Traditional East Asian Medicine in the lives of queer East Asian young adults in North America:
A critical analysis of the gaps in literature

by
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ABSTRACT

This critical literature review frames a discussion about the reasons for a lack of research attention on the intersection of queer East Asian youth and their relationship to Traditional East Asian Medicine in North America. Without research evidence, queer East Asian youth are made invisible, while traditional East Asian medicine continues to be under-researched, under-funded, and under-regulated. These outcomes affect the availability, accessibility, and relevance of health resources. Both quantitative and qualitative approaches that deal with issues of racial minorities and queer populations will benefit from the explicit use of social theories such as Intersectionality, Queer Theory and Postcolonial Theory; doing so challenges shallow engagement with identity categories, as well as White supremacist, heteronormative, and homonormative assumptions implicit in research. Taking a critically reflexive approach is necessary for identifying and challenging power differences in research relationships.
ACKNOWLEDGEMENTS

I respectfully acknowledge that I have written this paper on the traditional, unceded territories of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), Seílíwitulh (Tsleil-Waututh), and Kwikwetlem (kwikwə̓łəm) Nations. I am grateful to the Coast Salish peoples for their continual stewardship of these lands, on which I work, live and play as a settler of colour. I also acknowledge the labour of the Anishinaabeg, Cree, Oji-Cree, Dakota, Dene peoples, and the Métis Nation, on whose lands I was born, for teaching me first what it looks like to resist colonialism. I would further like to thank Rodney Hunt and Maya Gislason for their guidance throughout the MPH program towards a more critical understanding of the institutions that we participate in. And I am grateful for the queer East Asian youth who submitted artworks to this project: your vulnerability and resilience are beautiful and important. It is an honour to include your works in this paper.
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Youth

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CONTRIBUTORS

In order of appearance

Bzbozo  | Banlangen

Amanda Wan  | of body

Joan  | Aloe
       | Kettle

Zoe  | The Exorcism

D. Ng  | Blood is thicker than water (but is still a liquid)

Sasha 周詩恩  | Insomnia

Elizabeth Grace  | A doctor a gay keeps the sickness away

David Ng  | My Culture is Maiden China
       | Yellow Peril, Queer Destiny

Lux Habrich  | Broken Heirlooms

Jane Shi  | Brue

Mei  | acupuncture
"Exotic" banlangen is available in the United States only because of globalization and the destabilizing of local economies. On the other hand, it is also a reclaiming and re-rooting way of resisting corporate pharmaceuticals and medications.
1. INTRODUCTION

I was first drawn to the field of public health because its goals of improving population health require explicit discussion of structurally enacted oppressions such as racism and queerphobia as determinants of health. Guided by a formal definition of health by the World Health Organization as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity” (WHO, 1948 pmbl.), the field of public health has moved beyond a biomedical understanding of health and healing to capture the necessary, but less tangible, factors that create states of health and disease. With the backing of critical theory, the field of public health offers solutions for transformative change on a system level. Systemic issues can most effectively be addressed with system change that recognizes the goal of health equity is synonymous with social justice.

But in my experience through the Master of Public Health program in the concentration of Social Inequities and Health, I have seen that it is not enough to do work that breaks down social barriers if that deconstruction does not start with the researcher and the assumptions that drive the research. Sometimes the research process itself contributes to social inequities, and this is most insidious when it is enacted implicitly through the blind reproduction of oppressive power dynamics. As a student, in preparing to do work in the field, part of my schooling is to learn a hidden curriculum in addition to my formal coursework. I am sure that people about to enter other fields of work experience this as well as they try on the identity of practitioner, standing on tiptoe and sucking in their stomach until it fits. In a field where we talk at
length about bias and using evidence to base decision-making, the lack of researcher
reflexivity (especially in quantitative research) creates a silence that creates harm
through omission. Despite the good intentions of public health, researchers need to
remember that it is not a neutral practice as long as its practitioners are influenced by
the biases of the society in which they were born, grew up, and studied in. And this will
always be the case: no one is exempt from bias, but there is a key difference between
public health research that is aware of its research context and public health research
that reproduces the status quo. Without talking about one’s motivations behind studying
a particular topic, why the researcher is particularly situated to research this topic, and
discussing the theoretical backing that influences the research design, the reader
reverts to default assumptions that are the legacy of a White, patriarchal academic
institution. For example, we cannot ignore the power dynamics at play in a situation
where a White researcher chooses to study Traditional East Asian Medicine, versus a
situation where a researcher with an East Asian background chooses to investigate the
same topic. Without naming one’s race, often the default assumption is that the
researcher is white. In the research study itself, the identities we select are as important
as the ones we choose to ignore: without naming disability, often the default assumption
is that the subject is able-bodied; without naming sexual orientation, the default
assumption is that the subject is heterosexual and cisgender. Both assumptions may
lead us to forget how race and sexual orientation may very saliently shape experience.
And without talking about these choices to omit or include certain factors, we support a
research culture that is uncritical of its own methods and may be enacting harm on a
community through inappropriate engagement methods or through under-study. In
public health, where research shapes policy and programs that affect large groups of people, it is crucial to be aware of the power dynamics in research that parallel those in the larger society and historical context, lest we risk drawing inaccurate and/or incomplete conclusions about a population’s health, and leaving out policy and program support where people need it most.

Traditional East Asian Medicine (TEAM) is an issue in public health from both a traditional public health and epistemological perspective. Please see the Glossary for a definition and rationale for using this terminology. TEAM is considered an alternative to the default of Western medicine, that is, its principles remain unsupported by explanations of Western biomedicine and its use is unregulated in many provinces and states (“TCM regulation in Canada”, 2014). While TEAM carries risks due to intrinsic factors that may or may not be higher than risks of using Western drugs, perceived risks from Western practitioners’ unfamiliarity heighten stigma towards TEAM from the medical and public health communities. In addition, the unfamiliarity of herbal medicines means that drug interactions with Western pharmaceuticals are unknown (Thorburn et al., 2013, p. 579). These risks are particularly relevant for queer East Asian youth (QEAY), the subject of this paper, who are not represented directly in public health research but can be seen, via extrapolation of existing research studies, to be a population that is more likely than others to use TEAM. People who have experienced discrimination from a healthcare provider are more likely to use herbal medicines (Thorburn et al., 2013), and people of colour, women and queer people (Upchurch et al., 2017) are more likely to use CAM (which includes TEAM in this study’s definition).
Queer populations are also more likely to avoid seeking the advice of a health care practitioner as a way to avoid stigmatizing situations (Czaja et al., 2016, p. 1108). What I see as a more foundational tension with the way TEAM is discussed in public health literature is that TEAM perspectives on healing and the body do not fit easily into the Western biomedical paradigm, and thus its existence is a challenge to Western claims to medical superiority. Thus, the way that TEAM is discussed in public health literature is largely from a perspective that finds fault in its methodology and efficacy, although it is used by many people across North America despite these “problems”. Qualitative research that delves into the reasons why people use TEAM and what they are getting out of it will help destigmatize TEAM as well as the people who practice and use it. One such group is queer East Asian youth, who also face additional stigma from queerphobia.

In this paper, I am interested in the lack of research on queer East Asian youth (QEAY) who have spent most of their lives in Canada and/or the United States (“North America”) and who use TEAM. I am a self-identified member of this group, and my experience in it sparks my curiosity into how TEAM use goes beyond just physical healing. The idea of “Otherness” is useful for any critical analysis of identity construction, and I use it here to examine how both public health research constructs QEAY identity and visibility in an academic space that is also built out of White cisgender heteropatriarchy. The term “Other” was coined by sociologist George Herbert Mead as a way to name the way that minority groups are constructed out of power relations set up as dichotomies (Mead, 1934, p. 194); these dichotomies exist to
maintain a social order. In this social order, where QEAY are seen as “other”, queer communities and East Asian cultures both offer healing spaces, although the resulting healing space is often negotiated out of tension between the two because neither may feel like a complete fit – one may feel “too North American”, “too queer” and/or “too East Asian”. Furthermore, queerness and East Asian identity are complex and interacting identities. Queer identity influences relationships in East Asian family and community, while East Asian identity influences visibility and power within queer community. In this silence in public health literature around the way that TEAM holds value for QEAY, the health inequities that this group experiences still exist, but cannot be acted upon without being represented through the medium of research evidence. The silence allows public health practitioners to not think about TEAM and what kind is used, how it is used, and when it is used, by a younger generation who also faces health inequities due to queerphobia. And without the answer to these questions, it is easy to dismiss TEAM as an alternative therapy without understanding it as having important value on a cultural level. TEAM is useful as more than just a biomedical practice. We need to know what QEAY believe and are doing for their health so that we can expand access to the health services that they find important. We cannot make policy decisions about regulation, or add items to health insurance plans, without evidence. But this evidence does not exist.

Health inequities faced by QEAY in North America are masked by research designs, and therefore I have taken a piece-by-piece approach to understanding what is going on for QEAY and TEAM. When trying to approach how the variable of youth influences TEAM use among QEAY, the variables of acculturation and time of migration complicate the task of isolating youth, creating inconclusions where these three
variables collide. We have evidence that young Asian-American adults are less likely to use TEAM the more acculturated they are (Lee et al., 2010); yet, we also have evidence that middle-aged Asian-American women continue to use TEAM despite acculturation differences (Wade et al., 2007). Although these results contradict one another, both studies determined that acculturation predicts greater likelihood of East Asian Americans’ adoption of mainstream non-TEAM CAM practices, independent of age. We also know that East Asians’ attitudes towards TEAM’s efficacy are different depending on where one was born: in a comparison of China/Taiwan born respondents and US-born respondents’ perception of TCM efficacy for psychiatric disorders, “51.4% of the China/Taiwan born group agreed that TCM would be helpful in treating such disorders compared with only 9.1% of the U.S.-born group” (Yang et al., 2009, p. 6) although their ratings of TEAM efficacy on physical disorders did not significantly change. Part of the reason why acculturation is so difficult to capture is because it is a “complex, multidimensional phenomenon not easily or accurately measured” (Lee et al., 2010), and there is no standard approach to capturing its essence. Lee et al. (2010) attempted to address the acculturation variable with a self-reported rating of English proficiency and proportion of life spent in the US. Wade et al. (2007) evidently also recognized the complex nature of acculturation, by combining the length of time spent in the US divided by age with language preference and a score given for the race/ethnicity of close friends. Scores in each category were given a score of 0 (least acculturated) to 1 (most acculturated). But it is not entirely clear how friends’ race/ethnicity was ranked. How close did one’s friends have to be to be considered? What I see missing in the literature is a study stratified by age, time of migration, and degree of acculturation, that examines
how East Asians use TEAM. There is also a missing variable of sexual orientation in these studies and more options for gender. A longitudinal study of queer East Asian people’s perceptions of TEAM would illuminate the relevance of TEAM at each stage in their lives. We need to disentangle the noisy variables of age, acculturation, and time of migration.

In a similar fashion, while queer populations are generally well represented in studies of CAM (which usually include TEAM), it is difficult to isolate the variable of race, because the evidence is convoluted by the absence of discussions on race, and by unclear definitions. Sexual minority young adults, particularly lesbian, Asian, and Hispanic women, are more likely to use CAM than heterosexual young adults, and lesbian and bisexual women differ from gay and bisexual men in their reasons for using CAM (Upchurch et al., 2016). This may be because queer people consistently report discrimination from mainstream health care providers (Jaffee, Shires, & Stroumsa, 2016; Macapagal, Bhatia, & Greene, 2016) and heterosexual health care providers in mainstream health care tend to treat patients more favorably if they perceive them as being heterosexual (Sabin, Risknd, & Nosin, 2015). It is no surprise, then, that people who have experienced discrimination with healthcare providers are more likely to use herbal medicine (but not acupuncture), a chiropractor, or traditional healer (Thorburn et al., 2013). But what of QEAY? How does race influence use of TEAM vs CAM? One of the few qualitative studies that exist on East Asian people’s relationship with traditional medicine found that Chinese young adults tend to have poor health-seeking behaviours, yet may use what we define as TEAM (food therapy) on their own without necessarily
believing that they are doing so (Ou et al., 2017). And because studies that focus on queer people’s use of CAM do not differentiate between TEAM and other complementary therapies, a silence remains.

In this paper, I use Intersectionality, Queer Theory and Postcolonial Theory as perspectives for a critical discussion of issues around the gaps in research about queer East Asian youth and their relationship with traditional East Asian medicine. The literature I reference (see Appendix for search strategy) comprises a set of research articles that together touch on topics relevant to QEAY. These studies lead me to several calls to action. Within quantitative approaches, particularly survey approaches to understanding the use of TEAM, I call for researcher reflexivity and explicit use of sociological theory. I build a rationale for clearer definitions of CAM and TEAM, and a move from deficits-based to strengths-based approaches that can more ethically center multiple minority populations that face health inequities. Work that engages with communities who use traditional East Asian medicine needs to model a radical paradigm shift for essential for meaningful and substantial research about TEAM.

2. EMBEDDED ANTHOLOGY

Throughout this discussion paper I have embedded an anthology of community-based art submissions. I invited self-identified queer East Asian youth in Canada and the United States to submit visual and textual artworks that speak about their relationship with East Asian traditional medicine. They did so through an electronic
Google Forms portal hosted on a custom WordPress webpage. My recruitment strategy was through social media and snowball sampling. I posted reminders for the Call for Submissions at regular intervals on several Facebook groups, and directly contacted eligible people within my personal friend groups. The submission period was from November 24, 2017 to March 10, 2018. The caption under each work lists the contributor’s name, the year of creation, medium, and any information provided about themselves including age, cultural identity, and country of residence. Contributors were free to provide as much or as little information as they comfortable with, including the use of pseudonyms.

I am not doing content analysis on the artistic submissions because I need to let them speak for themselves in this context. They constitute what Foucault calls *subjugated knowledges*, or “historical contents that have been masked or buried in functional coherences or formal systemizations.” (Foucault, 1978, p. 81) As double minorities in sex/gender and race, QEAY voices are unrepresented as both research subject and researcher, and their knowledge has been consistently been considered unworthy of consideration time and again. In this anthology, QEAY knowledge exists unaltered, resisting silencing, showing that even in the constructed absence of public health literature, they exist.

I do not own the artworks submitted to this project; all rights remain with their original owner.
body memory of boiling roots not finding them / after flat
words on tight limbs / sweat drops into pot turning saltwater
ocean / into medicine into saltwater ocean into / memory of
love in setting bone broth / chest dies then returns / in living
pot of memory / of body

Amanda Wan
of body
2018
Pencil, pencil crayon, and brush pen on acid-free sketch paper; Photoshop
Age 22, Han Chinese, Canada
3. CONTEXT

3.1 Situating this discussion

The idea for this discussion paper arose out of an October 2017 post that was made in a Vancouver queer community Facebook group. The post was made by a White acupuncturist who was advertising low-barrier acupuncture services at a Vancouver community clinic. In the responses that followed, a stark ethical divide was quickly apparent. On one side, comments illuminated the White queer and disabled community’s needs for low-cost access to complementary and alternative therapies. On the other side, comments from queer people of colour argued that the practice of traditional Chinese medicine by White practitioners is appropriative and fundamentally problematic. People in the middle, who identified as East Asian and disabled, stated that they would never consider receiving accessible services from White Traditional Chinese Medicine practitioners.

This thread prompted me to think some more about how the routes people look to for healing are never separate from their historical, social, and cultural contexts. Health and medicine developed out of racist ideologies that used biological explanations of inferiority to justify social stigma against people of colour and gender and sexual minorities. These racist legacies continue to affect queer (and) people of colour in many ways, and even seemingly innocuous assumptions of normative Whiteness can have long-reaching effects. For example, medical textbooks use illustrations of people with white skin as the default (Louie & Wilkes, 2018); rarely do students learn about how changes to skin colour due to different medical conditions could look on a range of
darker skin tones. In health research, decontextualized correlations of race with susceptibility to disease can contribute to overlooked screening procedures for people who may be at risk due to factors other than their race (Mastroianni et al., 1999, p. 183). In the same way, institutionalized queerphobia can lead to queer people’s health needs being overlooked (a queer cis woman in a relationship with another cis woman still needs Pap testing). It can also have the opposite effect, or making queer identities hypervisible but not necessarily relevant in every context (not all trans people’s health needs are related to their transness).

Although I was familiar with instances of racism enacted from outside the queer community, by medical personnel, this was the first time that I saw the need for queer community health resources intersect so saliently with issues of racial privilege. Some questions that came up for me were: How can we act to mitigate a serious lack of accessible, queer-friendly health services without reproducing harm on racial terms? East Asians have faced a long history of racism in the Vancouver context (i.e. Japanese internment, redlining out of affluent neighbourhoods, and the extortionate head tax and unsafe working conditions borne by Chinese railroad workers). Currently, in Vancouver, Chinese seniors still face displacement by gentrification, East Asians are blamed for the housing shortage, and implicit assumptions being Canadian requires one to be White continually throw EAs’ nationality into question. These tensions are mirrored in the history of the United States (Daniels, 1995, p. 29, p.100; Sue et al., 2007). Furthermore, when we are faced with the choice to support a much-needed community clinic that is not run by East Asians, how much does this disenfranchise East Asian TEAM
practitioners? How can we call for a cultural shift that recognizes TEAM as legitimate, without requiring that White people first neutralize it through their own visible practice to make it palatable to the public? What is happening when East Asian traditional medicine is practiced without acknowledgment of its cultural importance, and it is treated as just another therapy? At whose benefit are silencing and delegitimization and cultural erasure happening? Whose traditional medicine is it if you take out the words “East Asian”?

I decided to step back from these questions and centre my own discussion and reflection on the relationship that queer East Asian youth have with their traditional medicine. I am a student of public health and I have limited access to funding and time to conduct my own study. Instead, I chose to examine existing literature for some answers. Instead of centering White practitioners and their motivations for practicing TEAM, thinking about TEAM and QEAY in existing public health research is a much richer topic that puts the focus back on people whose medical practices have historically and continue to be disregarded by medical institutions and Western society. I am a researcher based in Canada, but in this paper I extend my research to include American studies. I believe this is acceptable because while the history of East Asian migration differs between the two countries, Canada is culturally influenced to a great extent by the United States. Unfortunately, there was no literature on this topic. I decided to investigate what I could about it by doing searches of combinations of the variables “queer”, “East Asian”, “traditional medicine” and “acculturation” (See Appendix Table 1: Search Strategy).
Joan
*Aloe*
2016-18
Mixed, India ink, pen and digital
Age 29, Taiwanese-American, United States
Joan Kettle
2016–18
Mixed, India ink, pen and digital
Age 29, Taiwanese-American, United States
When I was a maybe 6 or 7, I was getting a lot of nosebleeds. I ruined a lot of pillowcases. I was taken to the white doctor but don't remember what they did for me. Next, I remember being taken next to a Chinese herbalist, then to the herbal store, to get my prescription. It looked to me like a bunch of wood chips, bark, leaves, dirt … crud from the gutter. My mom took a big ceramic kettle, set it up in our backyard and cooked it for hours until it was a dark unbearably acrid and pungent soup. I was probably a whiny brat about drinking it. I recall after every spoonful I would get a little bit of crystal rock candy. And then after a while month of drinking this daily, I was rewarded by being taken to the mall to pick a toy - unheard of.

I remember, more - foods as medicine - the stiff and bracing taste of bitter melon, the barely sweet dessert soups with lotus seeds and translucent white fungus, the thin congee that was the only thing I could hold down when i had stomach flu. I remember aloe from the backyard, soothing my burning eczema, and the bright fragrances of peppermint, lavender and lemon basil.

These descriptions are not really a reflection of my home life, which was actually stifling, violent and unsafe. There were the usual clashes - language barriers, educational distance, expectations, rules, ideological differences. But there was also my parents’ volatile tempers, rules and discipline, shaming and accusations, manipulation, their fear of failure as immigrants, my own fear for my body, my desire for escape through death, not knowing what more to life there could be. Growing up, I felt different and dysphoric and lonely as hell in the suburbs.

Getting out of there as a adult and coming into my queerness was a matter of time and survival. But in a way it highlighted the old dynamics between me and my parents. Queerness was just another thing to add to their disapproval and shame of my life choices - seeming to confirm the depravity they saw in me since I was a tomboy child. The way I came out to them even followed this pattern: I was confronted by them, accused of being gay, and forced to come out. We cut off contact for several years after that.

These old distant memories of herbs and foods are the few remnants I have of feeling truly cared for in my relationship with my family, my ancestors, and where we come from. I’m holding these tenderly as a I try to heal and carve out a life and future for myself which is both shaped by yet liberated from my parents, and in closer spiritual communication with both blood and chosen ancestors. I see Chinese medicine as a queer, often othered and most intimate kind of healing, in opposition to the forceful, dominant and impersonal interventions of Western biomedicine. These ways are secret and strong, stewed for hours in the backyard, rewarded with sweetness. These are healing methods that work in relationship with the body, mind and spirit as one, rather than against them, as divided and separate entities. I’m inspired by Chinese medicine and my parents and my ancestors, the ones who gave it to me, as I try to envision a new way for all of us to be in relationship with each other.

Joan
Age 29, Taiwanese-American, United States
3.1.1 Methodology

To find articles framing QEAY and TEAM, I used search engines Ovid, CINAHL, and a manual Google search. I reviewed titles and keywords when selecting abstracts, and arrived at eight key studies. I used MeSH (Medical subject headings) and included all subheadings in every search. When results were too plentiful to use or too broad, I used more specific search terms to attempt to narrow the results down. See Appendix: Table 1 and Table 2 for inclusion/exclusion criteria and key studies.

Figure 1. Topical focus of studies in the literature search.

This figure illustrates the topics covered in my literature search. I used a small sample of studies, but these are recent articles that are representative of the general patterns in the larger literature. The grey shading separates articles about CAM from
articles about TEAM, in white. Most articles were about CAM; only three made a distinction between CAM and TEAM. The beige circle denotes race, and in particular the ethnic group of East Asians. All articles focused on East Asians in North America. The purple area refers to sexual minorities, which I used as a proxy for the concept of queerness, since “queer” is not a MESH term. The blue area refers to acculturation. Lee et al. (2014)’s study straddles the line between CAM and TEAM. In their study, they looked at how Chinese-Americans used CAM as well as ethnic-specific CAM, which I operationalized as TEAM. The green area refers to youth. In summary, sexual minorities are not discussed as a key factor in TEAM. And in studies where sexual minorities are involved, the conflation of TEAM and CAM makes it impossible to pick out what is happening for QEAY.

Figure 2. East Asian ethnicities in the literature search.
This figure visualizes the span of East Asian ethnicities in the literature search results. The majority of studies focusing on Chinese North Americans parallels the global visibility of the Chinese ethnic group as compared to other ethnic groups from Asia. Other articles discussed Japanese and Korean groups as part of their sample. Others used the term “Asian” without clarification as to what ethnic groups this included.

### 3.1.2 Summary of studies

Despite the differing definitions of CAM and TEAM throughout these papers, I was able to draw out this brief summary. Sexual minority young American adults, particularly “lesbian, Asian, and Hispanic women”, are more likely to use CAM than other sexual minority racial groups and heterosexual young adults of any racial group (Upchurch et al., 2016). Among sexual minority young adults, lesbian and bisexual women differ from gay and bisexual men in their reasons for using CAM (Upchurch et al., 2016). This is supported by findings by Salamon & Davies (2014), who found similar results: stereotypical CAM users are “White or Asian, female or homosexual male”, and CAM users are also likely to be “highly educated, [identify] as socially liberal and [have] a religious affiliation of Buddhist or Hindu”. Society is not kind to people of colour, women, and sexual minorities; these prejudices bleed into health care, and for people who live with one or more of these identities, a history of discriminatory health care experiences is significantly associated with using herbal medicines (but not with use of “practitioner-provided CAM i.e., use of acupuncture, chiropractor, traditional healer or herbalist, alone or in combination with herbal medicines” - Thorburn et al., 2013). The types of discrimination experienced (i.e. racism, queerpobia, sexism) were not
individually associated with any use of CAM in this study, but these more specific correlations may yet be revealed.

TEAM is often thought to serve a different purpose than Western medicine, and this belief may drive characteristic use patterns of TEAM among East Asian North Americans. Chinese-Canadian young adults tend to see Western medicine as having more adverse side effects, and combined with disinclination to seek mental health support and preventive health Western care (Ou et al., 2016), they may avoid using Western health care. TEAM is most often discussed in the context of physical health; however, Choi & Kim (2010) found that Western medicine is underutilized by Asian-Americans, who turn instead to CAM for mental health support, but generally have a high prevalence of CAM use regardless. Chinese-Canadians may regard Western medicine and CAM/TEAM as appropriate in different contexts. CAM is thought of as appropriate for chronic disease management, and Western medicine as being appropriate for acute conditions (Quan et al., 2008). It is notable that even if Chinese-Canadian youth may hold the view that they do not believe in traditional Chinese medicine, they may nevertheless incorporate traditional Chinese medicine into their personal healing practices (Ou et al., 2016, p. 176).

The variable of age makes it difficult to draw solid conclusions about CAM and TEAM use among East Asians in Canada and the United States. Both Wade et al. (2007) and Lee et al. (2010) determined that acculturation predicts greater likelihood of East Asian adults’ adoption of CAM practices, but they were in disagreement about how the use of TEAM changes with acculturation. Wade et al. (2007) found that (middle-
aged) Chinese women continue to use TEAM despite acculturation differences, while Lee et al. (2010) found that (younger) Asian- and Mexican-Americans were less likely to use TEAM the more acculturated they were. Fang & Schinke (2007) observed that CAM users tended to be “older, female, employed, less well functioning physically, and less acculturated” although their definition of CAM overlaps with TEAM.

I found it interesting that among the papers above, none discussed four variables of queerness, youth, East Asian identity, and TEAM. This was surprising, given that my anecdotal experience had shown me that queer people are much more likely to use CAM, and the reasons that White queers have for using CAM are different than QEAY reasons for using TEAM. The majority of available research on either utilization of TEAM or CAM was conducted through a cross-sectional secondary analysis of longitudinal surveys, or primary research involving a cross-sectional survey. A general dearth of qualitative studies on the experiences of East Asian North Americans leaves the literature without a nuanced understanding of reasons for TEAM use. The limitations of these methods fail to capture the ways that context may shape differential use of TEAM, CAM, or conventional Western medicine by QEAY. The problems I found in the literature surrounding this topic prompted me to write this discussion paper on the reasons for this silence in literature.
The Exorcism

Following his steps,  
We enter a foreign film.  
What is this office?

I’m searching for clues  
On faces waiting in room.  
I don’t belong here.

Greeted by a man,  
Dad fades behind a curtain.  
My fear starts to show.

In a split second,  
I caught sight of my dad’s pain  
Dancing on his back.

He carried his guilt  
On the back his mother built  
Across the ocean.

He carried his doubts  
Of self-worth every morning  
On his way to work.

Matters of the soul,  
No Western drug is enough;  
I understand now.

I could see them all—  
Guilty ghosts leaving footprints  
On his weathered skin.

Suffocating them  
In dome-shaped glass cups, we pray  
Homeland ghosts can rest.

Zoe
Age 27, Vietnamese, Canada
3.2 Situating myself

My relationship to this topic is very personal, and this influences my critical attention to the way both TEAM and queerness have been represented in Western public health literature. I am a QEAY and a health researcher; both of these identities guide my expectations for representation. I want to intend this paper to be read by public health researchers who are interested in exploring the experiences and behaviours of people who are considered marginalized by intersecting oppressions. My intentions for this paper are to encourage intersectional, queer and critical perspectives on assumptions often made in public health research, as well as to prompt reflexivity in public health research and work. I also intend this paper to be read by QEAY, in particular the people who have so generously shared their art as part of this project. My intentions for this are to call out the non-representation problem I see in health research that involves multiple minorities. The artwork submissions are a way that I hold space for other opinions and experiences than my own within this paper.

As a settler of colour, I cannot ignore the ways that my work affects Indigenous peoples. My ability to speak about CAM and TEAM is indebted to the work of Indigenous healers and academics who have made space for discussion and resurgence of Indigenous medicine in the academy through their constant work of resisting colonization. Settlers since the beginning of their arrival on Indigenous territory have attempted to eradicate Indigenous medicine because they recognized its power to physically and culturally heal communities that were fragmented by colonialism.
Indigenous medicine continues to be appropriated for profit by non-Indigenous people (e.g. smudging kits for sale) while simultaneously being ignored (e.g. building codes that do not recognize how smudging is different than smoking indoors). My work runs alongside this as a different but connected practice of resisting colonialism and White supremacy through naming oppressive structures that create knowledge gaps and health disparities.

I must also acknowledge that my middle-class socioeconomic status, ability, and cisgender identities are privileges that facilitate my doing this work. I am proud to publish this paper on SFU Summit, where it will be accessible for free to the public.

3.2.1 My cultural background

I am an East Asian person as I am Chinese on both my parents’ sides. My parents emigrated from Hong Kong and Vietnam in their late teens as refugees and students. I grew up in a very White neighbourhood as one in a handful of people of colour in my elementary, middle, and high schools, with little connection to my family’s culture beyond the food I ate and the Cantonese we spoke at home. I also identify as queer. My connection to the Winnipeg queer community was formed at the same time that I started my undergraduate degree in Biopsychology, and as a young adult, that connection was immensely important for my sense of belonging to a culture and a place, especially in lieu of closeness to Chinese culture. My queer identity has been heavily influenced by the politics of place: In my early twenties, I only understood queerness as interpreted through norms of whiteness – whiteness was requisite for being the right
kind of queer; thin, white bodies were the only ones read as androgynous and desirable. Now I am learning how to reclaim space as a racialized queer person and to make space for other queer people of colour.

My educational and life experience give me the language and tools to question the ideas and motives behind the mainstream healthcare institution, which is rooted in a history of white supremacy and queerphobia. My East Asianness and queerness are inseparable: my race impacts my hypervisibility and fetishization in queer community, and my femme queerness makes me a hidden other in the Chinese communities I have access to. Being East Asian and queer in a suburban/urban Winnipeg context is very different than how it looks in the Vancouver context. I know that my personal struggles with my cultural identity have been shaped by the lack of multigenerational East Asian history in my life, and the lack of representation in mainstream pop culture, positions of power, and in queer circles; this is not the same experience as those who have grown up embedded in East Asian communities and (chosen) family.

3.2.2 My relationship to TEAM

In my experience, practicing TEAM is a way for me to locate my physical body within the diaspora and the abstract notions of ethnicity and ancestry. It is a way for me to keep myself alive and healthy by at the same time keeping tradition alive and healthy. TEAM is an alternative to Western medicine’s fragmented, culturally insensitive, and symptoms-focused approach. I see the healing power in actively choosing to practice some of the rituals passed down to me and which live on through myself and my
community. Finding personal ways to cultivate resilience to both queerphobia and racism is essential when academia often implies that queerness and East Asianness do not exist together.
“Tell me,” the acupuncturist asked, after removing a suction cup from my shoulder, “is blood a solid or a liquid?”

“Pardon me?” I said, thinking that I had misheard her.

“Is blood,” she repeated, “a solid or a liquid?”

The acupuncturist’s name is Eileen, a middle-aged woman from Shanxi, China. She has been practicing acupuncture for over 15 years and speaks with the intimidating authority of a preschool teacher who is used to handling 50 toddlers at a time.

“Liquid?” I answered hesitantly.

“That’s right!” she bellowed, “Blood is a liquid, and liquids are supposed to FLOW!”

She was working herself into a bit of a mini-rage, and still uncertain about the intention of the question, I decided to hold my tongue and wait.

“Blood is supposed to FLOW!” She repeated.

“Yes ma’am,” I said.

“So tell me, how is it that this crap just came out of your body?”

As she said this, she thrust the removed suction cup dramatically in front of my face. The suction cup is clear and shaped like a menstrual cup, but slightly larger. In the cup is a substance whose colour and consistency reminds me of black currant jello, and it jiggled with the force of her shove.

After an hour of acupuncture, Eileen had announced that my shoulder joint is very inflamed and she would like to perform “cupping” to let some blood out. I agreed to the procedure, and using something that’s like a cross between a stapler and a stamp, she poked some small holes into the skin near my shoulder joint, placed a small suction cup over the holes and pumped air out with a gun-shaped tool. The coagulated jelly-like substance was apparently what came out of those holes.

“This right here,” Eileen continued, still juggling the cup in my face, “is why your shoulder hurts so much!”

“Oh,” I said sheepishly, fascinated that such a solid substance had apparently come out of my body, and still slightly intimidated by the boisterous woman.
“You said your shoulder has been hurting for a month now?” Her rage had suddenly subsided and her tone changed into one of pained concern. “How did you let yourself get so bad before coming to see me?”

How did I, indeed.

Eileen’s practice was located in a basement suite in North Burnaby. I had never tried acupuncture prior to that day, having been taught by my parents and grandparents that traditional Chinese medicine is mostly superstition. Eileen, however, came highly recommended by my lion dance partner, who swore that Eileen’s acupuncture has saved her from numerous sprains and tears over the years. Besides, my “western” doctor’s advice of “just ice it and take some Advil” really wasn’t helping me much. So I decided to give it a try.

Minutes after I arrived at her clinic, Eileen had already efficiently laid me down on a massage table, swung a heat lamp over my belly to keep me warm, and inserted 23 needles into my shoulder area with practiced, expert pokes.

“An acupuncture session needs to be at least 40 minutes long to be effective,” she explained. “I’m going to check in on you after 40 minutes to see if you can go longer.”

With that, she gave me a bell to ring in case of emergencies, turned on the radio to keep me entertained, and left the room to poke other patients.

40+ minutes is long time for me to reflect on all the life choices and events that had led me to a massage bed in a windowless basement suite in North Burnaby, with 23 needles poking out of my shoulders, pop and acoustic versions of Christmas classics looping on the radio, while my belly gently toasted under a heat lamp like an egg being hatched.

At the time I worked part-time at a non-profit and part-time at a busy all-you-can-eat Korean bbq and sushi restaurant. It was the winter holiday season, the busiest time of the year for restaurants, and my shoulder had started to hurt from the motion of wiping tables. I had ignored it until I could no longer lift my arm higher than my shoulder to reach the spinach salad on the top shelf of the fridge. Although my doctor had, in addition to his advice of “ice it and take some Advil,” recommended that I took at least 3 months off of work, and was willing to provide a note, I didn’t qualify for medical employment insurance because my restaurant earnings did not constitute 40% of my income.

I thought about how I had briefly attempted a career in freelance and copy-writing, but when people saw my face and read my name, although they tell me that “wow, your English is so good,” they never thought that I may be good enough to write for them.
I thought about how I struggled to find work outside the Chinese-Canadian community, even though I was born in Vancouver and English is my native language.

I thought about how I lost all my tutoring students when I began presenting as genderqueer, and parents no longer felt that it was safe to leave their children with me.

Staring at my jiggly blood in a suction cup, I suddenly had a moment of clarity with regard to my life. Intersecting oppressions, crappy medical insurance policies, and the prevalence of low-waged, part-time work in the nonprofit sector had landed me on this massage table.

“You’re going to have to come see me for at least three more sessions,” Eileen said suddenly, interrupting my thoughts.

“It’s a good thing you came to see me when you did. Your shoulders are a relatively easy fix now, but left untreated, it could become problematic in your old age,” she continued, her voice becoming more gentle now with each sentence spoken.

“I probably can’t ask you to take time off work, but maybe for now use your other arm to wipe tables. After work, make it a habit to take a long warm shower, and let the warm water run over your shoulder joints to improve circulation.”

That night as I was taking a long warm shower at the advice of Eileen and I found suddenly that I could reach the bar of soap on the shower caddy without pain, I had another thought. If my Chinese-queerness has destined me to a life of body-deteriorating manual labour to subsidize my passion-work, then at the very least, I am grateful that my ancestors had invented superstitious magic cures that lets me survive.

D. Ng
2017
Age 29, Chinese-Canadian, Canada
4. A DISCUSSION OF KEY THEORETICAL PERSPECTIVES

Research about minorities and the social inequities they face need to be guided by explicitly named theories, because social inequities are complex, and need similarly complex lenses through which we can investigate, observe, analyze and interpret societal phenomena. The language of theories, or *theoretical constructs*, give us names for concepts (Crosby et al., 2011, p. 28) by which we can identify patterns across situations and with these we can create action. Theories allow us to see how phenomena exist as the result of historical processes based on particular belief systems and how they interact with one another. In this way, theories are directly effective for guiding policymaking as they are powerful enough to address the large-scale barriers that create health inequities; they can act as a scaffold on which to propose public health interventions, and allow us to predict what will be successful and why. Intersectionality, Queer Theory, and the concepts of Orientalism and Hybridity (via Postcolonial Theory) are theoretical lenses that have particular relevance towards informing better health equity research about QEAY and TEAM.
on poh-poh’s memory foam

percussive no crys and mou haams
ride AM radio croons from Perry Como, The Foundations

ping-on gou kneaded into pressure points,
sips of warm prune juice

her gift of sleep

Sasha | 曹詩恩

insomnia
2018
digital
Age 24, Chinese-Canadian
4.1 An overview of intersectionality

Intersectionality theory was coined by the American civil rights advocate and UCLA professor Kimberlé Crenshaw in 1989 as a reaction to the need she perceived for greater depth and relevance to contemporary discussions of race and gender. In contrast to the commonly employed unitary and multiple approaches (Hancock, 2007, p. 68) to understanding social phenomena, intersectionality addressed the problem of how academic literature at the time ignored how each dimension of a person’s identity affected the other; for example, how the experiences of Black American women differ from those of White American women because of how racism shapes each experience of womanhood, although both live under patriarchy in the United States (Crenshaw, 1991). Intersectionality and social justice are inseparable, as illustrated by a quote from Audre Lorde: “[…] If I fail to recognize [other women] as other faces of myself, then I am contributing not only to each of their oppressions but also to my own […] I am not free while any woman is unfree, even when her shackles are very different from my own” (1981, pp. 284-285).

An intersectional approach can help us remember to think of differences within a group of similar people. It also helps us to think of who is included and who is excluded, and why this is so. Intersectionality is a flexible and non-prescriptive approach that can be applied to both individual and systems levels. Resources exist for integrating intersectionality into research and policy work, but because it is so context-dependent (and actively avoids being reduced to a “how-to guide” - Hancock, 2007, p. 74),
intersectionality tends to be confusing as a praxis for research, policy, and evaluation (Hankivsky, 2012, p. 2).

The concept of intersectionality can also be illuminated through common misconceptions of what it is not. An intersectional analysis does not just point out the missing pieces in a situation but attempts to explain how the missing pieces give shape to the phenomenon at hand, and through this, figure out how those missing pieces can be restored. Furthermore, an intersectional approach is not additive; that is, simply naming different categories to which people belong is not the same as interrogating how they influence each other, such as how race influences the way women and non-binary people move through the world and vice versa. The point of intersectionality is to examine relationships, not to count and rank oppressions and dole out rewards and punishments. In public health, an intersectional lens helps us understand how social inequities are differentially embodied by populations and are expressed in health inequities.

Yet, in practice, there are difficulties with doing intersectionality in a way that is meaningful. Naming too few categories of identity can be dangerous in that it invites the reader to make assumptions about other dimensions of identity, while naming too many categories just for the sake of doing so may become too list-like and limit an understanding of the complex interplay of identities, privileges, and oppressions (Hankivsky, 2012, p. 1713). For example, without naming race, often the default assumption is that the subject is white; without naming queerness, often the default
assumption is that the subject is cisgender and heterosexual; both assumptions may lead us to forget how race, sexuality and gender impact experience, simply because they were not mentioned. On the other hand, naming “master categories”, such as race and gender, as Hankivsky (2012) calls them, can be harmful if doing so comes without reflection on how this is an appropriate choice. She states that, for example, gender is not always relevant to a situation (Hankivsky, 2012, p. 1717), and naming it can detract from more important issues as well as magnify the importance of gender when it is not important. Similarly, as Ford et al. (2010, S33) mention in their discussion of critical race theory, focusing on race as a proxy for things like insecure housing, low income, and low levels of education can pathologize identities and risk obscuring factors that could instead be more useful and accurate if they were seen as commonalities across groups.

4.1.1 Intersectional approaches in studies of QEAY and TEAM

Being seen as East Asian in Canada and the United States comes along with stereotypes that render one’s nationality invisible. While White Canadians have the option of identifying with different European cultures but otherwise comfortably default to being “Canadian”, for East Asian Americans, “being ethnic is a societal expectation for third- and fourth-generation Japanese and Chinese Americans, no matter how far removed they are from their immigrant roots or how different they are from their foreign-born counterparts” (Kim & Keefe, 2000). As well, many areas of discrimination that East Asian immigrants experience overlap with those of second-generation East Asian Canadians because white Canadians tend to conflate ethnicity with immigration status (Khan, 2015). In the study of QEAY and/or traditional East Asian medicine,
intersectionality calls for us to remember that race affects the way that East Asian people move through society, even in situations that are not ostensibly about race. Intersectionality calls for us to remember that not all queer people are white, and that not all East Asians are heterosexual.

Furthermore, intersectionality pokes at the solidity of the categories themselves to find a problem with the static “Asian” category often found in public health survey-based studies: “Asian” is so broad that it ignores important differences within the category. For instance, “Asian” is often used or interpreted as a proxy for East Asians, which erases the existence of Southeast, South, Central, and West Asians. The 2016 National Asian American Survey administered by NBC News (Lee & Ramakrishnan, 2017) highlighted that although people from India may consider themselves Asian, almost half (41%) of White respondents did not consider them to be Asian. 45% of Pakistanis, who are also South Asian, and other Asian Americans (Filipinos, Chinese, Japanese, and Koreans) felt the same. This is not really surprising given the visibility that East Asians have in North American media, but it highlights the importance of difference within what is supposed to be a meaningful category. We see this in use all the time: for example, the data set which Upchurch et al. (2016) analyzed about young adults’ use of CAM limited race options to White, Black, Asian, or Hispanic; Thorburn et al. (2013) also used a similar categorization in their discussion of discrimination in health care. But what does it mean to identify a Pan-Asian experience? Does this exist, or are some other unifying factors present among this group that we are really referring to? Do we know what we are really interrogating? An intersectional analysis would look at the commonalities within and between racial categories to challenge the easy conclusion
that “X happens to Y racial group”. Not all Asians move through the world the same way; there is a huge difference between a West Asian or Middle Eastern person who is racially profiled at the airport (Lee & Ramakrishnan, 2017), and an East Asian person who can move through security with relative ease. These differences in assumptions and microaggressions translate into tangible health effects over time. Even if it makes sense to use race as a category, an intersectional approach would push its assumptions. Mixed-race people, for example, are often forced to choose between several racial identifiers. In Upchurch et al. (2016)’s paper, there was no discussion of how people of mixed-race would have chosen their racial identifier: they may have been double-counted in the data, if multiple boxes were selected, or they may have only selected one of the racial groups that they identify with. Either case could have contributed to an unrepresentative data set. Those who identified as “other” races were excluded due to small sample size, but how would these responses have been analyzed if they had made up the majority?

4.2 An overview of Queer Theory

Queer Theory began with Judith Butler in the 1980s out of the influence of Feminist Theory and Michel Foucault. Queer Theory challenges the absolutism of sex and gender binaries, and argues that sex, sexual orientation, and gender are socially constructed. What is gender if the categories of “woman” and “man” are destabilized? What is sex outside of our definitions of “female” and “male”? Queer Theory states that ideas of what is normal, natural, and essential are shaped by the interests of groups with power (Appelrouth & Desfor-Edles, 2010 p. 373). What we often consider to be the ultimate objective truth – biology and science – is also influenced by social ideas that
are perpetuated by structures of power to enforce them. In other words, it is impossible to separate ideas of gender from the social contexts in which they were created (Butler, 1990, p.4-5). Queer Theory analyzes the ways in which sexual and gender identities are *created* through individual performance via the use of scripts, discourses, and symbols (Appelrouth & Desfor-Edles, p.374). Gender is not something innate that we express; we *do* gender when we employ culturally relevant signifiers.

4.2.1 Queer Theory approaches in studies of QEAY and TEAM

In public health, queer theory can be used to take behaviours that are usually perceived as “risky” and irrational (Argüello, 2016, p. 241) – such as using complementary and alternative medicine – and think of them alternatively as ways that individuals assert identity and agency in their relationships with themselves, with the medical system, and in their communities. This perspective centres the person’s desires, and allows a shift in public health perspective from a deficits-based to a strengths-based perspective. In doing so, work will have already begun to be more empathetic and less stigmatizing. Queer theory also calls researchers to question binarism and homonormativity in public health interventions that attempt to be inclusive, and think of how this singular-category approach perpetuates the invisibilizing of queer identities. For example, as Manning (2009) states, categorical guidelines for how to address the needs of MSM (Men who have sex with men), WSM (women who have sex with women), trans men, and trans women “does not address the sexual health needs of people who challenge hegemonic gender and sexual dichotomies; instead, it reinforces dominant understandings of sex, gender, and sexuality”. Queer people who are not gay or lesbian, and who may nonbinary or genderfluid exist, but not in research that uses
these sole categories. Moreover, queer theory calls researchers to understand that using identities as proxies for behaviour (Manning, 2009) causes primary care practitioners to miss asking important questions about testing and risk, and causes public health practitioners to overlook ways to make interventions more inclusive.
A doctor a gay keeps the sickness away

i.
Bitter red dates ginseng black
I swallow willingly because I am told
I'm not a child nor does my age end in a -teen, but
I am a 乖女, and mother knows best.
It is important to listen, to pay your respect.
preventative posture, bowl sipped clean,
the hot hours and tender care transmute
into medicinal magic. I thank my grandmother for her relationship to plants, to me she is
a real doctor.

ii.
The redness comes and goes,
my skin wears thinner every time
Western presumption lays it on thick.
Mother is agitated as I don't seem to care about my body,
“you disrespect me.” it is the whimsy of an eczema-prone fleshy shell, but it was not
always so.
It got tired of trauma, because
I am a gay 女, and my body knows best.
Against stresses external, and my denial of it all,
my body reminds me that it is listening and living.

iii.
“you betray you,“
I am a 軍女, and I hope I know best.
Benign homophobia eats at my stomach,
and I become smaller to make room for the growing aches stuck at my throat. Buried
tears harden into sour ulcers. I sob incomprehensible,
Mother says she'll make an appointment,
but I don't think she understands that what I need is
queer magic.

Elizabeth Grace
Age 24, Chinese-Canadian, Canada
4.3 An overview of Orientalism and hybridity in Postcolonial Theory

Postcolonial Theory is the study of how colonialism has affected countries and societies that have been colonized by Europe. Although most of East Asia was largely not colonized by the West, colonialism has left its mark on several areas. For example, Hong Kong was colonized by Britain from 1842 – 1997, Singapore was colonized by Britain from 1819 – 1959, Taiwan was colonized by the Spanish Formosa from 1626-1642 and the Dutch Formosa from 1624 – 1662. Furthermore, as Vukovich states in his 2013 analysis of China and postcolonialism, we colonialism is a force that has effects beyond its primary understanding as “an issue of political sovereignty and its loss or recapture (p.595)”. He states that in the presence of a “certain paternalist, even colonial arrogance from abroad (p. 595)”, “it is not the details of sovereignty and occupation that matter, so much as the cultural-ideological conflicts and the politics of knowledge and ‘face’ (p.595)”. In the example of China, he explains how Western political and media discourses paint China as a growing Communist threat and criticise it through the lens of western science [and] economics” (Vukovich, p. 597).

Orientalism is a useful concept to use in examining and deconstructing implicit White supremacy in academia and the society in which it is housed. Orientalism is a concept grounded in Postcolonial Theory by Palestinian-American literary theorist Edward Said in his text, “Orientalism” (1978). Orientalism states that a deliberate misrepresentation of Asian and Middle Eastern cultures as the “Orient” maintains and advances White, European power. It was, and is, used to justify violence towards “Oriental” individuals, and simultaneously reaffirming European identity, by casting the “Orient” as uncivilized, irrational, passive, morally degenerate; basically antithetical to
the developed, rational, active, virtuous Europe (Said, 1978, p. 40). The Orient is not a geographic place. It is an idea that refers broadly to the East of Europe and flattens all the cultures in Asia into a set of archetypes. But although the Orient functions as a representation, it has very real historical, institutional, and social legacies. Orientalism throughout the ages has shaped Western understanding of Eastern cultures as “other”, static, myths, objects -- to be studied and mastered, or disregarded. This study is only unidirectional, however. There is no “Occidentalism” because European power has nothing to gain from reducing or mythologizing itself. Understanding Orientalism is a warning, that “discourses of power [...] are all too easily made, applied, and guarded” (Said, 1978, p. 328).

A response to Orientalism is the concept of hybridity, which was first coined by the scholar Homi Bhabha. The process of hybridization is the merging of signs, practices, and ideas from two or more cultures into a composite set of values and understandings. This can be enriching and/or fracturing (Ruffner, n.d.) through an organic process which “will tend towards fusion”, or an intentional process, which “enables [...] a politicized setting of cultural differences against each other dialogically” (Bakhtin, in Young, 2005, p. 20). Acculturation is related to hybridity but is quite different. Acculturation “implies the assimilation of indigenous groups to the dominant culture” (Ortiz, 1995, p. 98; in Young, 2001), but ultimately it is simply process of learning to adapt to another culture (Nguyen & Benet-Martinez, p.23). Acculturation thus maintains both the dichotomy and the power differential between colonizer and colonized. Many people of diaspora struggle with the demands of acculturation in that it seems to necessitate giving up one’s culture in order to fit in with another (Singh, 2009). The
crucial distinction between acculturation and hybridity is that hybridity creates a “third space” (Bhabha, 1994), which is more than just a fusion of native and colonizer knowledges. In the third space, there occurs a constant construction and reconstruction of a new identity. While power relations between colonizer and colonized may still be maintained, they are negotiated here (Sterrett, 2015, p.655). Individuals in the third space learn alternate ways of seeing the world and performing within it. Hybridity is difficult to measure quantitatively, and proxy measures are used to approximately quantify acculturation.

4.3.1 Orientalism and hybridity in studies of QEAY and TEAM

Headlines such as “Why China’s traditional medicine boom is dangerous” (The Economist, 2017) and “From traditional Chinese medicine to rational cancer therapy” (Efferth et al., 2007) demonstrate the pervasiveness of Orientalist outlooks on TEAM in both grey and public health literature. This approach is limiting, because even if TEAM’s efficacy still needs to be ascertained through randomized controlled trials, the reality is that for many people, TEAM is important part of an integrative approach to healing regardless of evidence (Chung et al., 2012, p. 361). Furthermore, not all people who use one aspect of TEAM support other aspects; for example, someone may engage in therapeutic massage but avoid the use of herbal medicines. Therefore, a blanket opinion that TEAM is generally dangerous and irrational does not aid in the contribution of anything new to public health literature, nor does it facilitate the development of public health interventions that aim to target groups likely to use TEAM. An argument from this approach is not a useful way to understand behaviour or change it.
The limitation of the common survey approach to assessing CAM and TEAM use is their inability to capture complete truths and the complexities of identity, such as being East Asian and simultaneously North American. One example of this is in the phone-survey design of Chinese-American women’s medical choices in Wade et al. (2007)’s study. The participants, for the most part, had been born outside of the US, were of middle age, had been or were currently married, had high socio-economic status, had completed college, and were insured – which, to begin with, captures only a small subset of the entire Chinese-American population. These women were recruited via the use of a commercial database of surnames. One participant from each household who matched the inclusion criteria was selected for the study. However, there is no way that the database would have been comprehensive, because this method does not capture people who have taken the last name of a non-Chinese partner, who are mixed-race with a non-Chinese last name, or who have changed their last name for some other reason. This would leave out an important subset of the population of Chinese-American who may be particularly inclined towards using CAM, TEAM, or Western medicine. This study’s methods illustrate the difficulties of using rough tools for sampling which both bias the results and silence a population by ignoring the reality that people are not just either Chinese or North American; they can be both.

Research shows that East Asian youth in North America tend to take an integrative approach to their personal healing that draws from both East Asian and Western medicine. I am interested in this as an example of hybridity by which QEAY, as members of the East Asian diaspora, create a space for literal and cultural survival. For QEAY who do not use TEAM, I recognize that acculturation is also an adaptive
technique, and is just as legitimate. Hybridity is a strategy, not a goal or a marker of personal progress.
David Ng & Kendell Yan
*My Culture is Maiden China*
2018
Diptych, photography
Yellow Peril: Queer Destiny

Last night, over delicious Indian food, one of my closest friends announced to me that she was pregnant. We giggled about how her mom, like all of our Chinese mothers, is likely already sourcing out the best deals on herbs and tonics to get my friend started immediately on the “Chinese Pregnancy Soup Regimen™”. We joked (but also took very seriously), how she’s gotta make sure her qi is balanced, and immediately ordered dishes that were not too “cooling”.

These stories are so common in my life. As a second generation Chinese Canadian living in Vancouver, I grew up in a family where my parents were dedicated to keeping our Chinese traditions alive. My aunties would deliver us weekly pots of different medicinal soups that were meant to not only nourish our bodies, and were specifically made to address seasonal, age, and gender specific ailments. These ancient sciences were something I really took for granted as a child, and as I grew older, I developed a strong desire to seek out and reclaim these traditions. While “being Chinese” is an identity that I am never ashamed of honouring, there are places and spaces that invisibilize my “Chineseness”. The queer community is unfortunately one of those places, where I feel a discomfort around my cultural identity. Being Chinese, particularly in the queer community, relegates my social mobility in different spaces in the community, and as a result, my cultural identity is forced further and further into a closet.

Over the past year, there has been a resurgence of queer, Chinese artists who have been responding to this erasure in beautiful, and radical ways. For example, Shay Dior and Maiden China - drag queens of East Asian descent - have been enunciating their cultural identities within their personas and performances. Love Intersections - a queer arts collective I co-founded in 2015 - has been making films about queerness, medicine, and culture.

I believe there is a particular potency in this moment of cultural reclamation. There is a power in holding strong our cultural traditions as queer people. Embracing Chinese culture as a queer person defies erasure, and is a revolutionary act. Culture is medicine.

“Yellow Peril: Queer Destiny” is a visual and media arts project that comes out of a desire to fight for spaces where, as queer Chinese people living in Canada, we can have spaces where we can hold all parts of our identity. Spaces where we can thrive. This first series of diptychs explores the possibilities within this intersection of medicine, queerness, and culture. Can Traditional Chinese Medicine not only heal bodies, but also heal our experiences being silenced as Chinese queers in Canada? If reclaiming and making visible our use of Traditional Chinese Medicine defies erasure, what is the potential for Queer Chinese Medicine?

White supremacy beware, the (queer) Yellow Peril is here to stay.

David Ng

Age 32, second generation Chinese Canadian, Canada
5. CRITICAL REFLEXIVITY

Reflexivity is the “process that challenges the researcher to explicitly examine how his or her research agenda and assumptions, subject locations, personal beliefs, and emotions enter into their research” (Hsiung, 2008, p.211). Reflexivity is a reminder that the researcher is a part of a process that is happening even as it is being studied; the “behind the scenes” is just as important as what is on stage, because it is here that we understand the decisions behind what lighting was chosen, what the actors were wearing before they got changed, and how the stage crew really feel about the play. Although public health research seeks objective answers, the research process itself is also just as influenced by social forces; this is what Edge (2011) calls “prospective reflexivity”, the first of two types, where “rather than seeing such influences as potential contamination of the data to be avoided” (Attia & Edge, 2017, p. 35), prospective reflexivity expands the researcher’s capacity to understand the ways that their unique perspective influences each step of the research process; it uncovers the unconscious biases that might not have otherwise been named. The second type of reflexivity is “retrospective reflexivity”, the recognition that the researcher is changed by the research process.

While reflexivity is central to qualitative research, I believe that it is just as important for quantitative researchers to express their positionality to their research subject as a way to be accountable, transparent, and honest. But I have found that none of the surveys I have found relevant to QEAY and TEAM mention researcher identities
and motivations, and I find this silence curious and disturbing. From a social justice and health equity standpoint, this lack of intersectional analysis perpetuates an unfair exclusion of research participants, and a pool of studies that are not culturally relevant and accessible to multiple minority populations. This is not a new debate. The lack of researcher reflexivity in public health literature is part of a research context that is often elitist (in that the language of academia, and paywalls, for example, create inaccessibility) and too comfortable with the guise of objectivity and neutrality when it is not (Finlay & Gough, 2003, pgs. 4, 40).

How do we “do” reflexivity? Although reflexivity is often used synonymously with the act of “naming one’s privileges” or “describing one’s social location,” critical reflexivity goes further (Heron, 2005, p. 344): it requires one to question one’s motivations (as a researcher and/or public health practitioner) towards the work they do; to think about their desires (e.g. to be anti-oppressive), and how researcher and research subject have existed in relation to one another across history (are you, as a researcher, part of a group that historically oppressed by the other?) Then, a critically reflexive perspective requires one to think about how those motivations, desires, and power dynamics affect the interaction between researcher and subject (Heron, 2005, 347-348).

It can be difficult to do in the traditional context of “positivist research assumptions of researcher objectivity, generalisation of findings, power asymmetry within research relationships and methods” (Acker-Verney, 2016, p. 416). Being
reflexive may seem irrelevant to researchers who work from a quantitative approach. It may seem to even be at odds with the goal of creating a work that states facts, not opinions, and objective truths, not subjectivities. Yet all research is conducted in a social context laden with assumptions, histories, privilege, and oppression. It is impossible to isolate one experience from these influences. Therefore, to really be transparent and objective, it is imperative to state the externalities that shape both the researcher and subject’s realities. If we are studying the effects of an oppression on a group, do we not want to avoid reproducing those effects in our own research questions, methods, and analyses? For public health practitioners and researchers who want to prioritize health equity, critical reflexivity is extremely useful to highlight issues that could lead to more voices being heard in better ways. This understanding can be used to mitigate the risk of exacerbating the health disparities that are already exaggerated in this population due to racism and homophobia. And a focus on ethical research methods, participatory action, and qualitative data on a group with a newly-amplified voice can shape new interventions, modify existing interventions for better effectiveness, and direct more efficient resource allocation.

Heron (2005) has written an excellent article about employing a critically reflexive approach in social sciences research and the distinction between social location and subject position. Finlay & Gough (2003) have written an extensive guide on how to do reflexivity in qualitative health and social sciences research. I have drawn from these scholars’ work to suggest a set of critically reflexive questions for researchers who deal with populations where two or more oppressed identities intersect. The theories of intersectionality, queer theory, and postcolonial theory shaped these questions as well.
used these questions to reflect upon my own positionality in writing this paper, and I hope that you will find them useful tools for your own work.
6. KEY ISSUES

6.1 The problem with “Complementary and Alternative Medicine”

The lack of a standard definition for what is included under the umbrella of CAM presents a fundamental problem for the cross-comparison of studies on this topic. Generally, studies use Western medicine as the default comparator: if a practice is used in conjunction with Western medicine, it is “complementary”; if it is used in lieu of Western medicine, it is “alternative” (Keshet, 2014). This definition is not good enough because it does not work for groups who use more than one health care system. CAM’s inherent Western bias limits a culturally sensitive understanding of the range and reasons for using different therapies. For example, people who live in China and who have used traditional Chinese medicine all their lives would not consider traditional Chinese medicine to be either complementary or alternative (Wade et al., 2007). “Complementary” and “Alternative” are inherently biased and so are inappropriate for research that aims to be unbiased, but they are perfectly good for reinforcing the hegemony of Western medicine and reproducing Western imperialism through the othering of TEAM.

Furthermore, the false synonymy of TEAM and CAM is direct evidence of the privilege embedded in the employment of the term CAM when it really is used to refer to TEAM. When White people use TEAM, it is just another CAM, but CAM is not just another part of TEAM. QEAY may use TEAM, but perhaps for different reasons than they use CAM. CAM can also refer to therapies administered by regulated professionals such as chiropractors and massage therapists, as well as other practitioners who work
in hypnosis, energy healing, and spiritual healing. CAM may also include self-administered therapies such as relaxation techniques, self-help support groups, specialized diets, and imagery (Upchurch et al., 2016, p.566). Without a distinction, we lose the special cultural importance of TEAM vs. other CAM.

How do we ask questions about CAM or TEAM use if there is so much overlap? Lee et al. (2010) recognized the limitation of “CAM” and asked questions about CAM provider use, as this is an easy variable to quantify. However, this does not necessarily capture a full picture of CAM or TEAM use, as individuals may practice both on their own, without the assistance of a practitioner. Some researchers have attempted to capture the nuances between different kinds of TEAM: Wade et al. (2007) created three “mutually exclusive dichotomous CAM measures” to capture respondents’ use of traditional Chinese medicine: (1) Chinese herbs and acupuncture only; (2) Chinese herbs and acupuncture along with other therapies; and (3) a residual category of other therapies, but not Chinese herbs and acupuncture. However, these categories made it impossible to identify important distinctions between other TCM modalities and similar Western therapies, such as different types of massage, and as a result, “the proportion of TCM practices among other types of CAM may be underestimated” (Wade et al., 2007). A lack of a clear definition of CAM or TEAM leads to confusing responses: for example, within Ou et al. (2017)’s qualitative interviews with Chinese residents in Vancouver, participants contradicted themselves when speaking about their use of TCM, stating sometimes that they did not practice TCM while later going on to discuss their therapeutic food choices. The wide range of definitions of CAM make cross-
comparisons of “CAM use” essentially meaningless. Clearer delineation between what constitutes mainstream CAM as opposed to TEAM is needed to place research in the context of similar studies.

Questions for critical reflexivity

• What exactly am I interrogating?

• How have I chosen this definition?
  o Am I simply using what definitions exist?
  o What are the potential problems with using this definition?
  o Is it consistent with how the community defines themselves?
Lux Habrich

My roots are all sick (Broken Heirlooms)

2014

51cm x 53cm, cotton, wool, silk, homespun yarn, natural and synthetic dyes, photo silkscreen process on silk organza, based on drawings of myself, my mother and my grandmother

Age 26, mixed white East Asian (Chinese), Canada

These weavings are a textile adaptation of a drawing installation I made to commemorate my Chinese ancestry. It was made after discovering the cross-generational trauma and mental illnesses within the women in my biological family. It provoked research on the genetic qualities of mental health and the phenomenon of inheriting trauma on a physiological level. The weavings became a metaphor for a timeline of each of our lives, transitioning through a variety of color and texture – all the while using a cellular repeat pattern to evoke our biological linkage. Tapestry techniques were employed to interrupt the visual pattern and build wounds into each timeline.
Relationship to East Asian medical practices as a queer identified person

I felt pretty disparate from my East Asian roots growing up. I was my mother's only daughter and felt like I singularly had glimpses into the depth and subtleties of her ancestry and cultural traditions. She was rejected by her parents for marrying my white father - and being a mixed race grand-child was hard for her parents to accept, so I felt significantly cut off from my Chinese heritage, and thus it's many valuable medicinal practices.

My mother has always used food in a therapeutic way, e.g. making me drink Dong Quai healing soup whenever I got my period (with White Flower Embrocation on the side to heal any exterior aches and pains). Additionally, my mother regularly practices tai chi and acupuncture for it's immense pain relief and balancing properties.

As an adult, I have become distanced from my mother and my Chinese legacy as a result of hiding my life as a queer person and it saddens me. I aspire to be closer to the medicinal wisdom of my ancestors, and feel the empowerment of honouring that part of my history / have alternatives to the imperial western medical system – though I often find myself struggling as a member of the second generation to uphold the integrity of East Asian medical practices, while needing to assess my privileges and acknowledge that the best I can practice is a reinterpretation of those traditions as a Canadian born.

Lux Habrich
Age 26, mixed white East Asian (Chinese), Canada
6.2 Deficits perspectives in public health literature

A deficits perspective identifies a population’s adverse health outcomes, usually to make a case for action. The majority of approaches to minority health still take this perspective. Although necessary for understanding the depth of the health inequity, the problem with using this as the sole approach is that it risks tying health outcomes to the body instead of to the society in which they were formed. This can be especially disempowering if that relationship becomes internalized by the group being studied. It is not because one is, for example, queer or trans that they experience a higher proportion of mental and physical health issues than heterosexual people (Schuster et al., 2016, p. 101). The identity is not the risk factor: it is because queerphobia creates a society that allows violence and discrimination to happen from family, friends, the workplace, strangers, the law, partners, and health care providers. Because of the safety risks and discomfort of seeing a queer or trans-incompetent health care provider, queer and trans people are more likely than cisgender, heterosexual people to avoid getting an appointment (Hughto, 2017, p. 115); medical avoidance is not an inherent deficit of queer/trans people. Similarly, it is not because one is East Asian that they have a hard time finding a therapist who understands their world; it is because therapists are predominantly white, and cultural competence needs to be at the centre of counselling education. Public health is tasked with describing a problem and making a solution, but the solution cannot be change in the populations themselves; it has to be structural. Deficits perspectives paired with a lack of intersectionality are particularly harmful: queer/trans people that have physical and/or mental disabilities may find that their queer/trans identity complicates their access to care. Trans people who are autistic face
a double burden of having to overcome individual barriers (e.g. linguistic or interpersonal) in addition to having to convince medical gatekeepers that they need transition care because their gender identity is legitimate, not because they have been converted by trans activists (Burns, 2017).

An alternative is a strengths-based approach, which is grounded in respect for people’s agency and rationality. This approach imagines a possibility of finding space between resistance and complicity, by shifting the focus from impacts to responses. It is curious about the actions people take to adapt to a society that makes it difficult or dangerous for them to be themselves. These actions may be beneficial in some respects – e.g. culturally and psychologically – at the cost to short-or-long-term physical health. For example, avoiding the use of pharmaceuticals may strengthen one’s in-group identity, but doing so may unnecessarily prolong illness. On the other hand, it is also possible that using mainstream medicine may be physically healing, but culturally alienating. Centring the person’s desires and needs – particularly through the use of queer theory – can lead to a richer understanding of the issue.

Questions for critical reflexivity:

- **What are the historical and present power relationships between myself and my subject?**
- **How do subjects perceive me in relation to them?**
  - What do I represent as a researcher?
  - What kinds of power are being held by whom?
- **Does my research add a new perspective to the literature?**
• How does my research empower communities?
• What theoretical frameworks guide my research?
• Why do I want to do research with this population?
• What are my expectations of the research team and our relationship to this topic?
• What are my values in researching this community?
• What are the power relationships within the research team?
• What do I hope that researching this topic says about me as a researcher?
• How does this affect my relationship with my subject?
  o What happens if I cannot fulfill my intentions towards the subject?

6.3 Homonormativity in health research

As variables, sexual orientation and gender are often treated inconsistently and opacity. In many survey studies, sexual orientation is coded dichotomously as either heterosexual or LGB (Lesbian, gay, or bisexual). Upchurch et al. (2016) used this coding, and also had options for “mostly heterosexual” respondents (n=1,019), respondents “not sexually attracted to either males or females” (n=76), and “mostly homosexual” (no number given). Respondents who identified as “mostly homosexual” were included in the LGB category, but “mostly heterosexual” and “not sexually attracted to either males or females” were excluded. The limitations of using the LGB vs. heterosexual categorization is particularly obvious here: why was “mostly heterosexual” was not part of the LGB group? Why was it even an option in the survey if the data would be inevitably discarded? As to the gender variable, the researchers noted that “transgender” was not an available category as it was not part of the 2001 survey.
“Trans” is only beginning to be an option in surveys that collect demographic information, but of course one can be trans and LGB, which complicates the survey options and analysis. This loss of data from people who are trans, which includes people who are nonbinary, agender, or genderfluid is regrettable and reflects the fact that transgender identity has historically been ignored in scientific and medical studies that do not explicitly focus on gender identity. An intersectional approach would avoid analysis within variables and look across variables to see patterns. There is no unified queer experience. It is important to consider how less visible or vocal groups may be at increased risk because the conversation about queer rights (and by extension, queer health) tends to be framed as an issue about sexual health for White gay cisgender men (Arana, 2017), and to a lesser extent, White lesbian cisgender women. Because of the pervasiveness of White and cisgender privilege, the conversation is not typically sensitive to nonbinary, genderfluid, and/or asexual people, and leaves out the ways that people of colour’s queer rights and health equity interests go beyond same-sex marriage and STI testing (Arana, 2017). Culture shapes the way that queer people are even read as queer, and by extension, how they access or do not access queer spaces and queer-specific services.

Questions for critical reflexivity:

- How does my work support or challenge the gender binary?
- What am I afraid of seeing in my data or in the published work?
- What will happen to my self-image and my relationship to my subject if I have not accomplished what I hoped to do, or found what I hoped to find?
burning her tongue on droplets of ocean
flames that taste like forgetting
6.4. The need for a paradigm shift

In public health, policy-level decisions are made on an understanding of patterns of health status, health-seeking behaviour, and barriers to optimal health. Policies attempt to allocate resources efficiently and appropriately because financial, human, and natural resources are limited. To determine how this can be done, policymakers look at research evidence, which allows an informed consideration of the opportunity costs inherent in prioritizing one group’s health improvements over another’s.

But what counts as good research evidence? Practical knowledge, traditional knowledge, and personal experience carry little weight in academic circles. They are not “scientific” sources – that is, they are explicitly biased – and their lack of generalizability makes them not apparently useful for policymaking. Theoretical sources are considered more legitimate in the Western context. I argue that this is problematic because it is racist. Traditional knowledges are labelled “practice-based knowledge” because they do not fit in the Western understanding of theory-based knowledge; they do not derive from research that has been conducted and/or documented in a Western scientific way, although they may be based in other scientific paradigms. Often, CAM and TEAM are presented in research and media as inferior, risky, and static health practices and are inherently unscientific (Birch & Alraek, 2014). Acupuncture was regarded as pseudoscience for decades after its introduction into the Western context, but recent meta-analyses of studies have shown that “acupuncture is at least as effective as or possibly more effective than prophylactic drug treatment and has fewer adverse effects”
(Foon & Yeh, 2015). The reasons for its efficacy are still unclear from a Western scientific context, although they have been explained by TEAM theories.

The compatibility of TEAM and Western medicine is a longtime debate in research: some believe that the concepts are fundamentally incompatible (Lu & Busemeyer, 2014), yet others have attempted to “Westernize” TEAM by doing randomized controlled trials (Foon & Yeh, 2015). I am not taking the space here to make an argument that TEAM is “scientifically sound” because there is no winning an argument that is already biased in TEAM’s disfavour by the virtue of using a Western understanding of soundness. But we must remember that Western health care is not without its own issues: it is often criticized for taking an overly fragmented (Hai, 2009, p.29) and being too focused on symptom management.

What I see glimmering in the chasm between the different ideological bases of TEAM and Western medicine is a what Thomas Kuhn called a paradigm shift. Western science made paradigm shifts from a Ptolemic model of the solar system to a Heliocentric model; from the idea of divine decree to natural selection. These instances signify that the previous understanding was incomplete; in the example of TEAM and Western medicine, a paradigm shift in public health can allow researchers to move past solely consulting a limited “evidence base” and to consider qualitatively gathered, culturally sensitive, lived experience as sound evidence. As we move from one belief system to another we need to take a drastic perspective change, or we will not “get” where people who use TEAM are coming from. Our engagement with TEAM’s belief
system will be superficial, and in this shallow soil we can never grow the necessary empathy, respect, and cultural sensitivity that is so core to sustainable and anti-oppressive public health work. A paradigm shift challenges Eurocentric assumptions about what is normal and what is not, and challenges the pathology of typical cultural reactions to events. An Orientalist perspective has no place in a fair consideration of traditional East Asian medical practices that are dynamic and have been refined over thousands of years, and which continue to be used and studied (Xu et al., 2013, p. 7; Hui, 2009, p. 31).

I am also questioning the hierarchy of theory-based knowledge: Not all evidence is considered “good”. Randomized controlled trials (RCTs) are lauded as the gold standard of evidence in scientific studies. But it is not possible or ethical to conduct RCTs on complex social issues; in these cases, qualitative methods are more appropriate and allow an understanding of the how and why questions behind health-related phenomena. Hierarchies of evidence are unhelpful when blindly followed; to do so is to ignore methodological appropriateness to the research question (Petticrew & Roberts, 2003). The best research design is simply one that matches the study question. For example, the cross-sectional survey design of Upchurch et al. (2016), Wade et al. (2007) and Lee et al (2010)’s aids their comparison of health behaviours and health statuses among different groups of people. Such a snapshot offers a clear picture of the patterns among different groups and is very useful for policy change, as opposed to a cohort study, which would only provide information about one population whose health disparities have already been established. Furthermore, cross-sectional
surveys allow data to be quickly and easily collected, either at the time or retrospectively, about situations that cannot be created ethically or practically in a randomized controlled trial or laboratory. In contrast, Ou et al. (2017) took a qualitative in-depth interview approach to supplement results from the Chinese and South Asians’ Preferences and Expectations of Primary Healthcare Survey, which was based in Vancouver, Canada. The interviews aimed to explore contextual factors around Chinese young adults’ health status and health seeking behaviour. This qualitative design is appropriate as it can illuminate mechanisms of cause and effect. The fact that participants can share whatever and how much information as they like, centres them as more active co-creators of knowledge than in a survey approach, which has set questions and responses that are pre-set by the research team.

While the research design can be appropriate, there is still the possibility of using shallow methods that create an inaccurate or incomplete picture of reality. Said’s concept of *textual attitude* (in Ramiller, 2001) illuminates the way that public health research can entrench inequities for QEAY through their exclusion in Western public health research. Textual attitude is the phenomenon that occurs when decontextualized statistics on queer populations or East Asians (or silence) frames an understanding of a complex, heterogeneous group, and this “hamper[s] westerners' capacity to learn from their direct encounters with those peoples and places, and it reduce[s] their sensitivity, often with dire consequences, to the particularities in front of their faces” (Ramiller, 2001, p. 149). When we privilege survey data over qualitative data, it silences a group who has important insight into what information was gathered, and how it was
interpreted. This kind of data collection, especially if done in a participatory action approach, is time-consuming. But avoiding this important work further entrenches the idea that knowledge mined from a group by the researcher is more legitimate than honoring the knowledge held within groups themselves.

Questions for critical reflexivity:

- Who is this research for?
- How do participants/subjects benefit from this research?
- What kinds of knowledge am I using, and what kinds of knowledge am I deciding not to use?
- Why am I asking about X? or, Why am I not asking about X?
- Am I talking about risks associated with identity or behaviour?
- If my subjects were not minorities, i.e. if they were White, would I take this approach?
- Have I involved people from this community in the research team and research process?
- Am I using euphemisms for racism and queerphobia?
  - How would my work change if I named these forces directly?
- What assumptions form the basis for my questions? How do I know these are true?
  - Do my subjects share these assumptions?
7. LIMITATIONS

In making queer young adult East Asians the subject in this kind of work, I am in a position of power as the sole authorial voice. As talking about a group without giving them opportunity to speak would be a reproduction of the power I am trying to dismantle, inviting art-based submissions is an attempt to even out that balance somewhat. Although this anthology format has value in the way it is presented, time and resource constraints prevented the possibility of turning this anthology into a research study that involved interviews with QEAY and a qualitative visual analysis of the submitted artworks. I also regret that due to time and resource constraints of my MPH, I was not able to discuss the issue of QEAY and the historical, political, or cultural dimensions of disability, although I recognize that in the conversation about healing, the conversation about disability is intimately connected. The limited scope of this paper also forced me to choose focus on East Asians and TEAM, although I recognize that many Southeast Asians practice forms of traditional medicine with East Asian origins due to histories of East Asian colonization, and this topic is worthy of a paper of its own. In a future study, I would love to interview QEAY about their use of TEAM. I would also like to interview TEAM practitioners. Allyship is crucial in the fight for accurate representation and research focus, as well as in creating accessible TEAM practice. I would seek to understand how non-East Asian TEAM practitioners understand TEAM, reflect upon their role as a TEAM practitioner and an ally, and what they believe is sacred and should be reserved for people of East Asian heritage.
8. CONCLUSION

It has been a challenging task to make silence the topic of this paper. There is no research on QEAY and TEAM, but my own experience, close relationships and the art submissions prove that this research is necessary. Because I am also a researcher, I write from a desire to challenge my research community to a higher standard: I have chosen to write about this topic because I want to see research being done in a way that better serves QEAY and other multiple minorities who are invisible due to forces of racism, heteronormativity, homonormativity, and White supremacy.

This can be accomplished in both quantitative and qualitative research through a series of tools. Reflexivity encourages transparency and accountability in research. Strengths-based perspectives challenge research norms in which health inequities are framed as cultural deficits. Research that uses a survey or otherwise quantitative approach will benefit from the structure of social theories because they allow space for a greater awareness of the social forces at play in a seemingly objective research context. Three theories particularly useful for work with QEAY are intersectionality, queer theory, and postcolonial theory; they also enable us to shift our own perspective to be role models of a larger paradigm shift. The silence begins to be filled when we begin challenging the academic institutions, assumptions, and protocols that we have internalized. Awareness and refusal to perpetuate silencing research processes is the beginning of action towards the inseparable goals of health equity and social justice.
## 9. APPENDIX

### Table 1. Inclusion and Exclusion Criteria

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Exclusion Criteria</th>
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<tbody>
<tr>
<td>Articles published between 2007 - 2017</td>
<td>Studies explicitly about recent East Asian immigrants’ experiences</td>
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<tr>
<td>Peer-reviewed and scholarly journals</td>
<td>Studies older than the ones I had already found</td>
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<tr>
<td>Articles that explicitly discuss East Asians as a group</td>
<td>Studies which did not offer much new information to the range of studies already chosen</td>
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<td>Studies within Canada and the United States</td>
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<td>Studies that discuss acculturation</td>
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<td>Articles that centre on CAM or TEAM use in LBGTQ+ young people</td>
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<td>OVID Medline</td>
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<td></td>
<td>“exp Traditional Chinese Medicine” AND “exp Canada”</td>
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<td></td>
<td>exp Complementary Therapies/ AND exp Asian Continental Ancestry Group/</td>
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ary and Alternative Medicine supplement and a follow up survey to CHIS 2001. This study looked at responses from Mexican-Americans and Asian-Americans of Chinese, Japanese, and Korean descent.


Cross-sectional telephone survey of "randomly selected Chinese and white Canadians in Calgary in 2005"

<p>| exp Sexuality/ or exp Bisexuality/ or exp Transgender Persons/ or exp Homosexuality, Female/ or exp Transsexualism/ or exp Sexual Minorities/ or exp Homosexuality, Male/ or exp Homosexuality/ AND &quot;exp Medicine, East |
|---|---|---|---|
| None | 5 | None; articles were based in China or Korea and or were about sexual function as opposed to sexuality. |</p>
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<td>2007 - 2016</td>
<td>“LGBT” AND “traditional medicine” 0</td>
<td>N/A</td>
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<td>None</td>
<td>Semi-structured in-depth interviews with eight young adults in Vancouver</td>
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Complementary and Alternative Medicine

Complementary and Alternative Medicine (CAM) refers to a range of health practices that lie outside the established norms of Western medicine, and which often are characterized by natural products, holism, and an avoidance of pharmaceuticals. When I use the term “Western medicine” I am referring to conventional Western medicine as a separate entity from CAM, although both may come out of Europe and/or North America. There is no standard definition of what practices constitute CAM; whether or not a practice is considered complementary or alternative depends on how it is used in relation to Western medicine. CAM may refer to therapies administered by regulated professionals such as chiropractors, acupuncturists, and massage therapists, as well as other practitioners who work in hypnosis, energy healing, and spiritual healing. CAM may also include self-administered therapies such as relaxation techniques, self-help support groups, specialized diets, and imagery (as defined under “CAM Practices” in Upchurch et al., 2016). Some CAMs draw principles from global indigenous traditional healing practices. Some, but not all CAMs are recognized as being supported by Western scientific evidence.

East Asian

Cultural and ethnic tensions are very real among countries that the West has broadly defined as “Asia”, given their intertwined histories of colonization, slavery, and war. Within “East Asia” - China, Hong Kong, Japan, Korea, Macao, Mongolia, the Ryukyu Islands, and Taiwan – inter-ethnic conflicts and cultural pride are historical and
current factors that strongly resist these groups being homogenized. In the rest of Asia, East Asians have enormous class privilege and global hypervisibility as compared to Southeast, South, Central, and West Asians (who may also identify as “Middle Eastern”), who are often forgotten about in discourse about “Asians” that comes out of Canada and the United States.

Yet, in the Canadian and North American diasporic context, people with ancestors in East Asia have often been - and continue to be - flattened into an Orientalist idea of the East rampant with dragons, geishas, fans, pagodas etc. (“they all look the same”). This invisibilizing is predicated on the paradoxical fact of Chinese, Japanese and Korean hypervisibility over all other Asians and the fact that often “China that stands metonymically for ‘Asia’” (Vukovich, 2013, p. 588). But I believe that within this context, the term “East Asian” also offers possibilities of understanding these groups’ challenges and successes. “East Asian” has the potential to harness identity politics and use it subversively in reference to the intergenerational and intercultural solidarity that is possible in these groups’ resistance to White hegemony. This is also known as *strategic essentialism*, a deliberate mobilization of people under one unifying identity from which position they can be empowered to act “in a scrupulously visible political interest” (Spivak, 1985, p.214). However, if users of this strategy forget that it is a strategy for a purpose, the essentialized identity is at risk of “ossify[ing] into a fixed identity, which can ultimately perpetuate the subordination of the groups [it] claimed to emancipate” (Morton, 2007, p.126.) Strategic essentialism is only effective when it is strategic, this is, when the boundaries of the essentialism are within the control of the oppressed groups, used for their purposes, and are not in the control of the oppressor.
Queer

I use the word “queer” to refer to any combination of sexual orientations and/or gender identities that are anything other than heterosexual and cisgender. Originally a slur that referred to homosexual populations, “queer” has been reclaimed in the past several decades and encompasses a spectrum of identities that resist normative binary categories. Here, I include trans communities under the term “queer”, and therefore “queerphobia” refers to discrimination towards both queer and trans people. However, I use this definition knowing that not all queer people are trans (and not all trans people have reclaimed the word “queer”, which is still laden with pain and stigma for many people). Many health outcomes overlap for queer and trans people, although these groups are not consistently studied together. Other words that are used in public health literature to refer to similar groups are “sexual and gender minorities”, as well as the term “Lesbian, Gay, Bisexual, and Transgender (LGBT)”. “Queer” is also useful as an umbrella term, but at the same time, it resists conforming to a normative categorization that restricts movement between labels. In this way, “queer” is sensitive to gender and sexual fluidity, as well as distinctly separate from the mainstream gay and lesbian movements that foreground same-sex marriage as a priority over other movements. “Queer” recognizes that outside of the commercialized and mainstream “LGBT” movement, queer people may be interested in expanding definitions of legitimate partnerships and in addressing how gender and sexuality intersect with race, ability, and social class.
Traditional East Asian Medicine

Traditional East Asian Medicine (TEAM) encompasses a range of medical practices with roots that extend more than 2,500 years back to the Taoist philosophy of ancient China (NIH, 2013). Ethnic groups across East Asia share similarities in their traditional medical practices, but each reflect culture-specific values and needs. TEAM includes therapeutic techniques that manipulate the skin, musculoskeletal and nervous system. Examples are acupuncture, acupressure, tui na, shiatsu, reiki, gua sha, cupping, moxibustion, and bone-setting; medicines to be ingested such as herbal medicine and dietary therapy; and meditative mental-physical practices such as tai chi and qi gong. In this paper, I have deliberately chosen to bring focus to TEAM, as opposed to traditional Chinese medicine (TCM) alone. This approach widens the scope of the available literature; acknowledges the similarities among medical practices in East Asian cultures, particularly when they are brought into a diasporic context; and de-centers the Chinese culture in the conversation around TEAM to bring attention to other East Asian cultures. While TCM is nested within TEAM, the two are not interchangeable. This discussion occurs in the context of a society where non-Chinese East Asian traditional medicines are not granted the same amount of institutional legitimization (as in the examples of acupuncture and practitioner licensure) or social recognition. Most studies I consulted referenced traditional Chinese medicine if they made a distinction between CAM and TEAM at all. I could not find any recent articles that explicitly differentiated between traditional Chinese medicine and other types of TEAM.

TEAM is based on an understanding of the body that foregrounds holism (Xu et al., 2013, p. 7) and pattern differentiation (Scheid, 2016). As opposed to a reductionist,
either-or approach, TEAM recognizes that the body functions as a whole system (Birch & Alraek, 2014, p. 337). Organ systems are intimately connected to one another, and treating a disease involves treating multiple parts of the body, often via multiple modalities. The body is influenced by changes in the external environment, such as the weather and seasons (Hai, 2009, p. 21). Internal changes in the body are indicative of imbalances in complementary forces of yin and yang (Hai, 2009, p. 17). To balance these forces, practitioners manipulate the flow of qi (a “vital energy” (NIS, 2013) or life force) through the body in a series of meridians, or channels. TEAM understands that health care involves treatment of both wellness and illness; prevention and lifestyle practices are considered with equal weight to that of symptom management and curing disease.

**Evidence-based TEAM practice**

Because of the complexity of TEAM’s understanding of the body, health, and disease, it is difficult or impossible to match concepts in TEAM directly with concepts in Western medicine. TEAM does not focus on providing simple causal models (Birch & Alraek, 2014, p. 337). Evidence for TEAM efficacy comes primarily from observation of the patient’s treatment effects (Ip, 2015) and the establishment of patterns over time. Practitioners follow practice guidelines that have been established over thousands of years, yet each client may react differently to the treatment. Evidence of efficacy is derived from the patient’s symptoms and experience, not from larger academic literature (Ip, 2015).

**Integrated therapy**
Integrated therapy is the idea that TEAM and Western medicine can be used in tandem by a patient, with one kind of therapeutic model supporting different aspects of the problem or deficiencies in the solutions offered by the other. Patients may commonly use TEAM as part of their everyday lifestyle, for prevention, or for preliminary diagnostic purposes, whereas Western medicine may be used to confirm diagnoses or treat more acute illnesses (Ip, 2015).

Current legislation

While TEAM is used in tandem with Western medicine in many parts of East Asia, its acceptance has been slower in North America. Since the 1970’s, TEAM has found increasing acceptance within Canada and the United States as a result of professional regulation and legislation allowing certain TEAM practices (mainly acupuncture) into the wider therapeutic space (Cao, 2015). TEAM is not regulated nationwide, and legislation differs by province and state. For example, in British Columbia and Ontario, acupuncture and herbal medicine are regulated, but other provinces only regulate acupuncture, or neither acupuncture or herbal medicine. Furthermore, in British Columbia, four restricted titles exist for traditional Chinese medical practice: Registered Acupuncturist (R. Ac); Registered Traditional Chinese Medicine Herbalist (R.TCM.H); Registered Traditional Chinese Medicine Practitioner (R.TCM.P – combines acupuncture and herbology with restrictions); Doctor of Traditional Chinese Medicine (Dr. TCM – combines acupuncture and herbology without restrictions). Other classes of registrants exist as well. There are: limited registration, student registration, non-practising registration and temporary registration in BC (Cao, 2015).
Becoming a TEAM practitioner

According to the Chinese Medicine and Acupuncture Association of Canada, the requirements for working as a traditional Chinese medicine practitioner differ depending on the kind of license one seeks to hold. There are no licenses for practitioners of other East Asian traditional medicines. The role of Dr. TCM requires 5 years of training, followed by “completion of a 3,250 hours traditional Chinese medicine program including a minimum of 1,050 hours of clinical instruction of which 825 hours must be supervised practice”, and culminating in a series of exams (“TCM regulation in Canada”, 2014). Furthermore, established practitioners must meet minimum requirements for the volume of appointments per every two years (200), as well as hours of continuing education (50) (TCM regulation in Canada, 2014).

Accessibility of TEAM in Canada and the United States

In British Columbia, most acupuncture is covered by the Medical Services Plan, but all other aspects of TEAM are not covered. This means that to receive services, clients must pay out of pocket for appointments. This is the case for any TEAM treatments that are not covered by universal health insurance in other provinces. In the United States, Medicare does not cover acupuncture or any other aspect of TEAM, and Medicaid coverage of acupuncture and other TEAM differs by province and by practitioner status. Treatment prices vary depending on what course of treatment is being done, as well as for consultations, herbal medicines, and ongoing checkup appointments.
Modernization of TEAM

Modern approaches being taken to develop TEAM by East Asian researchers and theorists come with the view that “modernisation of TCM is more than Westernisation” (Xu et al., 2013, p.8). Three eras of developments in TEAM (in the Chinese context) can be identified, from the 1950s to the present (Xu et al., 2013). Phase I (1950s-1970s) focused on TEAM higher education and research networks; Phase II (1980s-2000s) focused on global legislation of TEAM products and practices, quality control and standardization, developing evidence bases and international networks for TCM, and Phase III (2011 to the present) is focused on “consolidating the scientific basis and clinical practice of TCM through interdisciplinary, interregional and intersectoral collaborations”. TEAM is finding a way into the Western market through clinical trials of herbal extracts and the subsequent labelling of these medicines as botanical drugs (“The modern face”, 2008). However, difficulties present themselves in the classification of herbal medicines as Western drugs, given that the two paradigms are completely different and at times have incompatible perspectives. Barriers also exist in the technicalities of labelling of such medicines, which are not the same as food and dietary supplements but would be treated as such under the category of “Herbal Remedies” (“The modern face”, 2008). How these research developments are received by the North American medical and social context is another matter.

Youth

Many definitions of “youth” exist. In this paper, I use “youth” to refer to young adults between ages 18 – 30. I am interested in this age range because it frames a rich journey from adolescence to adulthood in which a stable sense of self develops. But
unlike adolescence, this time of identity performance and discovery is also associated with greater independence and capacity for critical decision-making.
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