

Coping with future epidemics: *Tai chi* practice as an overcoming strategy used by survivors of severe acute respiratory syndrome (SARS) in post-SARS Hong Kong

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Abstract

Background Although SARS had been with a controversial topic for a decade at the time of this study, numerous SARS survivors had not yet physically, psychologically or socially recovered from the aftermath of SARS. Among chronically ill patients, the use of complementary and alternative medicine (CAM) is reported to be widespread. However, extremely little is known about the use of CAM by SARS survivors in the post-SARS period and even less is known about how the use of CAM is related to the unpleasant social and medical-treatment experiences of SARS survivors, their eagerness to re-establish social networks, and their awareness to prepare for future epidemics.

Objective To investigate the motivations for practising *tai chi* among SARS survivors in post-SARS Hong Kong.

Design, setting and participants Using a qualitative approach, I conducted individual semi-structured interviews with 35 SARS survivors, who were purposively sampled from a *tai chi* class of a SARS-patient self-help group in Hong Kong.

Results Health concerns and social experiences motivated the participants to practise *tai chi* in post-SARS Hong Kong. Experiencing health deterioration in relation to SARS-associated sequelae, coping with unpleasant experiences during follow-up biomedical treatments, a desire to regain an active role in recovery and rehabilitation, overcoming SARS-associated stigmas by establishing a new social network and preparing for potential future stigmatization and discrimination were the key motivators for them.

Conclusion The participants practised *tai chi* not only because they sought to improve their health but also because it provided a crucial social function and meaning to them.

Introduction

Severe acute respiratory syndrome (SARS) was one of the most challenging public-health crises faced in Hong Kong in 2003, infecting 1755 people and claiming 299 lives.¹ Many SARS survivors are still suffering physical, functional, and psychological and behavioural disorders after the acute infection,^{2,3} which requires long-term medical attention^{4,5} and reached a chronic phase.

The use of complementary and alternative medicine (CAM) has been reported to be widespread among chronically ill patients.^{6–8} In addition to addressing health concerns, the CAM practice of patients often conveys symbolic, non-health meanings.^{9,10} CAM practice is often correlated with people's health views and their failure to experience an alleviation of chronic suffering after being treated with mainstream biomedicine.^{11–13} Furthermore, the use of CAM is documented to be widespread among patients affected by communicable diseases.¹⁴ However, extremely little is known about the CAM-practice motivations of SARS survivors in the post-SARS period and even less is known about the social and cultural meaning of CAM practice to SARS survivors. *Tai chi* is one of the most widely used forms of CAM in Hong Kong. Therefore, in this study, I investigated how SARS survivors' motivations to practise *tai chi* were related to their health and social concerns in post-SARS Hong Kong.

Methods

A qualitative approach of data collection was used in this study, in which I conducted in-depth, individual, semi-structured interviews with 35 SARS survivors between December 2012 and April 2013. The participants were purposively sampled from a *tai chi* class with 60 SARS survivors that was organized by a SARS-patient self-help group in Hong Kong.

Participants

All 35 participants in this study (i) were infected with SARS during the 2003 outbreak; (ii) had been suffering from physical and/or psychological SARS sequelae at the time of the study; (iii) had been receiving follow-up biomedical treatment for their SARS sequelae; (iv) had started practising *tai chi* after the SARS outbreak; and (v) were Hong Kong Chinese. Most of the participants had enrolled in the *tai chi* class in 2006, whereas a few joined the class in 2008. I recruited 22 female and 13 male participants, whose ages ranged from 38 to 69 at the time of study.

Eleven participants were university graduates, four had completed post-secondary education, 16 had completed the fifth year of secondary school, and four had reached the third year of secondary school. Twenty-three participants were employed in the areas of servicing, sales and retailing, executive work and administration, information technology, and food and catering; 17 were full-time workers and six were part-time workers. Eight of the participants were homemakers and four had retired.

All the participants had been hospitalized for SARS treatment and eight had been admitted to the intensive care unit. All of them suffered from physical and/or psychological sequelae caused by SARS and, since infection, had been receiving follow-up treatment in public hospitals' outpatient, speciality clinics (orthopaedics, internal medicine and psychiatry). Several of the participants received follow-up treatment from more than one speciality clinic and four of them withdrew from the follow-up treatment during the time of study. Osteonecrosis, lung scarring, cardiac dysrhythmia and impairment of cardiopulmonary functions were the common physical sequelae suffered by the participants. The participants also experienced shortness of breath, bone pain in the back and hip, headache, fatigue, general weakness and energy loss. Since infection, the participants had also commonly

suffered psychological sequelae such as insomnia, depression, anxiety disorder and obsessive compulsive disorder.

Data collection

Because I sought to examine the motivations for *tai chi* practice among the SARS survivors in post-SARS Hong Kong and to determine how their *tai chi* practice was related to the social environment and to their social and illness experiences, I used purposive sampling (according to the sampling criteria listed above) to recruit the participants.¹⁵ All 60 SARS survivors enrolled in the *tai chi* class were eligible for the study and 35 of them were recruited because they consented to participate in the study. All of the male members of the class who consented to be interviewed were recruited to achieve gender balance; however, considerably more female than male members were recruited.

Before the interviews, I developed an interview question guide (Table 1) to ensure that

Table 1 Interview question guide

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1. How do you think about your experience since your infection of SARS?
 - a. Health
 - b. Family
 - c. Work
 - d. Friends
 - e. Social relation
 2. What are the changes in your experience before and after your infection?
 3. How do you feel with these experiences?
 4. How do you cope with these experiences?
 5. What motivates you to practice *tai chi* after the SARS outbreak?
 6. What would you expect to get and/or experience from *tai chi* practice?
 7. Can your expectation be matched through the practice? How do you think about your experience of practicing *tai chi*?
 8. What changes does *tai chi* practice bring to you?
 9. What are the differences between *tai chi* and other coping strategies that you have used to deal with the post-SARS experience?
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the interviews remained focussed on the selected topics and proceeded productively. The interviews were open-ended and the participants expressed their views, feelings and experiences freely.¹⁵ The interviews were conducted in a private room at the SARS-patient self-help group. Each interview lasted 1.75–2 h and, with the participants' consent, was audio-recorded. I conducted all of the interviews to ensure consistency and uniform quality in data collection.

Data analysis

The interview recordings were transcribed verbatim. Major themes were identified in the data by using thematic content analysis.¹⁶ Interview transcripts were segmented into meaning units and then collapsed into categories and eventually themes by using the process of abstraction and constant comparison. Repetitive codes and themes were highlighted. A coding table was developed according to the inductive coding process by allowing the discovery of patterns of behaviours and thoughts.¹⁵ New thematic codes that emerged from the data were added to the coding table, and categorical themes were identified and named when they emerged. The coding table was constructed that listed the themes, categories and codes with supporting interview quotes.

Reflexivity

My attention was first drawn to this area of study because of the previous research on SARS in Hong Kong that I conducted nearly a decade before this study. At that time, for my doctoral research, I was investigating the cultural construction of the SARS epidemic in Hong Kong. Initially, I reminded myself not to become emotionally involved with the participants and maintaining a distance from the participants to analyse the study results critically. However, I eventually realized that it was challenging to distance myself from the study participants. I began to establish a rapport and friendship with these SARS survivors

and have since been in contact with them over numerous casual occasions and have observed the changes in the lives. Therefore, my relationship with the SARS survivors has been transformed from that between a researcher and participants to one between mutual friends. Continual contact and interaction with the SARS survivors also enabled me to observe the numerous challenges they have faced because of their identity as SARS survivors; this instilled in me the desire to help the survivors by applying my research skills for raising public awareness about the life of SARS survivors.

Several studies argue that becoming closely involved with participants can result in research subjectivity, which presents certain risks such as projection on behalf of the researcher.¹⁷ Analyses might also be hampered because of researchers' 'blind spots' when they are in close contact with study participants.¹⁸ However, subjectivity can also potentially enable researchers to understand their study participants.¹⁹ Exploiting subjectivity and drawing on researchers' experiences can enhance our understanding of study participants.^{20,21} When researchers distance themselves from the participants in an 'objective' manner, it keeps the participants at a distance.²² Because of the long relationship I have had with the participants of this study, we have become friends, and this friendship, combined with my research skills, has enabled me to increase my understanding of the requirements of the participants and of the challenges they face. My relationship with the SARS survivors also reduced their sensitivity and reactivity to my research procedures, which, in turn, reduced their behavioural changes. Becoming closely and continually involved with the SARS survivors allowed me to immerse myself in, and closely experience, their lives. Concurrently, this enabled me, a person never infected with SARS, to reflect on the struggles of the SARS survivors. This subjective self gives meaning and life to a research study.

Results

Motivations of participants to practise *tai chi*

Data analysis revealed five motivations for the participants to practise *tai chi* in the post-SARS period. Although the health concern related to their past SARS infection was a major reason why the participants practised *tai chi*, their unpleasant social and medical-treatment encounters, their attempt of being an active patient and of overcoming current SARS-associated stigmatization and to prepare for it in times of future epidemics were also prominent motivators of the practice.

Deterioration of health caused by SARS-associated sequelae

Because the participants suffered the physical sequelae of SARS, a dominant motivator of *tai chi* practice in all of them was their attempt to slow physical deterioration. The problems associated with their bones and their pulmonary condition made the participants believe that only mild exercises such as *tai chi* were suitable for them. This participant suffering from osteonecrosis indicated a widespread concern:

'Water swollen' [oedema], gasping, and 'bone withering' [osteonecrosis] are bothering me. Sometimes, the bone pain is so serious that I can hardly walk, sleep, or do anything. I want to find some exercises that can prevent my physical condition from getting worse. I cannot cope with vigorous exercise; my lungs are not good because of SARS, so I practise *tai chi*. Also, people often say that *tai chi* is good for bones. [P14, 47-year-old female, completed Form 5, secondary school-educated]

Tai chi was also perceived by nearly all of the participants as being an effective method of obtaining relief from their psychological sequelae, with the expectation being that it would ease their emotional suffering. A participant suffering from obsessive compulsive disorder after SARS infection shared the following:

Every night, I cannot sleep, and I constantly want to wash my hands even though I know my hands are not dirty. The doctors referred me to

psychiatry [clinic], but that did not help either. This suffering makes me feel very depressed. I have heard that *tai chi* can help a person to relax and feel peaceful; therefore, I learn *tai chi* here to see if it can help me with my emotions. [P21, 39-year-old female, university-educated]

Unpleasant experiences during follow-up biomedical treatment

Because of chronically suffering SARS-associated sequelae, all of the participants routinely received follow-up treatment at outpatient specialty clinics of public hospitals. However, nearly all of the participants suffered unpleasant experiences during these follow-up treatments, which motivated them to practise *tai chi*. A failure to experience any relief from their chronic suffering even after years of treatment was a typical unpleasant experience:

I have been receiving follow-up treatment for years. However, it is ineffective in easing my bone pain. Doctors prescribed me painkillers, but the relief lasts for only a few hours. Physiotherapy is useless, too. It is frustrating to see that my pain has not decreased even after years of treatment. Therefore, I decided to try *tai chi* to see if it can help me. [P3, 51-year-old male, completed Form 5, secondary school-educated]

Contending with the scepticism and poor attitudes of health-care providers, particularly doctors, was another unpleasant experience that profoundly affected the participants. During follow-up treatments, more than half of the participants experienced situations in which their doctors were sceptical when told of the suffering; this strongly motivated the participants to practise *tai chi*. This participant complained about how doctors' scepticism and lack of empathy motivated her to practise *tai chi*:

Many doctors in the clinic were apathetic and inconsiderate. They did not listen to what I had to say about my suffering. They quickly concluded that my suffering was not real because I did okay in the tests, and they concluded that my suffering was merely my imagination. I feel hopeless during the follow-up treatment. If the doctors do not believe that I am suffering, how can they help me? Every time I see the doctors, I feel very bad. Therefore, I am trying *tai chi* with the hope that I can get better soon and thus get

rid of these doctors as soon as possible. [P15, 46-year-old female, university-educated]

In several cases, doctors referred the participants to psychiatry clinics for treatment for their emotional suffering. Such referrals increased the unpleasantness of the participants' treatment experiences, because they suspected that their physical suffering was misunderstood and misdiagnosed as 'psychiatric' problems. Twelve participants were referred to psychiatric outpatient clinics for treatment for emotional problems, and the notion of being misunderstood and misdiagnosed strongly motivated them to practise *tai chi*. One participant complained:

The doctors do not believe that I am suffering. They thought that my bone pain was merely imaginary. After several follow-up treatments, a doctor referred me to psychiatry [clinic]. I am suffering from physical pain, but the doctors think that I am crazy. I feel very bad because these doctors do not understand my suffering and assume that I have some psychiatric disease. Therefore, I turned to *tai chi*, and my hope is that it can treat my pain, so that one day I can stop going back to these doctors. [P1, 42-year-old female, university-educated]

These unpleasant experiences in biomedical encounters motivated four participants to withdraw from the follow-up treatment. They relied solely on *tai chi* not only because they hoped that it would alleviate their chronic suffering but also because they sought to escape from the scepticism shown by health-care providers and from the unpleasant biomedical-treatment experiences. A participant who had withdrawn from the follow-up treatment said the following:

I feel very bad after each follow-up. I do not think it is a big deal that I am not getting better with regards to my pain, but the doctors' attitudes really annoy me. The doctors thought that I pretended to be sick, and I was accused by these doctors during every visit. It is totally a waste of time for me to see these doctors, because they never believe that I am in pain; so, I terminate the follow-up, and am learning *tai chi* to help myself. [P16, 50-year-old female, completed Form 3, secondary school-educated]

Regaining an active role in recovery and rehabilitation

An attempt to regain an active role in their recovery and rehabilitation was a major reason why the participants practised *tai chi*. Most of the participants perceived their role in the treatment as being a passive one, which instilled in them a sense of insecurity. More than half of the participants were motivated to practise *tai chi* to regain a sense of control and security. This participant indicated how passive participation in the follow-up treatment motivated her to practise *tai chi*:

I cannot do much when I go and receive follow-up treatment in the clinic. I am passive during the whole process, and I cannot even ask questions. This makes me feel very insecure. Practising *tai chi* makes me move and helps me play an active role in improving my health. I feel like I am really working for my health and that makes me feel a lot more secure. [P20, 44-year-old female, university-educated]

In several cases, a sense of regaining an active role as a patient was coupled with the participants' unpleasant experiences during follow-up biomedical treatment, and this motivated the participants to practise *tai chi*. This participant shared how the unpleasant experience of the follow-up treatment had driven him to work actively towards improving his health by practising *tai chi*:

My bone and hip pain and gasping have not been going any better even though I have been receiving follow-up treatment for years. Moreover, the doctors do not believe in me for not getting any better. They merely repeat that I am imagining the pain, and that I am just too lazy to make myself feeling better. I feel very bad and frustrated. Therefore, I practise *tai chi*, so that I can become proactive in improving my health, and doctors can no longer blame me for being lazy. [P31, 56-year-old male, postsecondary-educated]

Overcoming SARS-associated stigmas

The stigmas attached to SARS survivors in post-SARS Hong Kong were strong, according to some of the participants. Seclusion in work

and the social sphere was the most common effect of the stigmatization experienced by the participants. More than half the participants practised *tai chi* to overcome this stigmatization; they used *tai chi* to build their new social networks. One participant shared how she built her new social network by joining the *tai chi* class:

My friends and relatives did not want to contact me much once they found out about my continual follow-up treatments in public clinics. They probably think that I can still infect people. I feel isolated because many of my friends have disappeared since I started the treatment. I hope I can make new friends in the *tai chi* class. Because we all have the same history of [contracting] SARS, I think we can become good companions and can understand and support each other. [P11, 51-year-old female, completed Form 5 secondary school-educated]

In addition to experiencing stigmatization and seclusion from their personal social networks, some of the participants sensed that they were stigmatized and excluded during social and civic occasions. This participant commented on how he felt stigmatized and excluded during a blood donation:

I think that the health [screening] questionnaire used before a blood donation is labelling and insulting. It is nonsense to ask me if I have been infected with SARS, and if I have ever been in contact with SARS patients before. SARS disappeared 10 years ago; so, I cannot understand the logic of Red Cross. I was honest and so I ticked 'yes' in the questionnaire, and I was blacklisted and I have not been allowed to donate blood since then. [P22, 43-year-old male, university-educated]

The SARS-associated stigmas attached to the participants remained noticeable in post-SARS Hong Kong. Although the stigmas were often invisible during ordinary times, it surfaced and became tangible when new communicable diseases emerged. Although some of the participants were able to maintain their original social networks in the post-SARS period, they could not do so during times of epidemic. Therefore, *tai chi* practice served as a critical means by which the participants searched for

new social-support networks. One participant recalled how *tai chi* practice helped her in searching for social support and overcoming SARS stigmas during a later Influenza A (H1N1) outbreak:

Just like during the 'pig flu' [swine flu in December 2006], I experienced isolation and a bad label [stigma] from my friends and colleagues. I then realised that my original social network was very fragile in times of a new epidemic, given my label as a SARS patient. I knew I had to build a new social network with people who can understand my situation. Hence, I came to practise *tai chi*. At least these people will not be scared away from me during times of epidemics like the 'pig flu', because we all have the same history and experience of being infected, isolated, and labelled. [P13, 40-year-old female, university-educated]

Preparing for potential stigmatization and discrimination during future epidemics

Because the participants often experienced SARS-associated stigmas in post-SARS Hong Kong, almost all the participants perceived *tai chi* practice as a preparation for overcoming possible stigmatization during future epidemics. This participant explained how she used *tai chi* to prepare for such potential stigmatization:

My colleagues and friends avoided meeting me during the 'pig flu' [swine flu in December 2006]; therefore, I am quite sure I will be labelled again if there is any new infectious disease. It is important for me to prepare myself not only physically but also socially. *Tai chi* can improve my health; so, I will have a low possibility of getting infected, and thus a low possibility of being labelled. Moreover, practicing *tai chi* together with other members enables me to maintain another social network. Even if I am stigmatised again, I can overcome it easily. [P27, 49-year-old male, university-educated]

Some of the participants perceived *tai chi* practice as a mechanism to defend themselves during future epidemics. Because of the history of SARS infection and their experiences of being stigmatized, the participants were enthusiastic about searching for methods to escape from additional disease-associated stigmas. Thus, the participants considered *tai chi* to be

a potential means to achieve this goal if there were epidemics in future, as noted by one participant:

I am pretty sure that I would again be discriminated against if I were infected with any deadly infectious disease in the future. The label might be more negative for me [than for others] because I have a history of [being infected with] SARS. I think practising *tai chi* can help me defend myself, because I can tell others that I have tried my best to improve my health. There are so many new infections like the bird flu [Avian Influenza] and the pig flu [swine flu]. Therefore, it is important for me to get well prepared [for future epidemics], and practising *tai chi* should be a good defence for me. [P19, 56-year-old male, postsecondary-educated]

Participants' sense of *tai chi*'s efficacy

When discussing how effective *tai chi* was in helping them manage with their chronic suffering, nearly half of the participants stated that they experienced improvements in their health and emotions. One participant shared this:

Tai chi can really help me. I feel strong and do not feel tired easily. My breath has become 'smoother' now [than before]. I can walk increasingly longer without gasping [for breath] so often [as before]. My sense of balance has also improved a lot. Before practising *tai chi*, I would feel dizzy easily; but now I rarely feel dizzy. Also, the bone pain has decreased. I can walk longer [than before] without feeling much pain. [P24, 57-year-old female, completed Form 5, secondary school-educated]

However, whether *tai chi* practice effectively treated their chronic conditions was not a dominant concern of most of the remaining participants, although their practice was initially health-motivated. Several of these participants did not know whether *tai chi* practice would tangibly alleviate their chronic suffering; they practised *tai chi* mainly because they believed that it was beneficial for their health:

Honestly, I do not know if *tai chi* can improve my health. My bone pain is still here; I still feel tired easily; and I have gasping easily. However, I believe in *tai chi*. Once you have practised it, you will not care much about the outcome. I do

not have high expectations for *tai chi* to really help with my current physical situation, but of course I should not feel worse after the practice. I guess practising *tai chi* is better than doing nothing; otherwise, my situation may worsen. [P17, 53-year-old male, postsecondary-educated]

The participants often considered the recovering of social function to be of greater importance than the efficacy of *tai chi*, as shared by this participant:

Of course, my concern for health makes me practise *tai chi*, but I also want to make new friends in the class. I have lost my old friends since [the] SARS [outbreak], and so it is important for me to have new friends who are not concerned about my SARS [infection] history. If SARS comes again, at least I can stick with them because they are the only ones who do not mind being in contact with me. [P10, 49-year-old female, completed Form 5, secondary school-educated]

Discussion

As demonstrated by the participants, five factors motivated them to practise *tai chi* in post-SARS Hong Kong. Although some of the motivations were primarily health-related and associated with their chronic suffering of the SARS sequelae, the motivations were interconnected with others related to the social environment and the social and illness experiences of the participants.

Suffering chronic ailments can strongly motivate a person to seek CAM treatment^{10,23,24} and unpleasant experiences associated with biomedical treatment for chronic ailments can motivate chronically ill patients to use CAM.¹⁰ In agreement with these previous studies, the participants of this study were motivated to practise *tai chi* because biomedical treatment failed to improve their chronic suffering; moreover, their unpleasant experiences during the biomedical treatment also strongly motivated the participants to practise *tai chi*.

Doctors' attitudes play a crucial role in influencing the treatment experiences of patients.^{25,26} The poor attitudes of health-care providers can lead to patients' unpleasant treatment experiences and, to certain extent, this

motivates a patients' use of CAM.²⁷ The unpleasantness and scepticism that the participants experienced in the follow-up treatment was closely correlated with the unequal power distribution and the relationship between the doctors and the patients. Doctors exercise authority in diagnosing ailments, and the patients are placed under constant medical monitoring and surveillance.²⁸ This difference in power and the hierarchy intensified the participants' unpleasant treatment experiences. For example, the diagnosis (or misdiagnosis) of psychiatric disorders in the participants signified how the authoritative voice of doctors, asymmetry of knowledge, and the unequal power and treatment relationship between doctors and patients resulted in the participants' unpleasant treatment experiences. Being referred to psychiatric clinics and treated as 'psychiatric' patients was a difficult experience for the participants, particularly because, in Hong Kong, stigmatization and self-stigmatization are common among psychiatric patients.^{29–32} Because of the social setting, being referred to psychiatric clinics increased the vulnerability of the participants to this additional stigma. However, because of the power differential, the participants must passively accept such a stigmatizing diagnosis provided by their doctors, whether or not they wish to accept it. Social stigmas were documented to cause patient distress and delay treatment-seeking behaviour.³³ To avoid playing this passive-patient role and to avoid this double burden of stigmatization, the participants proactively used *tai chi* practice as a counter-strategy: Their goal was not only to regain an active patient role but also to challenge the authority of doctors.

The self-practice and self-directed natures of *tai chi* were reported to help patients regain a sense of active participation and control in managing their chronic ailments.²⁴ Compared with biomedicine, CAM is more psychologically accessible to patients because of commonly held cultural views.³⁴ Biomedicine was 'culturally unfriendly' to the participants because of its power structure, and also because the views on health and disease differ

in biomedicine and *tai chi*. The technical and biological training obtained in biomedicine makes doctors focus on 'diseases'; by contrast, patients are more concerned about the feelings and experiences brought on by an 'illness' than they are about the disease.³⁵ Because of the disparities in their belief systems, biomedical doctors could not readily understand the participants' physical and social suffering, and thus the doctors appeared to lack empathy. This further motivated the participants to practise *tai chi*. The long-term self-practice nature of *tai chi* conveyed substantial symbolic meaning to the participants that they were self-disciplined in their quest to improve their health, which enabled them to overcome the doctors' misunderstanding and accusations during follow-up treatments. Furthermore, the practice conveyed a moral imperative of doing everything possible among the participants.

The intention to practise *tai chi* among the participants in the post-SARS period corresponded with people's wearing of facemasks during the SARS outbreak. During the outbreak, the SARS patients were not the only ones stigmatised; people in contact with the patients were quarantined at home.³⁶ Thus, SARS infection was considered to be spread not merely by the patients but by other people who were in the patients' social network. Consequently, people wore facemasks as a preventive measure against infection and, more importantly, to avoid, by adopting this behaviour, moral condemnation. The unfavourable experiences of being stigmatized as 'virus spreaders' and of being isolated throughout the treatment process during the SARS outbreak had a long-lasting impact on the participants. Because of such experience, the participants searched for all possible means to avoid similar moral blame in future epidemics, which motivated them to practise *tai chi*. The participants were not working merely towards protecting their own health by practising *tai chi* (or by wearing facemasks during the SARS outbreak); they were also working for the sake of the people in their social network. *Tai chi* thus served as a moral imperative for the participants that

they could demonstrate themselves as responsible citizens who cared about, and were considerate towards, others.

Although a decade has passed since the SARS outbreak, the stigmatization of the participants has not disappeared. The participants still remain isolated in their communities; although this isolation is not currently overt, the participants could be stigmatized again if new communicable diseases emerge. Moreover, the participants were prevented from participating in some social and civic activities (such as blood donations). Because of this continuing social seclusion, most of the participants gradually imagined that they would be the first people to be morally accused and stigmatized if another epidemic emerged. To overcome such SARS-associated stigmatization in the post-SARS period, the participants eagerly sought the reassurances of engaging in *tai chi* practice. Therefore, rather than merely serving as a health-related practice, *tai chi* became a crucial social activity for the participants. Using CAM serves to empower patients³⁷ and CAM practices such as *tai chi* are commonly adopted by chronically ill patients in an effort to overcome social setbacks such as stigmatization and discrimination.¹⁰

Chronically ill patients commonly use CAM as a strategy for building a social network in which people turn to each other for mutual support.¹⁰ Agreeing with this view, this study's participants used *tai chi* to build a new social network. In many cases, the participants' original social networks dissipated. Even for participants who were able to maintain their original social network, the network was fragile and often failed to function during outbreaks of new communicable diseases. By practising *tai chi* in a group, the participants sought to overcome the suffering caused by stigmatization and social seclusion: They sought to build a social network comprising people who had similar ailments and social experiences. This improves the social experiences and social functioning of chronically ill patients^{38,39} and enhances their connection and involvement within their communities.

Because of the social functions of *tai chi*, the participants' lack of attention to the efficacy of *tai chi* was expected. Although a concern for health remained a fundamental motivator of the participants' *tai chi* practice, they considered the social functions of the practice to be of considerably greater importance. Therefore, under the precondition that the practice did not harm them, the participants continued practicing *tai chi* even though some of them failed to experience any concrete improvement in health.

Conclusion

This article reports that the *tai chi* practice of the study participants was closely related to their illness and social experiences in post-SARS Hong Kong. The practice of *tai chi* enabled the participants to become actively involved in choosing the health-care management required for their chronic suffering and in recovering their social functions. By practising *tai chi*, the participants actively improved their health and also became involved in their communities. The practice not only helped the participants improve their health but also served as a crucial social function that conveyed key social meaning to them.

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Conflict of interest

The author declares no conflict of interest in conducting the study and publishing this article.

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