Chinese people living in England position themselves with respect to such diverse health knowledge? Do they combine traditional and scientific knowledges about health and illness? Do they keep these spheres separate? On what basis are particular strategies chosen and what do they express? As we hope to demonstrate, the social representations of health and illness constructed by the Chinese community do not simply reveal how people think about health and illness per se; rather, they encompass an entire world-view and they are shaped by the cultural dashes that guide the identity work of different sections of the community.

We shall address these issues first by discussing the relationships between social representations, identity and health in conditions of late modernity. We shall then spell out the methodological choices which guided our research. The presentation of results will centre firstly on how Chinese people perceive themselves as a group. This will highlight both the diversity and the homogeneity within the English Chinese community. We will then describe briefly the social representations of health and illness which we have uncovered. This will enable us to show how, depending on their identity needs - their position within the Chinese community and in relation to the host society - the Chinese draw upon both traditional Chinese health beliefs and western biomedical knowledge. Indeed, rather than considering their traditional beliefs and scientific knowledge as incompatible domains of thought, they integrate elements from both representational systems and build upon the differences between them to sustain their own Chinese identity and to integrate into the new environment.

**Social representations, identity and health**

Social representations have been defined as a form of social knowledge that is collectively elaborated and shared by a group, and whose aim is to enable people to make sense of their environment and to locate themselves within it so that they may then act towards it (Jodelet, 1989, 1991; Moscovici, 1973). As a system of knowledge collectively constructed, social representations are both dependent on and expressive of the identity issues experienced by the groups which produce them. In this sense, there are a number of key aspects of social representations which need to be singled out and related more explicitly to questions of identity formation and maintenance. Firstly, social representations are knowledge structures which afford interpretative schemes for understanding the world. These schemes provide a symbolic environment which both individuals and groups encounter as the "already there" of social life. They are open, however, to be continually appropriated, manipulated and put to use, thereby bearing the mark of those who re-enact and change them (Rose et al., 1995). Secondly, and in relation, social representations are rooted in the life of groups, expressing the wisdom and knowl-

[1] This paper was published in 1998 in Social Science Information 37, 4: 709-729

edge of past generations; they could not exist as such without being collectively realized in a public sphere (Harré, 1984; Jovchelovitch, 1995). "Making sense" is therefore not a private enterprise; it is not purely the activity of the rational subject facing a puzzling world on which order must be imposed anew every time and single-handedly. Culture and traditional knowledge shape how people perceive, think and feel: they provide the resources to understand one's social and material environment. Even the most private decisions can be understood only against the background of a shared language and culture, of one's embeddedness in a community. This, of course, applies to issues of health and illness as well as to other aspects of one's cultural inheritance. Thirdly, social representations are nonnative structures. They legitimize certain understandings, beliefs and practices, while they discredit others. Most of the time, and especially in traditional and homogeneous societies, social representations do not appear to those who hold them as representations at all; their power derives precisely from the fact that they seem to encompass the whole of the real, to constitute reality itself. They are consensual, taken for granted and routinized; therein lies the implicit normative function of social representations. But such representations can also be explicitly invoked to justify particular practices by grounding them in the shared traditions of the group. They are then called upon to maintain or restore the legitimacy of certain ideas and practices when these are challenged by alternative representations, a process ever more frequent in the modern world.

All these characteristics of social representations are indicative of how such symbolic forms relate to the formation and maintenance of identity, as well as to issues of health and illness. Social representations are always representations *of* something, and representations *by* someone or some collective (Jodelet, 1989). Thus, the work of representation not only links subject and object; it also demands an understanding of the type of logic which guides those who produce this social knowledge. This logic is, most of the time, the logic of identity, as many who have worked on issues bearing on social representations have shown (Breakwell, 1993; Duveen and Lloyd, 1990; Elejabarrieta, 1994; Gervais, 1997; Mugny and Carugati, 1989). Either as a symbolic environment or as a process in the making, social representations are permeated by the demands of identity. As constituted entities, on the one hand, social representations provide the symbolic materials and interpretative schemes necessary for the formation of identity, both at an individual and at a collective level. The sense of oneself and the sense of belonging to a collective are both shaped by the knowledge, traditions, values and practices one shares with members of the community. Social representations are part of the stock of common knowledges which shape the life-trajectory of individuals and groups. As: a constituting activity, on the other hand, the process of social representation also involves proposing an identity, stating who one is, and locating oneself within a representational field. Thus, social! representations reveal, in their very structure and content, both the social conditions of their production and the private and affective experiences of the subjects who reproduce, renew or challenge them.

These issues playa central role with respect to health and illness. Although research in the fields of health knowledge, attitudes and behaviour is generally predicated on individualistic assumptions (Crawford, 1994; Naidoo, 1986), we argue that the latter in fact hinder an adequate understanding of the complex role of health beliefs in everyday life. By focusing exclusively on individual rather than social cognition, by postulating that increased knowledge will somehow automatically yield sounder health decisions and better health, by assuming that each individual can be held entirely responsible for his or her own life-style choices, by underestimating or altogether ignoring the influence of larger cultural, social, economic and political determinants of health and by failing to appreciate that health beliefs contribute to the existential grounding of individuals, the dominant social psychological approaches in the field of health (e.g. Ajzen and Fishbein, 1970; Bandura, 1977; Becker, 1974; Rosenstock, 1966; Wallston and Wallston, 1982), in their different ways, have failed fully to address the complexities of health as a cultural and psychological phenomenon (Herzlich, 1973). As Campbell (1997; see also this issue) shows, information alone does not suffice to bring about consistent and long-term behavioural change. For this to occur, one must understand the logic of production of health beliefs as well as their functions at both an individual and a social level. It is all the more urgent to acquire such an understanding in the modern world, now that a plurality of social representations of health and illness co-exist in any society, and that social subjects are constantly called upon to position themselves amid this diversity.

*Modernity and social representations*

The programme of research on social representations aimed from its very outset (Moscovici, 1961) to investigate a new type of common sense whose structural and functional characteristics, as well as content, were intrinsically linked to and constitutive of a new kind of public sphere. Novel forms of communications and social interactions, related to the diffusion of scientific knowledge through the mass media, to the breakdown of traditional morality, to pluralism and to other processes of globalization have changed the production, transformation and distribution of knowledge. The outcome, which is still open-ended, is a new, more malleable, type of common sense: social representations. The latter would be the modern-day equivalent of the *representations collectives* - myths, rituals, religion and custom - of the more traditional societies Durkheim described a century ago (Durkheim, 1898). The distinction between social and collective representations, therefore, is not only one of content; it pertains, first and foremost, to the process of knowledge production in different societies, and to the changing relationships between self and knowledge in these different contexts.

Indeed, the widespread societal changes which prompted Moscovici to modernize Durkheim's forgotten concept have engendered a greater need to position oneself in a rapidly changing world and to reflexively construct one's own biography or self-identity (Giddens, 1991). Bauman (1996) recently noted that our era is obsessed with what it lacks most: traditions, a sense of community and a stable identity. Nowhere is this more acutely felt than among members of displaced communities (Hall, 1991). As people move from one country to another, from one culture to another, they carry with them the knowledge, values and traditions of their place of origins. Yet they also find themselves amid a puzzling diversity of options and are often asked to choose between the old and the new when the traditional criteria which used to guide action no longer apply.

They become deeply aware of the impossibility of sustaining cultural continuity in a society where their traditional social representations have neither relevance nor legitimacy. Indeed, they become aware that the world they used to take for granted is but one of the many possible versions of reality. Schutz's essay on the social psychology of the stranger remains a paradigmatic exposition of how displaced communities are thrown off the taken-for-granted and how they develop an acute awareness of the diversity of validities embedded in world views (Schutz, 1944). Thus the nature of tradition itself changes: from being a silent guide which yielded its power by virtue of its simple "being there", unrecognized as such, and buried in practices, tradition now owes its authority to the conscious and openly declared loyalty with which detraditionalized communities rhetorically imbue it. We report below on how the profound cultural and identity clashes experienced by Chinese people as they settle in England shape their representations of health and illness, and how the latter are used to express, sustain and defend a threatened cultural identity.

*Methods*

The data collection took place between January and April 1997. Our research design combined 6 individual interviews with experts on the Chinese community and 12 with lay subjects, together with 4 focus group discussions with 22 lay Chinese people. In total, 40 subjects took part in the study. They were recruited in the two geographical areas where the Chinese population is most concentrated: Greater London and Greater Manchester (Cheng, 1996; Owen, 1992, 1994). Expert subjects were initially recruited through specialist Chinese health centres and then through snowballing. Lay subjects were recruited opportunistically, on the basis of the following criteria: sex and generation (20-27- and 37-44-year-olds, which correspond roughly to the waves of Chinese migration to the United Kingdom). We excluded an elderly group since we assumed that the health beliefs of the older generation would have remained essentially traditional. The respondents were of diverse national origins (Hong Kong, mainland China, Singapore, Malaysia and Vietnam). Again, following the most recent census data (1991), we recruited lay subjects from amongst the following groups: students, catering industry workers, professionals and housewives. The resulting sample is not representative of the English Chinese community, but it does meet the dual requirements of typicality and diversity advocated for qualitative research (Patton, 1980).

Given the scarcity of research on Chinese representations of health and illness in England (for notable exceptions, see Chan, 1991; Tann and Wheeler, 1980), and considering the complexity of the issues involved, we have favoured a qualitative approach. In-depth individual interviews and focus-group discussions are both flexible methods which provide plenty of scope for subjects to explore and express their ideas and opinions in their own terms (Farr, 1993; Morgan and Krueger, 1993). Focus groups, in particular, provide rich data on interactions, on realities as defined in a group context, and on interpretations of realities which reflect each group's own dynamics (Burgess et al., 1988). Expert interviews were conducted during a preliminary phase in order to tap into the reflexive and critical knowledge held by leading community members about their own group and to generate insights about community structures and symbolic practices. The interviews and group discussions with lay participants focused on life-style and identity, health beliefs and practices, concrete experiences of illness (lay aetiology, symptoms, cure, encounters with health professionals, etc.), and attitudes towards biomedical and Chinese health knowledge and practices. All expert interviews and focus groups were conducted in English, but four individual interviews were held in Chinese via an interpreter. The interviews and group discussions were transcribed verbatim and coded for detailed qualitative analysis. The data were analysed according to two distinct but interrelated dimensions: thematic content and processes. We identified the main themes and analysed how these were linked by the reasoning of the participants. We examined how cognitive and motivational processes, affective needs and situational demands shaped the ways in which content was presented and negotiated. The quotations reported here reflect main trends in the data.

**The Chinese community in England: unity and diversity**

The structure of the Chinese community and the collective and personal identity struggles faced by the community members shape how people relate to issues of health and illness in important ways. Our research highlights both the unity and the diversity of the Chinese community. One can identify three generations, each bearers of very diverse life experiences (see also Parker, 1995; Watson, 1977; Wei, 1994). The elderly generation - whose concerns were voiced by younger subjects in this study - comprises a group of early settlers as well as the parents of later immigrants who brought their relatives over. Most of the first settlers migrated to England in the 1960s and originate from the New Territories of Hong Kong. They speak little or no English and therefore remain confined to their community. The middle generation is the most diverse sub-group. It includes newcomers as well as the children of early migrants. Some are very isolated, do not speak English, are involved in the catering industry and live within the boundaries of the Chinese community: they come mainly from rural Hong Kong, China and Vietnam. Others are functionally integrated into the host society, are bilingual and highly educated professionals: they either originate from cosmopolitan Hong Kong, Malaysia, Singapore and China or were born in England. Finally, the younger generation encompasses growing numbers of British-born Chinese adolescents and children. It also comprises a large number of foreign students who are in England as temporary rather than as permanent residents.

Clearly, the Chinese community in England is heterogeneous. Each generation faces specific problems. Yet such diversity does not preclude the sharing of a common Chinese culture and identity. As scholars studying communities across the Chinese diaspora have commented (King and Bond, 1985; Tu, 1994), a number of key values continue to shape the Chinese way of life despite years of acculturation in different societies. The importance of the family as the pivotal axis of both private and social life and the hierarchical structure of social relations were still particularly salient values in our sample.

> I think the thing that I like best is one of the things I detest most as well. It's hard to say, there's a sense of hierarchy. Traditional family, father on top, mother below, then the children come in. And even among them, there's a very strong se:nse that you are the eldestest [sic], I'm the eldestest, you're the younger one, you listen to me, and since you're the younger one, I'll have to take care of you, and all that. In my family, the hierarchy is very strong. If! want to do something, I will turn to my elder sister for support. If my elder sister says no, I'll turn to my mother. If my mother says no, I'll turn to my father. And if my father says yes, then what my mother says and what my sister says doesn't count. He's the ultimate decisionmaker. (Focus group, young women)

More generally, the sharing of a collectivist outlook (Hui and Triandis, 1986) which gives primacy to collective goals over individual wishes and desires is kept alive across all generations, even if it often engenders considerable emotional pain (Parker, 1995). As an older, highly reflexive woman who has lived in England for 17 years reveals:

> I had a depression period. It's due to a lot of things. Basically my life experience and the confusion with the mixed culture and mixed marriages and identity. I don't know where I am and I feel, I see different things in a different way and I could see I'm torn between, there's a conflict between the two cultures. . . . It's also the family values: you're torn between, you respect your parents, which is the way you've been brought up and raised, and you feel guilty when you can't be able to do that and of being a Chinese. And living in here, in this society. . . . It's different, you see, and you feel very unhappy yourself. That's why I say I try to be an individual and I try to do things that I feel good and I feel comfortable. I honestly try not to feel guilty anymore, you know, not being able to see to my parents and see to their needs and you know, if they have someone, they have their problems, because they have communication problems, you know, they can't communicate and I feel I could communicate but I live away from them. I can't help them that much, you know? And I have to live with that and I sort of, you can only do what you can. You can't spend your life living other people's lives because everybody has problems. But I had to seek help to go through that. (Focus group, older women)

The clash between Chinese and western values generates much confusion, both inside and outside the home. But it is these cultural values - the importance of family, respect for hierarchy, collectivism and, as we shall see, shared social representations of health and illness - which unite the very diverse collection of Chinese people in England and which, they claim, truly make them a community. Chinese cultural assumptions, values and practices are present throughout the community; what varies is the way in which they are appropriated and thematized by different members of the community. For some, these cultural assumptions are not in question and they still constitute the deepest level of taken-for-granted knowledge: they shape entirely the self-interpretation of those who bear them as well as providing the lenses through which the knowledge of the other is assessed. For others in the community, Chinese culture remains an important reference, but not the only one: here the decentration of world views (Habermas, 1992) guides the way in which one's cultural heritage is lived and provides hybrid lenses to assess not only the knowledge of the other, but also Chinese knowledge itself. Issues of health and illness do not escape the reflexive gaze of those who embark on the journey of acculturation and who aim to participate fully in the host society. Indeed, the different ways of living out the unity and diversity of the community find one of their key dimensions and modes of expression in the different ways in which the English Chinese combine traditional Chinese knowledge, folk beliefs and practices and biomedical knowledge in order to construct social representations of health and illness.

**Chinese representations of health and illness**

In this section, we turn to the content of the social representations of health and illness uncovered in our study. These representations are not only expressive of the tensions between the different cultural traditions experienced by the Chinese community in England, they themselves constitute a highly functional response to these tensions. Everyday knowledge about health and illness contributes to alleviate the dilemmas of the English Chinese population by efficiently absorbing into the millenary system of knowledge about health and illness which Chinese people possess the resources associated with biomedical knowledge. The former does not stand in contradiction with the latter; rather, each is pragmatically used as knowledge and as resources of a different kind. Chinese people in England recognize and use this difference and alleged complementarity to state both their cultural heritage and their permeability to the demands of their new environment.

The Chinese representational system is competent to define health and illness, to explain the aetiology of disease and to devise appropriate therapeutics to handle it. Chinese people see the human body, social relations, the natural world and supernatural forces as being interconnected. The healthy working of the body is thought to depend on the harmonious balance between elements and energy *(ch'i)* within the body, and between the latter and the social, natural and supernatural worlds. Good family relations, obedience to authority, self-discipline, daily routine, emotional stability, respect for one's ancestors and sound diet, for instance, all concur to maintain the self healthy. This gives to the Chinese definition of health a breadth and scope that extend far beyond mere assessments of bodily conditions.

> To the Chinese, when you're sick, it's more than just either you have ac virus in there or anything like that. It's got something probably to do with the way you handle yourself, the way you eat, whether you drink enough water, all these sorts of things. To us, sick is more than just what medicine can get rid of. It's a whole way of life. (Focus group, young men)

> You have to have a balance. That is the Chinese point of view. That is why the country is called China. China is called the Middle Kingdom. We beli,_ve we're in the middle of the world, of the Earth. Everything must be nicely balanced. So, for example, if you have dry lips, blisters or ulcers, you must b,_ hot. In order to balance that, then you must take something, not necessarily medicine but soups and other remedies which have the cold properties in order to balance that. (Expert)

The notions of "balance" and "harmony" are central to these social representations of health and illness; they refer to the interplay between the complementary, but antagonistic, forces of yin and yang by which everything that exists is formed. Good health results from sufficient and well-distributed energy. Illness, on the other hand, is the symptomatic manifestation of energetic imbalance which, in turn, can be caused by internal factors (such as heredity, age, diet and emotional states) or by external factors (such as temperature, humidity, wind, the movement of celestial bodies and the will of ancestors). Keeping healthy, or restoring good health, involves first and foremost having a balanced diet which properly combines so-called "hot" and "cold" foods and the proper timing of meals (see also Anderson, 1987; Ho, 1985; Kleinman et al., 1975; Koo, 1984, 1987; Manderson, 1987). But it also entails avoiding wet/dry or hot/cold climatic conditions, refraining from excessive emotions - be they joy or anger, sadness or fear -- and maintaining good social relations. Excesses and imbalances in any of the above domains conspire to bring about illness.

It is important to note just how all-encompassing such understandings of health and illness are. This explains why it is impossible to be socialized within Chinese culture without at the same: time acquiring traditional notions concerning the nature and the causes of health and illness, as well as therapeutics for various ailments. Every food item and cooking method is classified as having either "hot" or "cold", or sometimes neutral, properties which affect one's condition. Moreover, in Chinese culture, diseases are named by their traditional aetiology, such that arthritis, for example, would be called "wet-wind", as it is believed that exposure to humidity and strong winds are the joint causes of this condition. To be Chinese, therefore, is to share in social representations of health and illness which are embedded in linguistic categories, in food and in social relations, and which correspond to an entire world view.

Indeed, we have found that virtually all the subjects in our sample - men and women, young and old, lay and expert alike shared a common representational system. It is clear from our data that traditional Chinese concepts of health and illness dominate the representations held by the English Chinese (Kleinman et al., 1975; Unschuld, 1987; see Gervais and Jovchelovitch, 1998 for a more detailed account). Whatever biomedical knowledge they may possess, this information has been reformulated to fit their already existing and highly structured world view and cultural identity. Traditional Chinese health beliefs themselves allow for some combination with biomedical knowledge since, in the Chinese way of thinking, these are conceived as complementary rather than mutually exclusive.

As we noted above, however, it would be misleading to think that only traditional Chinese knowledge gives content to representations of health and illness. Chinese and western notions and practices co-exist side by side; they belong to different realms and do not compete.

> I think most of us look at traditional Chinese medicine and western medicine as co-existing quite nicely. . . . You'll find that the Chinese go to both: they see the western medical doctor and then toddle off to a herbalist to get herbs and then they'll use the two together. They wouldn't see the conflict. (Expert)

There is something inherent in the Chinese way of thinking in general (Bloom, 1988; Levenson, 1965), and in social representations of health and illness in particular, which facilitates this process of combination. With respect to matters of health and illness, the general principle according to which opposites must be harmoniously reconciled whilst maintaining their own distinctive attributes manifests itself in the following belief: Chinese medicine and folk remedies work better for minor conditions, when one needs to tackle the “root” or cause of the problem, and when intervention is not urgently needed because physical pain is relatively mild, whereas over-the-counter medicine and consultation with biomedically trained medical personnel are more appropriate in the case of major or severe conditions, when pain is acute and must be alleviated quickly, and in order to treat the symptoms of illness. On the basis of such traditional beliefs, it makes perfect sense to use both biomedical and Chinese therapeutics simultaneously. We observe this logic at work across the entire community.

> If you want to get well completely, to get rid of the root of the illness as such, you’ll have to take the Chinese medicine because only Chinese medicine could get rid of the root of your illness. If you just want to relieve the symptom for one day, then you can take western medicine. But if you want to get to the root, you have to take the Chinese medicine. (Lay participant, male, 44 years old)

The possibility of combining different systems of knowledge is, to be sure, a strong feature of social representations and other forms of lay thinking in conditions of modernity (Gervais, 1997; Moscovici, 1961). As we pointed out earlier in this paper, this possibility is accentuated now that processes of knowledge production are exposed to fundamental changes. However, while globalization introduces a new pace in the co-existence of different traditions (medical or not), it does not succeed in instituting the sovereignty of scientific knowledge. In fact, the growing awareness of different world views makes it easier to hold on to traditional beliefs. As this scientifically trained nurse who lived in England for nearly 30 years said:

> I know certain [Chinese] things work. And in those days, it was very hard to talk to anybody about herbal medicine. Nobody. They would just brush me off. Perhaps what happens now is that people are more open-minded. But in those days, in my days, probable they would just brush me off and say: “Oh! What the hell are you talking about?”…I might be giving you a conflict view of things but deep down I believe both work. Chinese medicine worked for thousands of years, yes? And without that, probably there would not be such a vast population in China. It must have worked somehow. (Lay subject, female, 44 years old)

The representational system constructed by the Chinese: thus comprises two ways of knowing, derived from two different sets of traditions and cultural assumptions, which are themselves used in different ways in order to fulfil different functions. One believes in and trusts Chinese medicine. By learning its fundamental precepts, one also learns how to be Chinese, since

these are transmitted and enacted through the most fundamental dimensions of culture: food, language and kinship relations. Biomedical understandings, by contrast, belong to the realm of the "knowledge one has to learn"; they are grounded in science, are open to proof and challenge and, by their very logic, defy traditional beliefs. Unlike Chinese health beliefs, biomedical knowledge seems far removed from the realm of everyday life; it is associated with acute pain and serious conditions. It comes from the doctor and, one can only hope, will remain confined to the realm of the exceptional. Thus traditional beliefs endure in parallel with biomedical knowledge. This combination reveals just how successful Chinese people are in dealing with issues of health and illness but also, perhaps more importantly, in managing the complexities of everyday life in an alien and rapidly changing world.

**Hybrid social representations and strategies of identification**

In the foregoing we have argued that social representations are inseparable from issues of identity construction and maintenance. We have also discussed how late modernity changes the process of production of social representations: as the world enlarges and shrinks at once, uprooting people and subverting traditional ways of life, systems of knowledge become detraditionalized and enter into novel processes of combination. Moreover, we have examined briefly how the Chinese way of thinking in general, and Chinese health knowledge in particular, facilitate the combination of different modes of knowledge and cultural resources because they define as complementary what would appear to the western observer as contradictory. Here we explore in greater detail how the diversity within the Chinese community in England, as well as the tensions over collective and personal identity, are related to the mixed social representations that we have uncovered.

Indeed, notwithstanding the prevalence of hybrid representations throughout the community, there emerge some fundamental differences with respect to the ways in which different sectors of the community put these representations into use to defend their collective and self-identity. Different levels of acculturation involve different strategies of relating to the hybrid representational field which the community as a whole sustains. As we stated at the beginning of the paper, different generations of Chinese people in England relate differently to their cultural heritage. But generation and level of acculturation do not always conform perfectly. The only group for which this direct correspondence applies is the elderly generation, whose contact with the host society is very limited. For them, the ancient knowledge of the Chinese people is not questioned. It is just there, like life itself. This, as they often remark, is what "we Chinese people know". They know it with the paradoxical intensity and indifference of what is taken for granted.

Most of the people we spoke to, however, are confronted with the difficult and painful effort of calling into question an entire way of life. Their traditional knowledge must now be actively assessed. The effort of questioning was particularly salient among those who were born in England, who hardly speak the dialect of their parents, who refuse to enter the catering trade, who reject their parents' expectations and yet honour them, who suffer discrimination because they look Chinese but cannot be proud of a culture which is no longer theirs: the so-called "bananas" - yellow on the outside, white on the inside. For them, the existential crisis is profound (Parker, 1995). Indeed, being a "banana" often entails deeply painful experiences which are concealed by the over-simplification implied by the name itself. One is never simply "white inside", if only because of one's physical appearance.

Young parents, similarly, are constantly challenged by their children as they come back from school; and yet they are themselves blamed by their own parents for failing to uphold traditions. Intense feelings of guilt and shame, of confusion and conflict all seem integral to the experience of Chinese people who seek to belong in their new environment. A redefinition of one's self-identity -- from a primarily relational being enmeshed in a network of roles and obligations to an atomistic individual caught in a web of ill-defined and relatively egalitarian relations - is necessary.

It is here that the simple equation, greater integration, more westernized identity and more biomedically informed representations of health and illness, breaks down. As greater participation is achieved, there emerges an intensified need to re-establish a connection with one's culture. This was clear in the case of many young students in our sample who, despite sustained contact and interaction with western culture, held on to traditional Chinese values and knowledge. Traditional health beliefs are a privileged means to assert that, somehow, one remains Chinese. It is a means of belonging when this is no longer easy.

The practice called "sitting a month" can illustrate these dynamics. It essentially involves staying indoors, avoiding wet and windy conditions and modifying one's diet for a whole month following childbirth, in order to allow mothers to recover. Since childbirth is deemed very traumatic because it entails a massive expenditure of energy and considerable "loss of blood" (which irrigates the body and therefore is central to good health), mothers believe that they must "bring up" the level of yang energy to restore the body's balance. This is achieved by ingesting "hot", "tonic" and highly "nutritious" foods (such as garlic and ginger, wine and meat) cooked at high temperature and, conversely, by avoiding "cold" foods (such as fruit and vegetables) or humidity and wind, which would all raise their yin energy.

> We believe [women] lose a lot of blood [during delivery]. They lose a lot of yang already so they have to bring it back to the neutral. That's why we have to be careful, that's why you have to sit in the home, don't do anything and keeping back whatever you lose, on a special diet. (Focus group, older men)

> Sl: You're supposed to eat the food with just a ginseng and to add some Chinese wine *to* cook the meat. And a lot of ginger, a root ginger. . .
> S2: That's to enrich the blood that you lost.
> S3: Or garlic. That's something else that enriches your blood.
> S2: Ginger is full of fibre, you see? You must remember I was told not to eat fruits during the first month because it's something to do with the flow of the yin yang in your body. Your body is very down after birth so you must eat all this

wine and chicken.
S3: Things to boost it up.
S2: To bring it up.
Sl: Your circulation.
S4: Also heaty food like fried food, greasy food and baked, you know, things like that. Ginger is good. And some vegetables.
S2: No they are not, not at this time. (Focus group, older women)

Irrespective of age, gender, national origins or level of education, everyone knows and understands the logic of "sitting a month". Even the mothers who did not comply with this practice did not fundamentally revise their trust in Chinese prescriptions. Indeed, some of the women who did not follow these prescriptions recalled how they had experienced all the very symptoms which "sitting a month" was meant to counter; others expressed deep feelings of guilt and anxiety for having failed both to acknowledge the wisdom of the Chinese people and to provide their babies with the best possible conditions to start their lives. More generally, we could retrieve in our subjects' discourse the way Chinese practices were used differently in changing contexts to build and express different identities. Thus a British-born Chinese woman who had refused to believe what her mother had "tried to drum into her" still exclaimed: "Look at her! That's the Chinese way and ginger!", pointing with pride to a youthful and healthy-looking 45-year-old mother of four. While she disavowed the virtues of "sitting a month" as a way of establishing her own westernized identity in relation to her mother, she also invoked this traditional belief system when addressing us in order to claim the superiority of her Chinese cultural heritage and identity, thereby re-instituting her community's traditional health beliefs. This illustrates how detraditionalized Chinese people in England draw on hybrid representations of health and illness as a way of recovering and stating their identity, sometimes eastern, sometimes western. These representations are used in order to work through the challenges posed by the way of life and identity needs which the Chinese people face in a different culture. They express the range of possible identities open to the community. It is in this broader context that the hybrid representations of health and illness held by the Chinese community in England must be understood. These representations are not just about being healthy. They are, first and foremost, about being Chinese or not, about being able to state an identity and to have it recognized, about remembering and performing th(_ stock of symbols and practices handed down through generations, and about deciding how to cope with the differences between "the Chinese way" and that of the host society.

**Conclusions**

In this paper, we have argued that social representations of health and illness are deeply intertwined with issues concerning the maintenance, the transmission and the transformation of a cultural identity. We have shown that the community constructs a hybrid representation composed of both traditional Chinese knowledge and western biomedical knowledge. The different elements of this representation are not seen as contradictory by the Chinese people; on the contrary, they provide the resources from which different members of the community work through their different levels of acculturation to English society as well as enabling identity to be stated and affirmed. They also reaffirm the most essential feature of the Chinese way of thinking, which is the combination of complementary opposites. Like any other ethnic groups, the English Chinese "seek to create some continuity between past and present, between old selves imprinted by the mother tongue and the new ones invented with painful freedom" (Schwarcz, 1994). They do not simply develop an identity in isolation from the pressures of wider society.

The case of the English Chinese shows that the social changes which call traditional knowledge into question, which displace peoples and meanings, which uproot each and everyone of us in more or less fundamental ways, are not just processes "out there". They are at the heart of who we are "in here", shaking the construction of identity and the knowledge we use in everyday life. Processes of globalization entail important changes in the nature and role of tradition as a means of making sense of the world, of providing existential grounding in the world and of creating a sense of belonging (Thomson, 1996). Traditional beliefs are more and more reflexively used to sustain a sense of continuity in a world in flux; their structure and content reflect both the social conditions of their production and the agency of the social subjects who enact them. Sensitivity to such social and psychic dynamics remains one of the great challenges facing health professionals today.

**References**

Anderson, E.N., Jr (1987) "Why is Humoral Medicine so Popular?", *Social Science and Medicine* 25 (4): 331-7.
Ajzen, I. and Fishbein, M. (1970) "The Prediction of Behaviour from Attitudinal and Normative Beliefs", *Journal of Personality and Social Psychology* 6: 466-87.
Bandura, A. (1977) "Self-Efficacy: Towards a Unifying Theory of Behaviour Change", *Psychological Review* 84: 191-215.
Bauman, Z. (1996) "Morality in the Age of Contingency", in P. Heelas, S. Lash and P. Morris (Eds.) *Detraditionalization: Critical Reflections on Authority and Identity,* pp. 49-58. Oxford: Blackwell.
Becker, M.H. (1974) "The Health Beliefs Model and Personal Health Behaviour", *Health Education Monograph* 2: 324-508.
Bloom, A.H. (1988) "The Linguistic Shaping of Thought: A Study of the Impact of Language on Thinking in China and the West", in A. Lock and E. Fisher (Eds.) *Language Development,* pp. 243-75. London: Routledge.
Breakwell, G. (1993) "Social Representations and Social Identity", *Papers on Social Representations* 2 (3): 198-217.
Burgess, J., Limb, M. and Harrison, C.M. (1988) "Exploring Environmental Values

through the Medium of Small Groups: Theory and Practice", *Environment and Planning* A, 20: 309-26.
Campbell, C. (1997) "Migrancy, Masculine Identities and Aids: The Psychosocial Context of HIV Transmission in the South African Gold Mines", *Social Science and Medicine* 45 (2): 273-81.
Chan, W. Y.Y. (1991) "Concepts of Illness, Dietary Beliefs and Food-related Health Practices: A Study of Health Care Professionals and the Chinese Community in Britain", PhD thesis, University of London.
Cheng, Y. (1996) "The Chinese: Upwardly Mobile", in C. Peach (Ed.) *The Ethnic Minority Populations of Great Britain: Ethnicity in the 1991 Census,* vol. 2. London: HMSO.
Crawford, R. (1994) "The Boundaries of the Self and the Unhealthy Other: Reflections on Health, Culture and AIDS", *Social Science and Medicine* 38 (30): 1347-65.
Durkheim, E. (1898) "Representations individuelles et representations collectives", *Revue de Métaphysique et de Morale* 6: 273-302.
Duveen, G. and Lloyd, B. (Eds.) (1990) *Social Representations and the Development of Knowledge.* London: Cambridge University Press.
Elejabarrieta, F. (1994) "Social Positioning: A Way to Link Social Identity and Social Representations", *Social Science Information* 33: 241-54.
Farr, R.M. (1993) "Theory and Method in the Study of Social Representations", in D. Canter and G. Breakwell (Eds.) *Empirical Approaches to Social Representations,* pp. 15-38. Oxford: Clarendon Press.
Gervais, M.-C. (1997) "Social Representations of Nature: The Case of the *Braer* Oil Spill in Shetland", PhD thesis, Department of Social Psychology, London School of Economics.
Gervais, M.-C. and Jovchelovitch, S. (1998) *The Health Beliefs of the Chinese Com munity in England: A Qualitative Study.* London: Health Education Authority.
Giddens, A. (1991) *Modernity and Self-Identity: Self and Society in the Late Modern Age.* Cambridge: Polity Press.
Habermas, J. (1992) *The Theory of Communicative Action,* vols I and II. Cambridge: Polity Press.
Hall, S. (1991) "Old and New Identities, Old and New Ethnicities", in A. King (Ed.) *Culture, Globalisation and the World System,* pp. 41-68. London: Macmillan.
Harré, R. (1984) "Review of Social Representations", *British Journal of Psychology* 76 (1): 138--40.
Herzlich, C. (1973) *Health and Illness: A Social Psychological Analysis.* London: Academic Press.
Ho, J. (1985) "Dietary Beliefs in Health and Illness Among Hong Kong Chinese", *Social Science and Medicine* 20 (3): 223-30.
Hui, C.H. and Triandis, RC. (1986) "Individualism-Collectivism: A Study of Cross Cultural Researchers", *Journal of Cross-Cultural Psychology* 17: 225--48.
Jodelet, D. (1989) "Representations sociales: un domaine en expansion", in D. Jodelet (Ed.) *Les representations sociales,* pp. 31-61. Paris: PUF.
Jodelet, D. (1991) *Madness and Social Representations.* London: Harvester Wheat sheaf.
Jovchelovitch, S. (1995) "Social Representations in and of the Public Sphere: Towards a Theoretical Articulation", *Journal for the Theory of Social Behaviour* 25: 81-102.
King, A.Y.C. and Bond, M.H. (1985) "The Confucian Paradigm of Man: A Socio logical View", in W.S. Tseng and D.Y.H. Wu (Eds.) *Chinese Culture and Mental Health,* pp. 29--45. London: Academic Press.
Kleinman, A. et al., (Eds.) (1975) *Medicine in Chinese Cultures.* Bethesda, MD: Fogarty International Centre, NIH.
Koo, L.c. (1984) "The Use of Food to Treat and Prevent Disease in Chinese Culture", *Social Science and Medicine* 18 (9): 757-66.
Koo, L.C. (1987) "Concepts of Disease Causation, Treatment and Prevention Among Hong Kong Chinese: Diversity and Eclecticism", *Social Science and Medicine* 25 (4): 405-17.
Levenson, J.R. (1965) *Confucian China and its Modern Fate.* Berkeley, CA: University of California Press.
Manderson, L. (1987) "Hot-Cold Food and Medical Theories: Overview and Intro duction", *Social Science and Medicine* 25 (4): 329-30.
Morgan, D.L. and Krueger, R. A. (1993) "When to Use Focus Groups and Why", in D.L. Morgan (Ed.) *Successful Focus Groups: Advancing the State of the Art,* pp. 3-19. London: Sage.
Moscovici, S. (1961) *La psychanalyse, son image et son public.* Paris: PUF.
Moscovici, S. (1973) "Foreword", in C. Herzlich *Health and Illness: A Social Psychological Analysis,* pp. ix-xiv. London: Academic Press.
Mugny, G. and Carugati, F. (1989) *Social Representations of Intelligence.* Cambridge: Cambridge University Press.
Naidoo, J. (1986) "Limits to Individualism", in S. Rodmell and A. Watt (Eds.) *The Politics of Health Education: Raising the Issues.* London: Routledge and Kegan Paul.
Owen, D. (1992) "Ethnic Minorities in Great Britain: Settlement Patterns, National

Ethnic Minority Archive Data, 1991", *Census Statistical Paper* 1. Warwick: Centre for Research in Ethnic Relations, University of Warwick.
Owen, D. (1994) "Chinese People and 'Other' Ethnic Minorities in Great Britain: Social and Economic Circumstances, National Ethnic Minority Archive Data, 1991", *Census Statistical Paper* 8. Warwick: Centre for Research in Ethnic Relations, University of Warwick.
Parker, D. (1995) *Through Different Eyes: The Cultural Identities of Young Chinese People in Britain.* Aldershot: Avebury Press.
Patton, M.Q. (1980) *Qualitative Evaluation Methods.* Beverly Hills, CA: Sage.
Rose, D., Efraim, D., Gervais, M.-C., Joffe, H., Jovchelovitch, S. and Morant, N. (1995) "Questioning Consensus in Social Representations Theory", *Papers on Social Representations* 4 (2): 150-6.
Rosenstock, I.M. (1966) "Why People Use Health Services", *Mil/bank Memorial Fund Quarterly* 44: 94-124.
Schutz, A. (1944) "The Stranger: An Essay in Social Psychology", *American Journal of Sociology* 49 (6): 500-7.
Schwarcz, V. (1994) "No Solace from Lethe: History, Memory and Cultural Identity in Twentieth Century China", in W.M. Tu (Ed.) *The Living Tree: The Changing Meaning of Being Chinese Today,* pp.64-87. Stanford, CA: Stanford University Press.
Tann, S.P. and Wheeler, E.F. (1980) "Food Intakes and Growth of Young Chinese Children in London", *Community Medicine* 2: 20-4.
Thomson, J.B. (1996) "Tradition and Selfin a Mediated World", in P. Heelas, S. Lash and P. Morris (Eds.) *Detraditionalization: Critical Reflections on Authority and Identity,* pp. 89-108. Oxford: Blackwell.
Tu, W.M. (Ed.) (1994) *The Living Tree: The Changing Meaning of Being Chinese Today.* Stanford, CA: Stanford University Press.
Unschuld, P.U. (1987) "Traditional Chinese Medicine: Some Historical and Epistemological Reflections", *Social Science and Medicine* 24 (12): 1023-9.
Wallston, K.A. and Wallston, B.S. (1982) "Who Is Responsible For Your Health? The Construct of Health Locus of Control", in G.S. Sandres and S. Suls (Eds.) *Social Psychology of Health and Illness,* pp. 65-95. Hillsdale, NJ: Lawrence Erlbaum.
Watson, J. (1977) "The Chinese: Hong Kong Villagers in the British Catering Trade", in J. Watson (Ed.) *Between Two Cultures,* pp. 181-213. Oxford: Oxford University Press.
Wei, L. (1994) *Three Generations, Two Languages, One Family: Language Choice and Language Shift in a Chinese Community in Britain.* Clevedon: Multilingual Matters.