Family, health, and wellbeing: the lives of Chinese immigrants in the Netherlands

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Chapter 1

General Introduction

The Chinese diaspora are one of the largest migrant populations worldwide. In 2011, 40.3 million people of Chinese descent were residing in 148 countries (Poston & Wong, 2016). In the Netherlands, Chinese immigrants comprise the fifth largest non-western migrant population, which is estimated at 110,000 people (Gijsberts et al., 2011). Approximately one third of total Chinese immigrants have reached the older age of 60+ years. On average, the second-generation that followed comprises a third of the immigrant population (Linder et al., 2011). As is characteristic of the Chinese population in the Netherlands, the older first-generation immigrants are poorly educated since the majority originate from the rural areas of Hong Kong where it is common to have little or even no education (Liu, 2014). In contrast, second-generation Chinese immigrants are remarkably highly educated compared with other immigrant populations and the native Dutch population. About 28% of the second-generation have obtained a university degree, which is on a par with the native Dutch population (Gijsberts et al., 2011). To date, little is still known about Chinese immigrants in the Netherlands, especially with regard to their health, wellbeing and cultural aspects concerning family.

Chinese immigrants in the Netherlands

The first settlement of Chinese migrants in the Netherlands was over 100 years ago, in 1911. The first and only national large-scale survey conducted by the The Netherlands Institute for Social Research (SCP) was to report on Chinese immigrants and was devoted to a century of presence of the Chinese immigrants in the Dutch society (Gijsberts et al., 2011). Generally, Chinese immigrants are typified by their traditional characteristics: hardworking, silent, and collectively oriented in their own community. Consequently, the general observation is that this population is *invisible* in the Dutch society. This is reflected in the limited societal dialogues regarding the Chinese immigrants, as well as in the lack of necessary services tailored to the Chinese immigrants. However, a recent social movement, Asians Raisins, has formed in response to the increased discrimination of Asians in the Netherlands since the COVID-19 pandemic by the younger generation (Pan & Yeers, 2020). Nonetheless, the Chinese immigrant population has gained little attention, and they are rarely involved in research, and in that sense are a marginalised population.

The migration history of the Chinese to the Netherlands

The periods of Chinese migration history to the Netherlands can be distinguished in four migration waves (Liu, 2014). In early 1900 (1910 to 1940s), the first Chinese sailors came to the Netherlands with the Dutch Merchant fleets. The second wave took place between 1950 and the 1970s after the Second World War. These migrants mostly came from Indonesia and Surinam after the Dutch colonial period. It was during this period that the demand for Oriental food increased due to its rapid popularity. It was this demand that led to the third wave of migration, from 1970 to 2000. Migrants in the third wave originated mainly from Hong Kong for economic reasons, and they worked in the catering business. Moreover, this wave of migrants consisted of individuals seeking family reunifications and migrating for political motivations in response to the cultural revolution. From 1990 onwards, most immigrants originated from mainland China. In the new millennium, the rise of international Chinese students and highly educated and skilled expats from mainland China formed the fourth wave of migration (Gijsberts et al., 2011).

This dissertation mainly involves the first- and second-generation Chinese migrants in the Netherlands. Largely, this group stems from the third migration wave. Most of the older first-generation have worked in the catering industry. The second-generation in the Netherlands

largely consists of offspring from the third wave of migrants. The migration itself can be considered a life event, with long-term influences on the lives and generations thereafter (Brown, 2018). Specifically, influences on the health and culturally specific intergenerational relationships between first- and second-generation immigrants. This chapter continues with an introduction in which the main concepts and their relevancy to older Chinese immigrants worldwide are explored. Finally, the aim and the outline of this dissertation are presented.

Frailty

Frailty is increasingly prevalent among the older age group and is a natural part of the aging process. Generally, there are two common perspectives as regards frailty in the field of medical sciences. The underlying definition of increased vulnerability is a decline in reserve and function, where the ability to cope with every day or acute stressors is comprised and forms the basis of these approaches. Fried's phenotype of frailty defined frailty as weakness (in grip strength), unintentional weight loss, exhaustion, lower gait speed and low physical activity (Fried et al., 2001). Therefore, Fried's frailty phenotype accounts for a characteristic syndrome. Conversely, a frailty index (FI) was proposed to define frailty as a state of age-related deficit accumulation (Mitnitski et al., 2001). The FI is a dynamic model of frailty between the deficits and assets of the individual, as well as incorporating the other domains of health, such as psychological and social aspects.

The study of frailty among older populations remains an important contributor to new insights in public health. Immigrant populations are structurally underrepresented in health research (Redwood & Gill, 2013). However, few studies have focused on frailty among the older immigrant populations. Older immigrants in the Netherlands, especially the Turkish, Surinamese and Moroccan have shown higher rates of frailty in comparison to the native Dutch population (Franse, 2018; Hoogendijk et al., 2021). The disparity between the immigrant and native population is also observed in the broader setting of Europe (Brothers et al., 2014; Walkden, 2018). Nonetheless, the insights regarding frailty among Chinese migrant populations are scarce.

Quality of Life

Another important and well-established indicator of wellbeing is the health-related Quality of Life (hereafter called QoL). The concept of QoL was developed in reaction to the rise of technology in medical care (Sirgy et al., 2006). As medical and healthcare has become more technologically advanced during the past century, the QoL research movement has recognised that prolonging life and survival are equally as important to an individual as their quality of the life (Sirgy et al., 2006). McNeil's work first brought the QoL concept into the medical decision-making debate in the late twentieth century (McNeil et al., 1975). Since then, the World Health Organization (WHO) has developed a definition, and it has conceptualised and operationalised it as a measurement instrument. The leading definition of the WHO is formulated as "*individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns*" (WHO, 1998). Subjective wellbeing is therefore central to QoL. Conceptually, QoL encompasses physical, psychological, social and environmental aspects. In health and medical research, QoL is an important indicator to the subjective wellbeing of the individual, especially in relation to their health.

Older Chinese immigrants in Australia have reported a lower quality of life than native Australians (Lin et al., 2016). New older Chinese immigrants in Canada have expressed how micro and macro factors, such as physical and mental wellbeing, family relationships, economic independence and social support and service availability are important to their QoL (Da &

Garcia, 2015). It is suggested that a community atmosphere and social participation enhances the QoL for older Chinese immigrants. Specifically, social capital, a sense of trust and partnership with the community, and living with children are important contributors to a better QoL (Kim et al., 2019). Moreover, loneliness is found to be a determinant in their QoL (Lin et al., 2016).

Loneliness

Loneliness has been described as "a complex set of feelings encompassing reactions to the absence of intimate and social needs" (Ernst & Cacioppo, 1999). It is represented along an emotional dimension that is related to the need for intimacy, and a social dimension related to the lack of network partners (Weiss, 1973). The academic study of loneliness has covered many years and extended beyond the fields of psychology. Various relationships with physical and mental health have since been established with loneliness. Loneliness is a predictor of mortality, and it is associated with higher blood pressure and coronary heart disease (Hawkley et al., 2010; Penninx et al., 1997; Shiovitz-Ezra & Ayalon, 2010; Thurston & Kubzansky, 2009). Furthermore, the connection with mental disorders includes personality disorders, depressive symptoms and an increased risks of Alzheimer's disease (Richman & Sokolove, 1992; Wilson et al., 2007).

Specifically, older Chinese immigrants have demonstrated associations with loneliness on a personal, household and community level. The triggers include mental impairments, living in a single household and a lack of social support and interactions (Wang et al., 2019). Furthermore, in Western societies such as Canada, Chinese immigrants demonstrate higher rates of loneliness compared to the native population in their host country (Wu & Penning, 2015). Reported prevalence rates of loneliness are 26.2% in the US (Simon et al., 2014), 36%–40% in the United Kingdom (UK) (Victor et al., 2012, 2021) and 49% in Au stralia (Lin et al., 2016). Older Chinese immigrants living in an ethnic dense community have reported lower loneliness levels (Tseng et al., 2021).

Mental health

Mental health is recognised as an important aspect of health and is defined by the WHO as "*a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her community*" (WHO, 2013). Keyes approaches mental health from a hedonic and eudemonic tradition, also known as positive mental health (Keyes, 2002). Positive mental health is composed of three core elements: emotional, psychological and social wellbeing. Emotional wellbeing refers to an individual's satisfaction, interests in life and happiness. Psychological wellbeing entails the liking of one's own personality, the ability to manage the responsibilities of daily life, having good relationships with others and satisfaction with one's own life. Social wellbeing involves the sense of being part of a community, the ability to contribute to society, believing that society has become a better place for everyone and that the way society works makes sense (Keyes, 2002).

In the context of older Chinese immigrants, mental disorders are commonly stigmatised by their cultural beliefs. Consequently, this hampers an individuals' health-seeking behaviour and mental healthcare utilisation (Tieu & Connert, 2014). However, among Chinese immigrants in the Netherlands, the practical issues of accessing mental healthcare were found to underlie their underutilisation (Liu et al., 2011, 2015). These issues include language barriers, the unavailability of interpreters and a lack of knowledge of the healthcare system. Depression was less prevalent among older Chinese immigrants who had sufficient quantity and quality of social contact (Li et al., 2021). Moreover, those individuals with worsening family relationships

(such as family conflicts, or lack of help or social support from their family) were associated with depression and the uptake of mental healthcare utilisation (Choi et al., 2013; Guo et al., 2019; Kwan et al., 2014; Mui & Lee, 2014).

Filial piety

Confucianism is one of the most influential philosophies to shape social structures and behaviour in East-Asian societies. Rooted in ancient Chinese culture more than 2,500 years ago, it has become an important tradition in East Asian countries such as China, Hong Kong, Taiwan, Korea and Japan (Canda, 2013; Kim et al., 2015; Park & Chesla, 2007). One important moral principle within the Confucian teachings is *xiào* (孝), which translates as filial piety and characterises East Asian intergenerational familial relationships. Filial piety follows the Confucian teaching that requires unconditional and unlimited devotion and respect to one's parents as a reciprocity for one's upbringing and nurturing. As such, collective interest should be prioritised over the individual's interest, as this is the ultimate virtue that one should fulfil (Canda, 2013; Ebrey, 1993; Hsueh, 2001). This is expressed by means of respecting, supporting, and caring for one's parents (Canda, 2013).

Filial piety is practised among East Asian families and can be traced back to Ancient China. Despite this, contemporary Asian societies are changing as a result of their migration to Western societies. As a consequence, the traditional practises of filial piety are thought to be under modification, if not erosion among the Chinese immigrant population (Chappell & Kusch, 2007; Hsueh et al., 2008; Lan, 2002; Lieber et al., 2004; Lo & Russel, 2007). For example, the traditional practices of filial piety, such as cohabitating with aging parents and providing financial support, are less common among Chinese immigrant families (Lo & Russel, 2007). Moreover, filial caregiving practices have been reinterpreted according to the current social and cultural context within Chinese American families. The traditional practice of women taking care of their in-law parents has changed to a genderless defining role for the caregiver in the migrant context (Hsueh et al., 2008). Further, the tradition of adult children taking care of their elders is dying out, instead they are paying care workers as a substitute for their hands-on care provision (Lan, 2002). The changed meaning of filial piety is preceded by the worried thoughts of Chinese American mothers who fear that their children are becoming incongruent to the concept of filial piety (Lieber et al., 2004). As expressed by one Chinese American mother:

> *People of my generation believe that taking care of our parents in the future is a universal truth, but I don't know if our children will have this sense of responsibility. I believe they won't have this sense of responsibility, but maybe if they really love us, they will want to take care of us…if they feel close to their parents. When the time comes, then I will know. (Lieber et al., 2004, pp. 324–325)*

Although filial piety has been somewhat researched among the Chinese American and Canadian populations, this important cultural element is rarely, or little studied among the Chinese immigrants in European countries.

Aim and outline of the dissertation

Despite the facts, a general health overview of Chinese immigrants in the Netherlands is still lacking. Moreover, the current body of knowledge lacks detailed insights on immigrant-based ethnicity. Although comparative studies have been conducted between immigrants and their host country's native population, comparisons between immigrants and their native Chinese populations are still lacking. Comparisons within the same ethnic groups could therefore provide novel insights into the consequences of migration on health-related concepts, specifically, frailty, QoL and loneliness. Moreover, it is unclear whether loneliness measured using Chinese instruments in China is equally valid for the Chinese migrant in the Netherlands. Further, it is unclear whether filial piety will prevail among the Chinese population after immigration, especially among the first- and second-generation Chinese immigrant populations in the Netherlands, and how it relates to older Chinese immigrants' mental health. Moreover, filial piety has not been researched before among second-generation Chinese immigrants and as such, the absence of a suitable measurement has hampered further study.

Therefore, this dissertation focuses on Chinese immigrants where migration is considered to be a crucial life event. It seeks to provide an overview of the health and wellbeing of older Chinese immigrants, as well as the intergenerational relationships regarding filial piety among first- and second-generation Chinese immigrants. The following dissertation is divided into two parts. Part one will examine frailty, QoL and loneliness in Chapter 2. In Chapter 3, the cross-cultural equivalence of the De Jong Gierveld Loneliness Scale between native Chinese from China and Chinese immigrants will be studied.

Part two will involve the intergenerational relationship with regard to filial piety. The association between mental health and filial piety among the older first-generation Chinese immigrants is studied in Chapter 4. Filial care and the relevance of filial piety is studied through a qualitative study among second-generation Chinese immigrants in Chapter 5. Finally, Chapter 6 seeks to validate the psychometric properties of the Dutch normative filial piety scale among second-generation Chinese immigrants.

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Part I