Suffering in silence?

The adequacy of Dutch mental health care provision for ethnic Chinese in the Netherlands

Cha-Hsuan Liu

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Lijden in stilte?

De adequaatheid van de Nederlandse geestelijke gezondheidszorg voor etnische Chinezen in Nederland

(met een samenvatting in het Nederlands)

Proefschrift

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To my late beloved mother

Prof. Kuei-Mei Lin

獻給敬愛的先慈

林貴美教授

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When the great physician practices medicine …
If someone with illness comes for help, he should not investigate
if the patient is noble or ordinary, rich or poor, old or young,
beautiful or ugly, a relative or an enemy, a friend or an acquaintance,
Chinese or foreign, wise or foolish.
He must treat them all on equal grounds and as his own close kin.

"On the Absolute Sincerity of Great Physicians (Dayi Jingcheng)"
SUN Simiao. Tang Dynasty. 652AD

凡大醫治病…若有疾厄來求救者，不得問其貴賤貧富，長幼妍媸，
怨親善友，華夷愚智，普同一等，皆如至親之想。

《大醫精誠》
唐．孫思邈．西元 652 年

Chapter 1

Introduction

1.1 Background and research aim

This thesis is concerned with the utilisation of mental health services by the Chinese minority in the Netherlands. Roughly two-thirds of this group are migrants, who were born either in Chinese-speaking countries or in other countries – mainly former Dutch colonies – to which they or their ancestors had migrated. The other one-third were born in the Netherlands to persons of Chinese nationality or descent. In 2012 the Chinese minority in the Netherlands was estimated to number about 110,000 people (Overseas Chinese Affairs Council ROC [OCAC], 2014).

This group is part of the much larger population of 'overseas Chinese' worldwide, sometimes referred to as the Chinese diaspora, whose number is difficult to estimate but is said to be upwards of 41 million (OCAC, 2014). Most overseas Chinese live in Southeast Asia, a region to which Chinese have been emigrating for centuries. Ethnic Chinese make up a majority of the population of Singapore, while there are substantial Chinese minority populations in countries such as Thailand, Malaysia, Indonesia and Vietnam. From the mid-19th century onwards, however, emigration has primarily been to Western countries such as the United States, Canada, Australia, New Zealand, Brazil and the nations of Western Europe (Pan, 1999). The total population of overseas Chinese in these countries is currently about 10 million.

Many studies have shown that migrants and ethnic minority groups in general are often poorly served by health care, especially by mental health services (e.g. Watters, 2002). Chapter 3 reviews the development of approaches to improving services for these groups, while Chapter 4 describes the problems that have been reported concerning access to services as well as their quality.

Such problems have also been frequently reported among overseas Chinese in the West, those in the Netherlands being no exception. Many researchers consider the Chinese diaspora to be of special interest because Chinese are regarded as showing strong attachment to their culture of origin, including traditional notions about health and illness (Kleinman, 1978; Bond, 1996). These notions are often seen as a serious barrier to the use of Western mental health services. Aside from such cultural barriers, however, there are other more practical issues which have been found to impede access and lower care quality – such as lack of entitlement, communication problems, unawareness of the services available, discrimination and lack of specialized knowledge among professionals. One of the main questions the present study sets out to answer is which of these factors are particularly important for Chinese in the Netherlands.

Although the Netherlands has a strong tradition of research on the health of ethnic minorities, the majority of studies up to now have focused on the four largest ethnic groups (Turkish, Moroccan, Surinamese and Antillean). The Chinese group has been seriously neglected (Gijsberts, 2011; Huiskamp et al., 2001). Chinese have been present in the country for over a hundred years, yet very little is known about their health and their relationship with the health system. This lack is serious because the size of this group is

growing rapidly. It has doubled in the past decade, and a marked increase in its size is expected (Garssen & Van Duin, 2007).

Among the reasons for this scarcity of research is the traditional perception in the Netherlands that the Chinese minority prefer to keep themselves to themselves, are self-sufficient, and have no serious problems. The difficulty of studying them is also added to by their diversity. They come from different regions, speak different languages and dialects and have different migration experiences, educational levels and relationships to Dutch society. Chapter 2 discusses in detail what is known about this minority, describing their migration history, demographics and social position, and attempting to characterise the norms and values which are central to traditional Chinese culture.

The rapid increase in the numbers of Chinese living in the Netherlands during the first decade of the present century has finally led researchers and policy-makers to start paying attention to this group. Slowly, more studies concerning issues such as aging and health are being carried out. Despite the scarcity of studies, there are already clear indications that mental health care for ethnic Chinese is needed and that service delivery to this group is far from optimal. Compared to native Dutch and other ethnic minorities, their self-reported mental health is poor. At the same time Chinese in the Netherlands are less likely to make use of mental health care services; when they finally do so, they present with more serious symptoms (Schellingerhout, 2011; Liu, Sbiti, Huijbregts, & Tonk, 2008; Geense, 2003). However, as yet little insight has been acquired into the reasons for these problems. There is an urgent need for better understanding of the mental health of Chinese in the Netherlands and their relationship with the services provided. Chapter 4 discusses in detail the problems of health service delivery to migrants and ethnic minorities that have been reported in the literature, concluding with a review of what is known about the utilisation of mental health care services by ethnic Chinese in the Netherlands.

Three main reasons lay behind the decision to undertake the research reported in this thesis. The number of Chinese in the Netherlands is steadily increasing; there is continuing concern about problems in health service delivery to this group; and very little research is available to shed light on the nature of these problems. The thesis aims to gain insight into the problems that undermine the access of Chinese to mental health services and impair the quality of the care they receive. The studies reported investigate their mental health needs and help-seeking behaviour, entitlement to care and care utilisation, as well as the accessibility and quality of care. Recommendations for improving service delivery and for refining existing theories are made on the basis of the results. The research sets out to answer the following questions:

1. Who are the Chinese in the Netherlands? (Chapter 2)
2. How has attention for health service delivery to migrants and ethnic minorities arisen, and what developments have taken place in the main approaches? (Chapter 3)

3. What are the basic concepts used to analyse health service delivery to migrants and ethnic minorities? What is known about (a) problems in service delivery to these groups in Western countries, and (b) problems concerning Chinese living in the Netherlands? (Chapter 4)
4. What patterns of help seeking are found among Chinese in the Netherlands? How easy is their access to health care? What are their attitudes concerning mental health problems and Dutch (mental) health care? (Chapter 5)
5. What role do beliefs about mental health play in mental health care utilisation among this group? What kinds of problems are perceived as mental health problems? What is regarded as causing them and what kinds of help are considered appropriate? (Chapter 6)
6. What are the experiences of using mental health care among Chinese in the Netherlands? What light do these experiences shed on their underutilisation of mental health care? (Chapter 7)

Literature reviews provided the basis of chapters 2, 3 and 4, while chapters 5, 6 and 7 report empirical studies undertaken for this thesis. A mixed-method approach was applied in data collection and analysis.

1.2 Theoretical approach

Migration increases the cultural and social diversity of host countries and creates challenges to health and mainstream healthcare. There are two main reasons for safeguarding standards of health service delivery to migrants. First, according to the Universal Declaration of Human Rights (United Nations, 1948) and the International Covenant on Economic Rights (United Nations, 1966), adequate health care is a universal human right. Second, ill-health affects migrants' ability to engage in education, work and other activities in the host society. This may impede integration and lead to marginalization and social isolation, which again undermine health (Nørredam & Krasnik, 2011) leading to a vicious downwards circle. Not only migrants, but also their offspring may experience problems with health care.

Many aspects of health service delivery, including in particular mental health care, are culture-bound. Culture influences the way mental disorders manifest themselves, the idioms people use for communicating distress, and their help-seeking behaviour. Kleinman (1978) developed the concept of 'explanatory models' to embrace the links between culture, health and illness, and health behaviour in dealing with illness. Cultural differences need to be taken account of in service delivery for migrants and ethnic minorities. However, many other considerations are important as well, and in this thesis we will examine the balance between 'cultural' and 'practical' barriers to good care.

1.3 Methodology

As mentioned above, Chapters 2 - 4 of this thesis are based on literature reviews, while Chapter 5 - 7 report empirical studies.

1.3.1 Literature reviews

Chapter 2 is based on a wide range of literature concerning the Chinese diaspora in general and the Chinese minority in the Netherlands in particular. Sources in Dutch and English have been used, as well as some publications in Chinese (with a preference for those also available in English translation).

Chapters 3 and 4, which concern health service delivery, embrace a range of disciplines in medical and social sciences, such as psychiatry, clinical and health psychology, medical anthropology, public health policy, and cultural sociology. The literature examined ranges from general to specific: from publications on migrant health care in general, to specific articles on the Chinese community in the Netherlands. Publications concerning both migrants and ethnic minorities were included.

Articles of interest were identified by searching in databases such as Pubmed, Medline, EMbase and PsychLit, as well as Science Citation Index and Social Science Citation Index. A further search for published books was be made using online catalogues. Other material such as unpublished reports and similar 'grey literature' was also studied, as well as data from agencies such as Statistics Netherlands (Centraal Bureau voor de Statistiek; CBS), Community Health Services (Gemeenschappelijke Gezondheidsdienst; GGD), Netherlands Institute for Health Services Research (Nederlands instituut voor onderzoek van de gezondheidszorg; NIVEL), etc.

1.3.2 Empirical studies

The three empirical studies reported in Chapter 5, 6 and 7 concerned mental health service delivery for Chinese in the Netherlands. This was 'mixed-methods' research, in which quantitative data from structured questionnaires were supplemented by qualitative data from open-ended questions and in-depth interviews. The data gathering consisted of two phases. In the first phase (Chapter 5), a survey was carried out to examine the utilisation of health care services by Chinese in the Netherlands, as well as their attitudes concerning health (with particular attention to mental health). In the second phase (Chapters 6 and 7), the research was exploratory in nature and focused on the views, opinions, and concepts of ethnic Chinese, as well as their experiences in dealing with mental health problems in the Netherlands. This study used in-depth interviews, which were subjected to qualitative analyses of their content.

Because of the practical difficulties and ethical objections involved in directly approaching Chinese with mental illness, it was decided to adopt an indirect method in

which Chinese respondents were recruited during street interviews in the major Dutch cities. The persons interviewed to provide data for Chapter 5 were also invited to participate in a longer interview during which they could tell us about one or more Chinese persons in their social environment whom they regarded as having (had) mental health problems (精神問題).

In these empirical studies we used the more open-ended term 'mental health problems' rather than 'mental illness' because we were not primarily interested in medical diagnoses but in lay beliefs. Moreover, 'mental health problems' is a more discrete term, which respondents would probably be more willing to use in discussion.

In the first phase, 102 respondents were recruited on the streets in Amsterdam, The Hague, Rotterdam and Utrecht (the '*Randstad*' region, in which half the Chinese in the Netherlands live). A semi-structured questionnaire was used to gather data on respondents' demographic characteristics, acculturation, access to health care, help-seeking tendencies, opinions about Dutch health care, and mental health issues. We examined both the statistical associations of behaviour and attitudes, and the reasons or explanations given by respondents.

In the second phase, in order to explore cultural beliefs and experiences relating to mental health care, respondents who said they knew one or more Chinese people living in the Netherlands with mental health problems were invited to tell us about them in an in-depth interview. A 'snowball' sampling technique was used to increase the number of participants. A total of 30 stories were collected from the 23 interviews. To analyse the data the coding procedure described by Boeije (2010) was applied. This approach is derived from the methods of grounded theory (Corbin & Strauss, 2008). NVivo 9 software for qualitative data analysis (QSR International, 2010) was used for data management, analysis and processing. The same corpus of data underlay the analyses in both Chapters 6 and 7: Chapter 6 focused on beliefs concerning mental health and illness, while chapter 7 studied the experiences of Chinese in dealing with mental health problems in the Netherlands.

1.3.3 Ethical considerations

This research followed the applicable ethical guidelines for protecting respondents' rights and interests. Prior to the interviews, the interviewers explained the aim of the research and the procedure to respondents. The respondents were given written information about the study and gave their informed consent to participate. They received assurances that they had the right to withdraw from the study at any time and that all data they provided were treated confidentially and only used for the research aim. Results were reported anonymously and details modified where necessary to prevent any individuals from being identified.

1.4 Innovative value and relevance for science and society

This study brings an interdisciplinary approach to bear on the problems of providing adequate mental health care for the Chinese minority in the Netherlands, a group that has not yet been properly investigated.

Approaches from both medical and social sciences are combined to investigate the causes of problems in care delivery. An interdisciplinary approach creates a critical dynamic by confronting different analyses of the same problem with each other.

The research also has an international dimension. Data from other countries have been used and collaboration has been sought with researchers studying the same or similar problems in other countries through three EU projects: MIGHEALTHNET and COST Actions IS0603 (HOME) and IS1103 (ADAPT). In this way it has been possible to link up with research being carried out on the same problems in other European countries. During the course of the research, preliminary findings have been shared at various international conferences and meetings, e.g. European Health Psychology Society (EHPS) and International Convention of Asia Scholars (ICAS).

The social importance of this research is that it increases the understanding of an important but under-researched ethnic minority, thus filling a serious gap in our knowledge. It not only generates recommendations for improving health care for Chinese; the proposals for 'good practice' can also contribute more generally to improving mental health care in multicultural settings.

The research further advances theory formation by casting light on the question of whether problems of care delivery are primarily related to culturally determined differences in people's understanding of health and illness, or to other factors. The interdisciplinary approach applied in this research makes possible both theoretical and methodological innovations, which can subsequently be utilised in the study of health care for other minorities.

Chapter 2

Ethnic Chinese in the Netherlands

Chinese in the Netherlands are often viewed as hard-working, strongly oriented to their own community, having an economic niche in the catering industry, and hardly participating in Dutch society. Because of this they are often described as an 'invisible' group – one that seems to get by on its own strengths, for which no additional attention (for example in the form of special policies) is needed (Liu et al, 2008). In comparison with the four biggest ethnic groups in the Netherlands – Turkish, Moroccan, Surinamese and Antillean – very little research has been carried out concerning the Chinese. Consequently, not much is known about the current composition or characteristics of this group; not to mention their health status or health-related behaviours. The only national survey concerning Chinese was carried out by the Netherlands Institute for Social Research (Sociaal-Cultureel Planbureau [SCP]) in 2009 (Gijsberts, Huijnk, & Vogels, 2011).

Before discussing the issues related to their general or mental health, we should first examine who these people are. How homogeneous is the ethnic Chinese community in the Netherlands? Do they share certain typical characteristics? What is their current position in Dutch society? What is their life in the Netherlands like?

This chapter sets out to provide a sketch of this community. First, the patterns of migration of the Chinese are presented to give an overview of the history of Chinese migration to the Netherlands. Then the chapter will examine the group's demographic composition and social and economic position, including education, proficiency in the Dutch language and participation in Dutch society. Norms, values and communication styles which may be shared in the Chinese community are also investigated. Four subgroups of the Chinese community were distinguished based on findings in the literature. Their features are discussed in the last part of the chapter.

2.1 Migration Patterns: A century in the Netherlands

Although there were already a number of Chinese diplomats, businessmen and students in the Netherlands in the 19th century, the Chinese are usually regarded as having started settling in the early 20th century. The total Dutch population of Chinese descent is estimated at 110.000, excluding undocumented Chinese (OCAC, 2014). The population of Chinese from Chinese-speaking areas (People's Republic of China [PRC], Taiwan, Hong Kong and Macau) has tripled between 1971 and 2011 and a continued increase in its size and importance is expected (Garssen & Van Duin, 2011).

Most Chinese migrants came to the Netherlands during four waves of migration (Cheung & Lam, 2006). The first wave arrived in the early 1900s when young Chinese sailors, recruited as cheap labour, arrived in Rotterdam with Dutch merchant fleets (Wubben, 1986). After the Second World War, Chinese from former Dutch colonies such as Indonesia and Surinam migrated to the Netherlands. The third wave was from the 1970s to the end of the 20th century when labour migrants came from Hong Kong and China, followed by their families. This coincided with the arrival of Chinese boat refugees

escaping from the war in Vietnam and from other Southeast Asian countries (Pieke, 1988). In the present century, increasing numbers have come for business or study (Li, 2011; Vogels, Gijsberts, & Liu, 2011). More detailed information about migration patterns is given in the following sections.

2.1.1 The four waves

(1) 1910s-1940s: Chinese sailors and peanut vendors

The first recorded Chinese immigration was in 1898, when (according to the archives of the Holland Ocean Company) a Dutch company employed 11 Chinese. In 1911 there was a widespread strike in the Dutch merchant navy, in response to which the shipping companies hired Chinese sailors as strike-breakers and cheap labour. The number of Chinese sailors rose rapidly to 765. Two years later there were 2165 Chinese working for Dutch shipping (Li, 2011). Most of these sailors came from the southern provinces, mainly from Guangdong. They worked mainly as stokers; some were stevedores (Van Heek, 1936). Many Dutch strikers lost their jobs through the recruitment of Chinese strike-breakers and this led to hostility towards the group (Van Heek, 1936).

When Chinese sailors were on shore they were accommodated in boarding houses near the ports in Amsterdam and Rotterdam, which were mainly run by Chinese (Cheung & Lam, 2006). Over the years the canteens in these boarding houses evolved into the first Chinese restaurants in the Netherlands. These neighbourhoods later developed into what we now call ‘Chinatowns’.

The economic crisis in the 1930s hit the Chinese sailors along with everybody else. While many were sent back to China by the Dutch government, the rest moved into niche economies such as laundries, food shops, or peddling peanut biscuits (Dutch: pindakoekjes) and other inexpensive oriental products (Bovenkerk & Brunt, 1977). Restrictive Dutch immigration policies and legal restrictions on the employment of foreigners further reduced the number of Chinese in the Netherlands. By the beginning of World War II there were only about 800 Chinese living in the country (Wubben, 1986; Cheung & Lam, 2006).

(2) 1950s-1970s: Post-colonial migration and the Chinese catering industry

In the years following World War II the Dutch colonists withdrew from Indonesia. Social and political unrest also led to the migration of approximately 14,000 Chinese to the Netherlands. Two-thirds of whom were students. Between 1965 and 1970 large-scale migration to the Netherlands again took place as a result of anti-Chinese violence (Li, 2011; Harmsen, 1998). Most of these migrants were highly educated and spoke Dutch well. As had happened in Indonesia, unrest in Surinam led to the emigration of about 5,000 Chinese to the Netherlands around the time when Surinam achieved independence in 1975.

The returnees and migrants from former Dutch colonies created a demand for oriental food, which the Chinese restaurants in the Netherlands were able to satisfy. Later the native Dutch population also discovered these restaurants, which became popular because they gave large portions for small prices (Van der Sijde, 1983; Leung, 1989). A period of great prosperity began for the Chinese restaurant business and employment in the catering industry expanded greatly. The demand for labour in Chinese restaurants led to the next wave of Chinese migration.

(3) 1970s-2000: Economic migration, family formation and political migration

During this period, three main reasons motivated Chinese migration to the Netherlands: economic motives, family reunification or formation, and political factors.

In 1955 there were only 65 Chinese restaurants in the Netherlands. Ten years later the number had risen to 1000. In 1975, 2000 Chinese restaurants were spread all over the Netherlands; on average, there was a Chinese restaurant for every 8000 inhabitants (Li, 2011). Accompanying this increase in the number of Chinese restaurants, family members and local contacts came from China to the Netherlands as potential labourers because of the shared food culture and the lower cost of their labour.

These labour migrants mainly arrived from villages near Hong Kong, and later from Mainland China. After a spell of working in a restaurant, they would open their own restaurant as soon as possible and arrange for other villagers and family members to come and work for them. Almost all of these migrants who arrived before 1970 were men (Pieke, 1988; Rijkschroeff, 1998).

Following the male Chinese migrants looking for economic opportunities in the Netherlands, many Chinese women and children migrated for reasons of family formation or reunion. Many marriages involved a woman from the same village or town, because of the preference for marrying a wife with the same background. Due to the severe restrictions on the entry of non-Western migrants that were put in place in Europe as a response to the economic downturn in the 1970s, the numbers of labour migrants arriving fell sharply during this period (Li, 2011).

In addition, during the 1970s the PRC undertook the reconstruction of society through the Cultural Revolution. The resulting political strife led large numbers of Chinese to emigrate in search of safety and a better life. The Cultural Revolution also led to anxiety in Hong Kong, triggering an exodus of many Chinese residents (Pieke, 1988; Cheung & Lam, 2006). Some of these migrants were attracted to the Netherlands. Later, in the 1970s and 1980s, more than a thousand Chinese refugees came from Vietnam, Thailand, Philippine, and other South-east Asian countries.

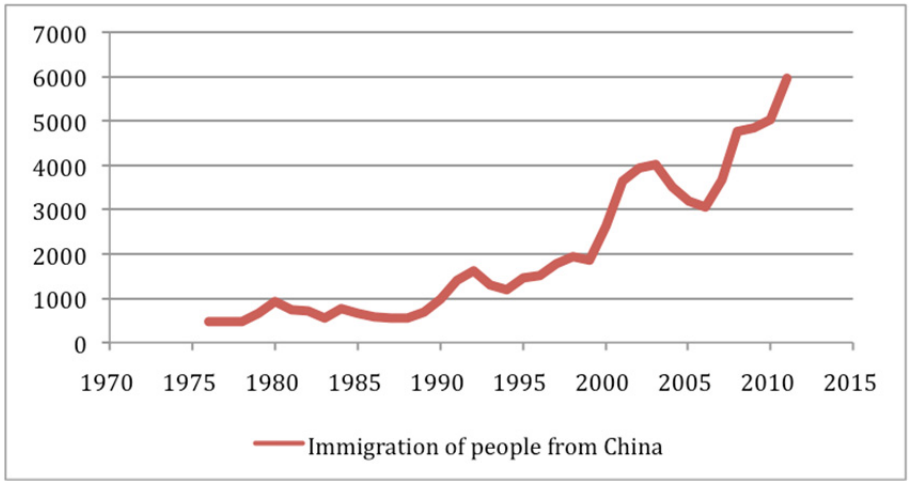
In 1983 Chinese emigration restrictions were eased, partly as a consequence of the economic ‘open-door policy’. Liberalized emigration resulted in an increase of migration from China in the late 1980s (Thunø, 2003). In addition, due to the fears about the

handover of the colony to China which took place in 1997, a number of people migrated from Hong Kong to the Netherlands in the 1990s. Their British National (Overseas) nationality made admission to the Netherlands easier (Cheung & Lam, 2006).

(4) 2001 - the present: New migrants

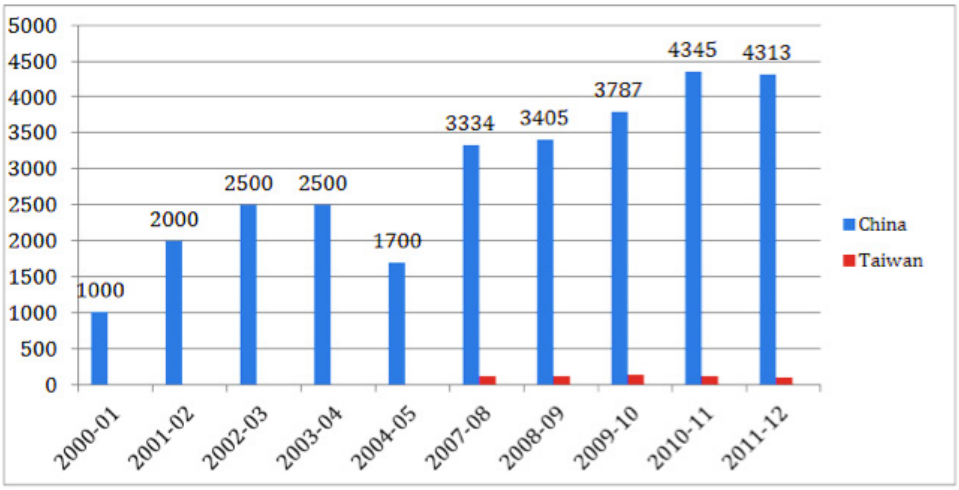
In the period 2001-2010 the total number of first-generation Chinese migrants in the Netherlands increased by 43% (Linder, Van Oostrom, Van der Linden, & Harmsen, 2011; see Figure 2.1). The most striking feature of recent trends in Chinese migration to Europe has been the substantial growth in the number of overseas students and skilled workers (Harmsen, 2011). Compared to the UK and the USA, Dutch higher education with its comparable quality and lower tuition fees attracts increasing numbers of students from China. The number of Chinese students in the Netherlands increased by 50% between 2000 and 2001 (Embassy of PRC in the Netherlands, 2002) and by 30% between 2007 and 2008 (Netherlands organisation for international cooperation in higher education [Nuffic], 2013) (see Figure 2.2).

Figure 2.1 Annual rates of immigration from China 1976-2011 (Source: CBS, 2013)



In 2012 around 5,700 Chinese students were studying in the Netherlands for their Bachelor, Master or PhD degree (Richters, Roodenburg, Kolster, & Willemse, 2012). In addition, China's decision to join the World Trade Organization (WTO) in 2001 has led to an increase of international business cooperation. The number of skilled migrants has also grown substantially in Northern Europe, including the Netherlands (Li, 2002; Laczko, 2003).

Figure 2.2 Chinese students entering the Netherlands (Source: CBS, 2013; Nuffic, 2013)



An important difference between the new migrants and earlier groups is that they do not usually have plans for permanent residence in the Netherlands. However, nearly half of the Chinese students in Europe do not return home but take up employment in the destination country, continue further studies, or move to another country (Laczko, 2003). According to the Organization for Economic Cooperation and Development [OECD] (2003) the return rate for Chinese students in France is 48%, in the United Kingdom 47%, and in Germany 37%. A Dutch national survey carried out by the Netherlands Institute for Social Research (SCP) showed that nearly 30% of the respondents who had come to study stayed in the Netherlands to work after finishing their study (Vogels et al., 2011).

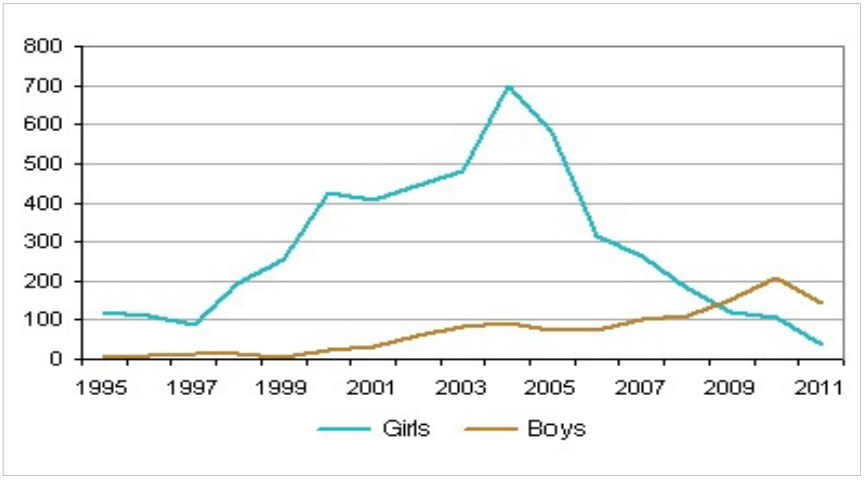
Although most Chinese came to the Netherlands as part of the four waves described above, two groups in particular form an exception: adopted children and undocumented migrants. Their migration patterns are discussed in the following section.

2.1.2 Special Groups

Adopted children

Since 1992 many Chinese children have been legally adopted by Dutch families (see Figure 2.3). By 2009, 5,500 adoptive children from the PRC had arrived in the Netherlands in this way (CBS, 2011). In Dutch national statistics these children are registered as Dutch-born, not Chinese-born (Van Duin & Wobma, 2010). Thus, they are not counted as ethnic Chinese in the CBS database, but as native Dutch.

Figure 2.3 Adopted boys and girls from China (Source: CBS, 2012)



Undocumented migrants and asylum seekers

After the death of Mao Zedong in 1976 major political changes and economic reforms took place in the PRC. As the reforms took effect, increasing population growth and economic disparities between regions in China created strong migration pressures. These resulted primarily in internal migration, currently estimated at around 10% of the population (Scheineson, 2009). Only relatively well-off Chinese were able to organize the bank guarantees, passports, visas and travel tickets that are necessary in order to migrate to another country.

A significant number of those who are unable to migrate to their desired destinations turn to human traffickers to emigrate via illegal channels (Wang, 2004). Many Chinese have been brought to Europe by 'snakeheads' (Chinese slang: 蛇頭, shé tóu, i.e. 'Chinese gangs that smuggle people to other countries'). Chin (2011) has described the path of the Chinese who are brought to the Netherlands by 'snakeheads'. These migrants usually travel by train via Moscow to Prague. They are then taken by car from Prague to the German border, where another 'snakehead' takes them across the unguarded frontier into Bavaria. From there they continue to Amsterdam by train, or to other destinations in the Netherlands by taxi. When they arrive in the Netherlands they are given information about procedures for claiming asylum, after which some of them are driven directly to an asylum-seeker centre. Thousands of Chinese may have entered the Netherlands by this land route. Some of them move on to other continental European countries, while others proceed via Dutch ports to other countries such as England or the USA (Wang, 2004).

There are some indicators that point to the numbers of people involved in this particular form of irregular migration. First, border apprehension data in Germany show that the number of Chinese nationals apprehended for attempted illegal entry rose from 370 in 1992 to 718 in 2000 (Laczko, 2003). Chinese have been consistently among the top five

nationalities included in amnesty programmes in European countries. Between 1989 and 2002, 7,000 Chinese applied for asylum in the Netherlands. In 2005, young Chinese asylum seekers (alleenstaande minderjarige asielzoekers or AMA's) were the biggest group in the reception centres. The number decreased to 8% of all young asylum seekers in 2008 (Centraal Orgaan opvang asielzoekers [COA], 2008). Few failed asylum seekers are believed to have returned to China. Rijkschroeff (1998) estimated the total number of illegally resident Chinese in the Netherlands was approximately 20,000 in 1997; more recent estimates are not available.

2.1.3 Return migration

Some of the Chinese who migrated to the Netherlands to start a new life return at a certain point to their country of origin. Vogels, Geense, and Martens (1999) estimated that approximately one-third of a sample of Chinese 'heads of family' (Chinese: 家長, jiāzhǎng) expressed a desire to return to China, and about two-thirds of them actually had plans to do so. The survey by Engelhard (2007) found that one-third of Chinese respondents aged 50 years or older thought about a permanent return to their origins. In fact, however, rather than returning permanently to China, the majority of the respondents stayed in the Netherlands or divided their time between the two countries. According to Engelhard (op. cit.), the main factors which affect the decision to return permanently or circularly include travelling expenses; health insurance costs in the country of origin; whether there is a suitable place to stay in the country of origin; the investment of effort required to travel; trust in the medical service in the country of origin; and the difficulty of organising journeys between two countries. Statistics Netherlands (CBS, 2013) reports that the number of Chinese migrants returning to their country of origin from the Netherlands increased from 1,800 in 2008 to 3,300 in 2012.

2.2 Demographics and social-economic position

Dutch statistics classify persons as 'allochtonous' (i.e. originating in a foreign country) if one or both of their parents were born outside the Netherlands. This definition includes both migrants (first generation) and their children born in the Netherlands (second generation). In this dissertation we define the Chinese ethnic minority in the Netherlands as comprising all people of Chinese origin born in Chinese-speaking regions (China, Hong Kong, Taiwan and Macau) or coming from other countries (such as Indonesia, Malaysia, Singapore, Vietnam and Surinam), as well as the later generations of ethnic Chinese born in the Netherlands. However, official Dutch statistics on the Chinese minority do not take account of those originating from non-Chinese speaking regions, nor do they include the third or later generations. Therefore, it is not exactly known how many persons of Chinese origin in total live in the Netherlands, although as we saw earlier a recent estimate puts the figure as high as 110,000.

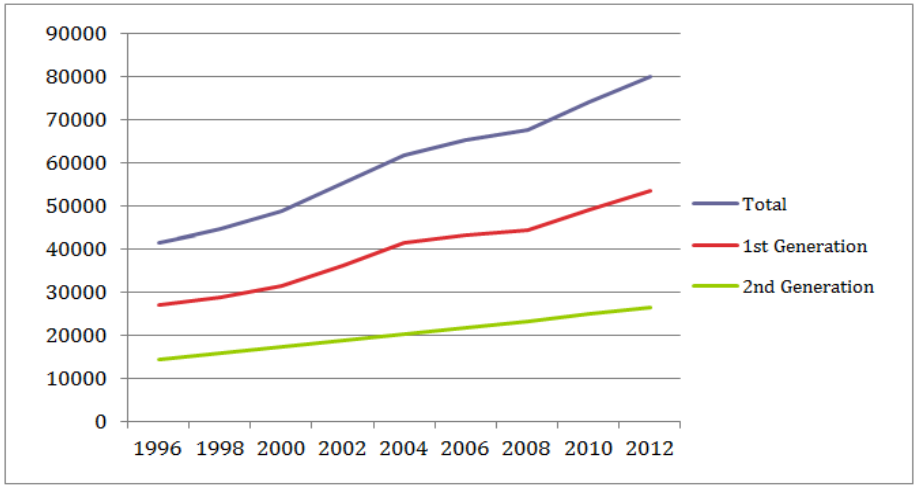
The following discussion of the demographics and social position of Chinese in the Netherlands is mainly based on data from Statistics Netherlands concerning persons born in Chinese-speaking areas (China, Hong Kong, Taiwan and Macau), as well as the second-generation offspring of these persons. These data do not include ethnic Chinese originating from outside these regions. In order to overcome this difficulty, the information about Chinese from non-Chinese-speaking areas and their descendants has been supplemented from other sources.

2.2.1 Demographics

Population

According to the CBS database, the total number of ethnic Chinese in the Netherlands with their origins in Chinese-speaking regions was 80,198 on 1st January 2012. Between 2000 and 2008 this figure increased by 58%. Thirty-one percent of this increase was due to the second generation (CBS, 2008) (see Figure 2.4).

Figure 2.4 Growth of Chinese population originating from Chinese-speaking regions (Source: CBS, 2013)



Using CBS data and the proportion of ethnic Chinese in the populations of those countries, Pieke & Benton (1995) calculations put the number of ethnic Chinese originating from Indonesia at about 14,000 and from Surinam about 5,000, and the total amount of Chinese from other Southern Asian countries (except Vietnam) is up to 1000. Harmsen (1998) estimated the total number of Chinese from other regions at about 25,000 using CBS data and the proportion of ethnic Chinese in the populations of those countries. More recent estimates put the Indonesian Chinese population in the Netherlands at about

16,000 and Surinamese Chinese at about 7,000 (Inspraakorgaan Chinezen [IOC], 2010). Kleinen and Custer (1987) estimated that 1,600 ethnic Chinese had arrived in the Netherlands from Vietnam, but there are no more recent estimates of this figure.

In 2010, the CBS estimated that the total of ethnic Chinese from non-Chinese speaking areas remains around 25,000 (Linder et al., 2011). Adding this number to the total from Chinese-speaking regions yields a total of ethnic Chinese in the Netherlands of about 105,000.

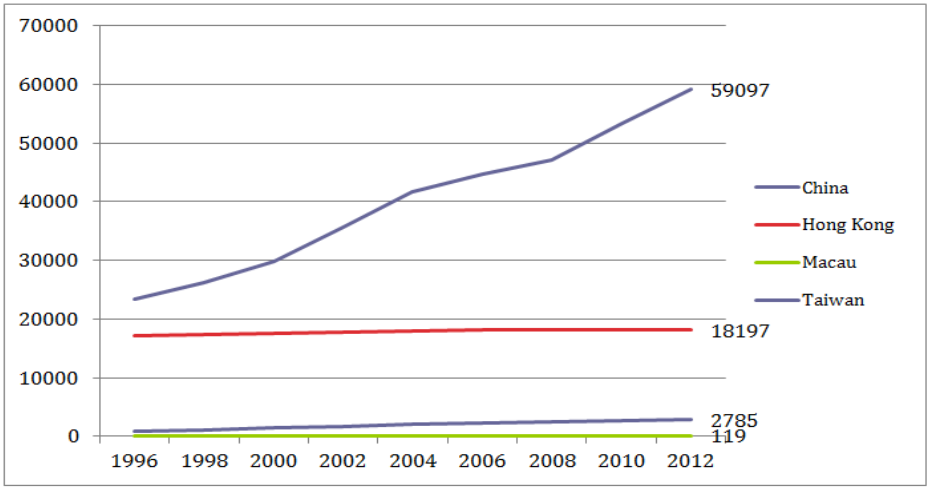
In addition to this number, an unknown number of Chinese live in the Netherlands without a valid residence permit. Rijkschroeff (1998) estimated this figure at 20,000. However, this number is extremely hard to estimate because irregular migrants may move from country to country within Europe.

The totals mentioned above (excluding undocumented Chinese) are in line with the estimate of 111,450 for 2011 reported by the Overseas Chinese Affairs Council (OCAC, 2013). Based on this figure, the Chinese ethnic group is not much smaller than the fourth major non-Western group in the Netherlands, the Antillean Dutch (141,345 in 2011 according to the CBS).

Origins of Chinese from Chinese-speaking areas

Chinese from Chinese-speaking areas come from a wide range of countries or regions. Before 1990, Chinese from Hong Kong formed the majority (52%) of the Chinese population in NL (see Figure 2.5). By 2012 this percentage had fallen to 20%.

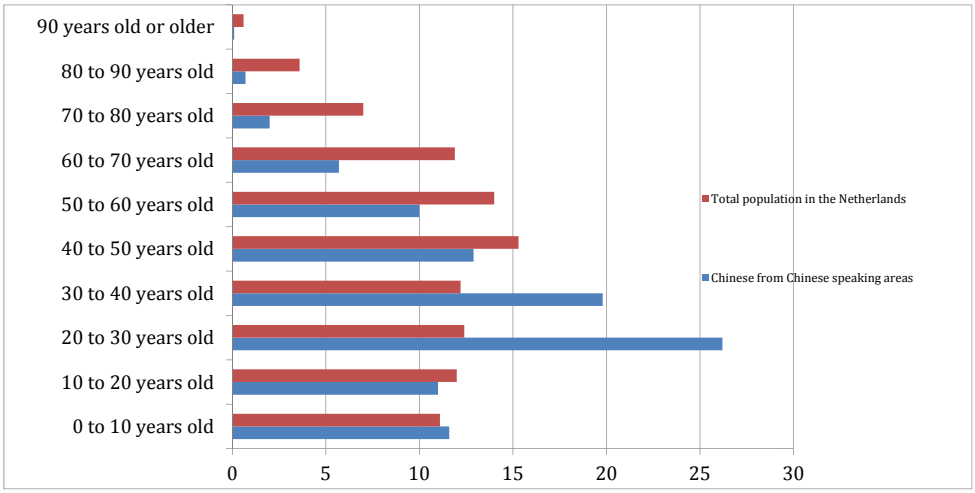
Figure 2.5 Origins of Chinese from Chinese-speaking areas (Source: CBS, 2013)



Age

Compared to the Dutch population, the Chinese group is relatively young (see Figure 2.6). In 2011, more than a quarter of the Chinese population were between 20 and 30 years, twice as many as in the total population in the Netherlands.

Figure 2.6 Chinese from Chinese speaking areas by age (%) (Source: CBS, 2013)

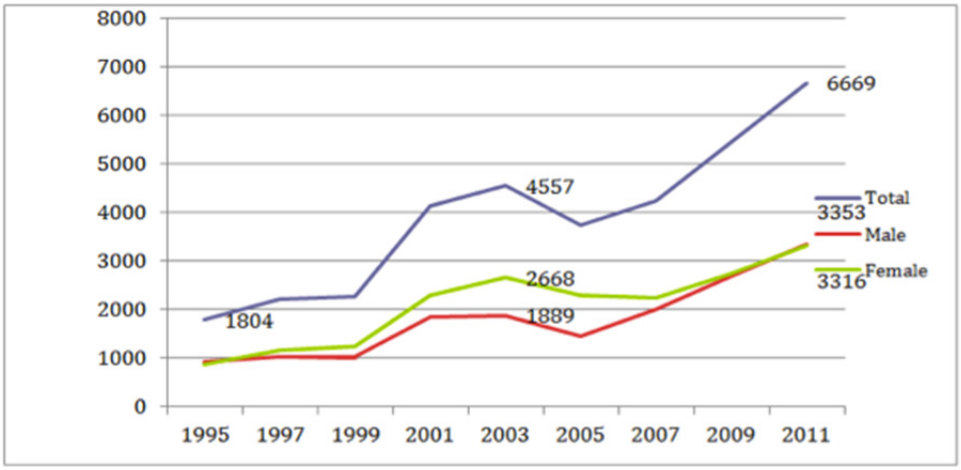


The average age of the first generation Chinese who came before 2000 is 49. The Chinese newcomers after 2000 are 30 years old on average, while the second generation averages 18 (Linder et al., 2011). Vogels (2011) reported that one-third of the new Chinese migrants came to the Netherlands in their twenties. This is linked with the influx of students and skilled workers from China in the first decade of the 21st century.

Gender

Overall, there are slightly more women (51%) in the Chinese population than men (CBS, 2013; see Figure 2.7). Between 1996 and 2008 more women than men migrated to the Netherlands. Up to 2003 their main motive concerned family formation or reunification, but after this date it was study (Harmsen, 2011).

Figure 2.7 Migrants from Chinese-speaking areas by gender and year of immigration, 1995-2011 (CBS, 2013)



Civil status

In the 1990's the percentage of Chinese who were married was higher than among all other ethnic groups (Vogels et al, 1999), though this is no longer the case. The married percentage among Chinese above 20 years old in 1999 was 64%. In 2012 it was 42%, which is lower than the percentage among non-western ethnic groups (45%) and native Dutch (55%) (CBS, 2013).

About a quarter of the relationships of Chinese (married or in partnership) are with someone from a different ethnic group. This is higher than the proportion among people of Turkish and Moroccan origin, but lower than among Surinamese and Antillean groups (Huijnk, 2011).However, there is a difference between men and women. Women of Chinese origin are more than three times as likely to have a relationship with a man with different ethnic background than men in a relationship with a woman from another ethnicity. Among people of Turkish and Moroccan origin it is the men who are more likely to have an ethnically mixed relationship (Van Agtmaal-Wobma & Nicolaas, 2009).

Language

There are two major Chinese spoken language groups present in the Netherlands, Mandarin and Cantonese. Mandarin is the official spoken language in China and Taiwan while the other 13 spoken language sub-groups are used in different Chinese regions (Lewis, Simons, & Fennig, 2013). Traditionally, Cantonese has been the most widespread form of Chinese spoken language overseas, as well as among Chinese in the Netherlands, though Mandarin and many other dialects such as Wu and Hakka are also spoken (Liu et

al, 2008). Because the dialects can differ greatly in pronunciation and grammar, Chinese from different regions may not always understand each other.

Before 2000 Hong Kong Chinese made up the majority of the total Chinese population in the Netherlands. The main spoken language in the Chinese community was Cantonese. Chinese from other regions have learned to speak Cantonese for better communication with different subgroups from various regions of China (Lin, 2011). However, after 2000 came the wind of change. Chinese from the mainland became the majority of the Chinese community. Along with the increased personal or business contacts between the Netherlands and China, Mandarin Chinese has become the most used spoken language in the Chinese community. Nowadays learning Mandarin is a trend in the Chinese community in the Netherlands, as it is indeed among native Dutch (for economic reasons).

Although second generation Chinese usually communicate with their parents in their mother tongue, their Chinese proficiency is not on the same level. Some Chinese of the second generation have largely lost their mother tongue: one out of five does not speak Chinese (Gijsberts, 2011a).

Despite a wide variety of Chinese dialects, written Chinese is universal – Chinese ideographs are common to all the dialects. The Chinese migrants who came from Chinese-speaking areas in the first half of the 20th century mainly used traditional Chinese characters in writing, as did the later migrants from Hong Kong, Macau, and Taiwan. Starting in the 1950s the Chinese government promoted the use of a simplified font of Chinese characters. As a result, the new migrants from Mainland China use simplified Chinese in writing (Liu, 2008).

As a group, given the relatively high level of education and the long duration of stay of Chinese people, it is noticeable that their Dutch proficiency is relatively low compared to the four main ethnic groups. The report of a Dutch national survey in 2009 (Gijsberts et al., 2011) showed that 33% of Chinese respondents often or always have problems with Dutch speaking; 37% often have problems with reading while 45% have difficulties with writing (see Table 2.1). By comparison, 23%, 24%, and 33% Turkish respondents in another national survey in 2006 have problems with Dutch speaking, reading and writing respectively (Gijsberts, 2011). According to this survey, the longer Chinese have been in the country and the higher their educational level, the better their proficiency in Dutch. An exception to the rule regarding education is the new migrant group which came after the year 2000. Most of them are students or skilled migrants and they mainly use English in communications. They show the lowest level of Dutch proficiency among all the first-generation Chinese.

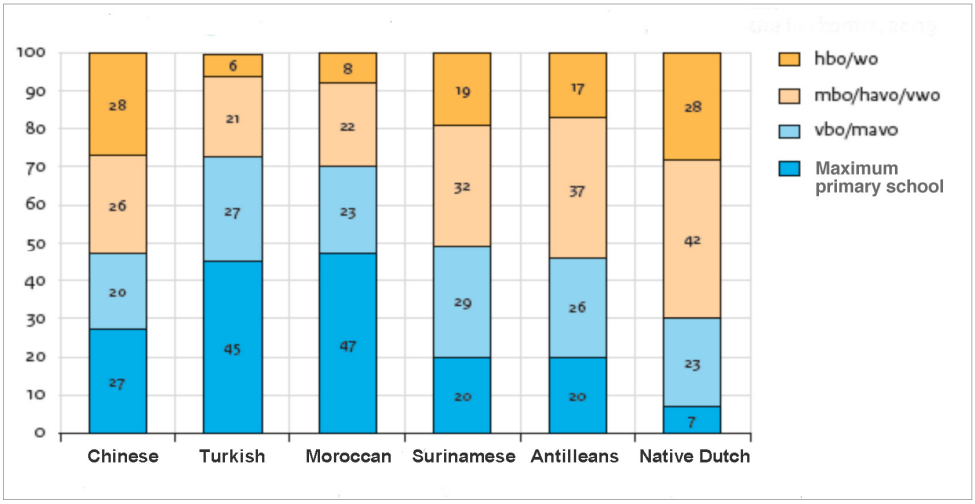
Table 2.1 Dutch language proficiency by ethnic origin (%) (Gijsberts, Huijnk, & Vogels, 2011)

	Chinese	Turkish	Moroccan	Surinamese	Antillean
Problems with Dutch conversation					
Often	33	23	25	1	3
Sometimes	31	30	25	6	15
Never	36	47	60	93	82
Problems with reading in Dutch					
Often	37	24	19	2	2
Sometimes	24	25	18	6	8
Never	40	51	63	93	90
Problems with writing in Dutch					
Often	45	33	24	3	4
Sometimes	20	19	17	5	12
Never	35	49	59	92	84

Education

According to the national survey SING09 (Gijsberts et al., 2011), 28% of Chinese respondents have acquired higher education diplomas while 27% have only completed primary education. Comparing these data with those reported 10 years ago (Vogels, 1999), the Chinese population shows a slight (14%) decrease in the percentage with the lowest level of education and a remarkable (52%) increase in the percentage with the highest level. The latter percentage is higher than for other migrant groups, but still lower than for native Dutch (Figure 2.8).

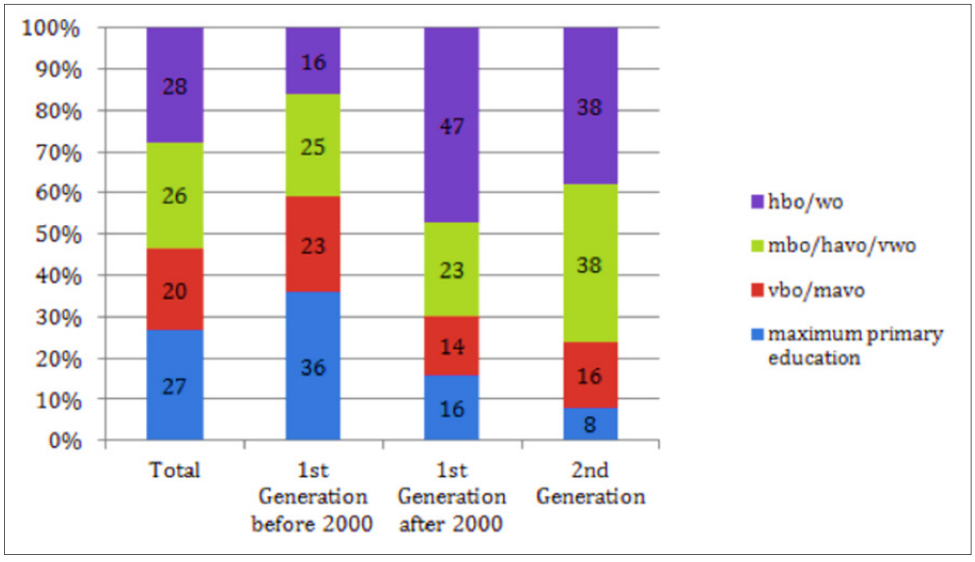
Figure 2.8 Education level by ethnic groups: Chinese, Turkish, Moroccan, Surinamese, Antilleans, and Native Dutch (%). (Source: SING09)



The first generation of ethnic Chinese who arrived before 2000 were often poorly educated compared with those who arrived after that date (Figure 2.9). An exception were the Chinese from Indonesia (Peranakans). According to Van Galen (1987), in 1980s one-seventh of this group were specialists, such as medical doctors, lawyers, architects, engineers and professors. Their education level was not only higher than other migrant groups, but also higher than that of native Dutch (Rijkschroeff, Gwan Tjaij, & Verlaan, 2010; Li, 2011). However, their demographic data are not presented separately in the CBS data.

Among the migrants arriving after 2000, almost half (47%) were highly educated. This group mainly came for further study at university or as skilled workers (Vogels, 2011). At the same time, the second-generation Chinese generally perform impressively in education (see Figure 2.9). 85% of the second generation continue on to higher education, much more than the native Dutch (59%).

Figure 2.9 Education level by generations (Source: SCP (SING09)



2.2.2 Position in Dutch society

Labour market participation

The labour market participation of non-western migrants is usually lower than that of native Dutch. Many such migrants have lower educational qualifications and the group is over-represented in unskilled and often physically demanding jobs (CBS, 2008). By contrast, Chinese do well on the Dutch labour market. According to Huijnk (2011), the level of unemployment among Chinese in 2009 was 6%, which was higher than that of

native Dutch (4%) in the same period. However, it was much lower than the average unemployment level of the non-western groups (12%) (CBS, 2011).

Furthermore, social benefit dependency is relatively low among Chinese. For example, the percentage receiving social security benefits under the 'Work and Social Assistance Act' (*Wet Werk en Bijstand* or WWB) among Chinese aged 15 to 64 in 2009 was 6%. This percentage was much lower than for the other main non-western migrant groups, i.e. Moroccan (12%), Turkish (8%), Surinamese (7%) and Antillean (9%), but higher than the figure for native Dutch (2%) (Huijnk, 2011).

Chinese who arrived before 2000, however, show higher levels of dependency on WWB benefits. In 2008 11% of them received these benefits, compared to 4% of the Chinese who arrived after 2000 (Linder et al, 2011). One explanation is that many Chinese from the earlier group have reached retirement age. Also, the more recent group have not yet had time to build up their social benefits.

Concerning the type of labour performed, Chinese tend to be active in service industries - especially catering (Li, 2011), which has been a traditional economic niche for them for decades. In 2009 43% of Chinese employees worked in a catering-related industry (Huijnk, 2011). However, in the 1990s the percentage was much higher (70%) (Rijkschroeff, 1998).

In the Chinese catering trade, the proportion of colleagues of the same origin is relatively high. This lowers the possibilities for contact between Chinese and other ethnic groups (Rijkschroeff, 1998). For these Chinese, employment in the catering sector usually means long hours of work, low income and lack of social support (Liu et al, 2008). They often live in accommodation provided by the Chinese restaurant owners and may only have few days off each month. Because of their long hours of work and the language barrier, their mobility is limited. These people seldom consider enrolling in further education or Dutch language courses. The language barrier and their low educational level further prevent them from finding a decent job if they become unemployed (Rijkschroeff, 1998).

Although most ethnic Chinese have traditionally worked in the catering sector, more and more Dutch-born Chinese have entered different occupations. Family members expect their offspring to have a better chance of entering mainstream society and to leave the burdensome working environment of the catering sector (Li, 2011). Nowadays the occupations of young Chinese are highly diverse, ranging from the catering sector to significant positions in medicine, the arts, and academia (Huijnk, 2011).

In addition to being employed, a strong preference for independent professions is clearly reflected in the percentage of self-employed entrepreneurs among the population aged 15-64: in 2009, 13% of Chinese had their own company or business. This percentage is higher than for native Dutch (7%) and for people of Turkish origin (7%), who are also known for their entrepreneurship. As expected, two-thirds of Chinese independent entrepreneurs are active in the catering sector (Huijnk, 2011).

Networks and organisations

Against the background of long days of hard work, contact with family and friends is important in the social life of Chinese in the Netherlands. As Chinese consider the family to be the basic social unit, social networks start from the clan. A Chinese clan is a patrilineal and patrilocal group of related people with a common surname (see also section 2.3.2). In the Netherlands, there are many informal associations (宗親會, *zong-qin-hui*) formed by the same clans (Li, 1999). Each clan has their own ancestral shrine which honours ancestral clan members. Members gather during the important traditional holidays, such as Chinese New Year or the Mid-Autumn festival. There is another kind of association based on the regions where members came from (鄉親會, *xiang-qin-hui*), such as the Association of Hong Kong or the Indonesian Chinese Associations (*Peranakanverenigingen*).

In addition to clans or origin-based associations, various Chinese organisations have also been established in the Chinese community, such as sport clubs, churches, temples and even political organisations. At the same time, there are 44 Chinese schools spread over the main cities in the whole country, providing Chinese lessons to the children in Chinese families (Li, 2011). The courses have the function of reinforcing and handing down Chinese culture and values to the young generation, as well as creating a platform for social contacts (Stichting Chinees Onderwijs in Nederland, 2013).

In 1995 there were more than 80 organisations registered under the umbrella associations 'National federation of Chinese organisations in the Netherlands' or 'Foundation for Chinese culture, recreation and social work' (Pieke, 1999). In the wake of the increasing number of newcomers after 2000 and the growth of the second generation, the organisations became even more diverse. There is cooperation between groups, but also conflict, which is seen as an obstacle for political participation in Dutch society (Pieke, 1999).

Political participation

Even though Chinese were the first non-western migrant group in the Netherlands, much time elapsed before they applied to become an official minority group. According to Pieke (1999), one reason for this delay was lack of knowledge among the Chinese community about the rights and benefits associated with recognition as a minority group. Another reason was that older Chinese were concerned about the negative image associated with minorities in Dutch society and preferred to remain self-sufficient. While the older generation of Chinese doubted the benefit of political participation, younger Chinese leaders were worried that the old strategy of self-sufficiency would not suffice for the rapidly growing younger population and were enthusiastic to participate in politics.

As soon as most Chinese finally realised the benefit of being an official minority, competition started to intensify between groups wanting to become the representatives of the Chinese community in the Netherlands (Pieke, 1999). After internal discussions over a

period of about two decades, agreement was reached on an application for a position in the National Consultation on Minorities (*Landelijk Overleg Minderheden* or LOM). Finally, Chinese were officially recognised as a minority group by the Dutch government in 2004. The Council of the Chinese Minority (*Inspraakorgaan Chinezen* or IOC) represented all Chinese as an advisory organ for the Dutch government until July 2014 (IOC, 2010).

Up until 2004, Chinese in the Netherlands showed very little interest in Dutch politics. Rates of participation in local council elections (*Gemeenteraadsverkiezingen*) and the parliamentary elections (*Kamerverkiezingen*) among Chinese were around 10% and 5% respectively (Huijnk, 2011). The Chinese Political Integration and Participation Fund (*Stichting Chinese Politieke Integratie en Participatie Fonds* or CPIPF) was established in 2005. This foundation aims to encourage Chinese in the Netherlands to participate in Dutch politics in order to represent the interests of the community. In 2006 the first Chinese candidate was adopted for the parliamentary elections.

Social identification and contacts with native Dutch

Despite the long history of Chinese in the Netherlands, identification with the majority population remains weak. Huijnk (2011) reported that less than half of Chinese respondents say they strongly identify themselves with the Netherlands. Another study on young Chinese also showed that only 31% of 200 respondents expressed this view (Chow, Zwier, & van Zoonen, 2008).

Huijnk (2011) further indicated that Chinese in the Netherlands participate relatively little in the activities of associations. Chinese do not have contact with native Dutch as frequently as ethnic Turks, who are also classed as highly focused on the own group (see Table 2.2). Verkuyten and Kwa (1996) found that Chinese who felt predominantly Chinese demonstrated a higher level of participation in ethnic practices, preferred in-group friendships and relationships, and reported less contact with their Dutch contemporaries and less cross-ethnic contact in general.

Table 2.2 Social contacts with native Dutch friends and acquaintances by ethnic origin in 2009 (%) (Huijnk, 2011)

	At least weekly	Less than weekly, but at least several times a year	(Almost) never
Chinese	45	32	24
Turkish	53	24	23
Moroccan	58	20	22
Surinamese	65	22	13
Antillean	70	20	11

While Huijnk (2011) reported that 90% of respondents from the second generation feel at home in the Netherlands, another study found that second-generation Chinese in the age group 20-45 feel discriminated in Dutch society (Witte, 2009). Compared to the second generation, who have Dutch education and good Dutch proficiency, first-generation Chinese can have more difficulty integrating even though they may have lived in the Netherlands for a long time. Many elderly Chinese people in the Netherlands feel they are neglected, undervalued and not understood by others (Liu et al., 2008). Especially for those who have spent their younger years in the restaurant business, Dutch society is still a mystery.

Relationship with origins

Chinese usually refer to themselves in terms of their ethnic origin rather than their nationality. As long as a person is of Chinese descent, that person is considered Chinese. According to the nationality laws of the PRC, any person born abroad to parents of whom one or both are Chinese nationals has Chinese nationality (PRC, 2013). The same rule is applied by the Taiwan (Republic of China on Taiwan [ROC]) (ROC, 2013). Governments have the responsibility to maintain and to protect the interests of their citizens, even if they are overseas (OCAC, 2013; Overseas Chinese Affairs Office of the State Council, 2013). For example, the ROC (Taiwan) Constitution clearly states that the nation must protect and assist the economic development of overseas Chinese.

There are cabinet level ministries to deal with overseas Chinese affairs and legislative representation for overseas Chinese. While the PRC sees them as potential contributors to the development of the PRC through their skills and capital, the ROC (Taiwan) tends to seek the support of overseas Chinese communities to promote its interests on the global stage. Both governments maintain intensive relationships with their overseas populations.

In the Netherlands, as in other countries, both the PRC and ROC (Taiwan) have set up offices for overseas Chinese to help their compatriots integrate into the new societies. They serve as cultural, educational, economic and informational exchange organizations between migrants and their home countries (OCAC, 2013). For example, up to 2013 OCAC (Taiwan) has supported 39 meetings of the 'Annual Conference for Overseas Chinese in Europe' in different countries. The offices also provide information about current policies related to overseas Chinese. The Turkish and Moroccan governments also have similar policies regarding their overseas citizens. The setting-up of a Presidency for Turks Abroad and Related Communities is an example (Albayrak, 2013).

2.3 Norms and values

Chinese in the Netherlands not only maintain a close relationship with their origins, but are also strongly attached to traditional culture (Li, 2011). The emphasis placed on educational achievements, hard work and family values illustrates the influence of

Chinese culture. Because research on the norms and values among ethnic Chinese in the Netherlands is scarce, studies of Chinese norms and values in general are employed additionally in this section in an attempt to characterise the mentality and behaviours of this group of people.

2.4 Belief systems

The shared belief systems that characterise social groups are often divided into 'philosophies of life' and 'religions'. There are many definitions of 'religion': it is usually regarded as comprising a philosophy of life, rituals and traditions, based on a belief in 'the divine' (which may be one or more gods, or something less concrete – cf. James, 1902). However, there is no general agreement about the definition of 'the divine'. In Chinese culture the distinction between philosophies of life and religions is sometimes very unclear. While Westerners tend to view 'religions' as contrasting with each other, followers of Chinese religions usually do not identify themselves as believers in one religion as opposed to another (Nadeau, 2012).

In traditional Chinese culture, Confucianism, Taoism and Buddhism are the three belief systems which have had the strongest influence in Chinese daily life. Confucianism is generally regarded as a philosophy of life but not a religion. Taoism and Buddhism are in general regarded in China as religions, but both contain variants which are arguably more akin to philosophies of life. Together with ancestor worship and folk religions, these three belief systems are adhered to in an eclectic mixture to varying degrees in Chinese communities (Liu et al., 2008).

Confucianism is a complex system of moral, social, political and philosophical notions that has had a tremendous influence on the culture and history of China and East Asia. The teachings are lessons in practical ethics without a religious content. In Confucianism, the individual is seen as the basic unit of the universe; at the same time, the family is the basic social unit. One of the Confucian teachings is the Five Cardinal Relationships (五倫, wǔlún). This defines the five relationships known as: ruler and subject, father and son, husband and wife, brothers, and friends. These relationships contain mutual and complementary obligations: the lower/younger ranks owe the higher/senior ones respect and obedience, and the higher/senior owe the lower/younger protection (Hofstede, Hofstede, & Minkov, 2010). Once the relationships are in order, the living environment achieves a stable society.

In contrast to Confucianism's political focus, Taoism encourages individuals to transcend self and secular awareness to integrate themselves with the Law of Nature or Tao (Yip, 2004). The Law of Nature is a process of constant change and transformation resulting from the dialectical and dialogical interaction between two opposite but complementary forces (yin and yang). The process transforms disharmony into harmony. When people's thoughts, feeling and behaviour follow the rule of nature, they reach a state of balance and stability.

Chinese Buddhism has been incorporated into Taoism and various folk beliefs and has become a distinct approach. Following the teaching of compassion and the law of causality, mutual aid is considered to be an excellent virtue. Through the practice with conscious of the universal truths, individual learns the wisdom to understand self, to cope with daily problems, and to know the better way to live in the present cosmos.

These three belief systems do not demand exclusive adherence. All three have played a part in Chinese beliefs and ritual practices for millennia and are allowed to coexist with each other. Most Chinese would find it hard to distinguish between them (Nadeau, 2012). People follow the virtues of Confucianism to deal with interpersonal relationships. They visit Buddhist temples while living according to Taoist principles, participating in local rituals of ancestor veneration, and celebrate Christmas. Taoism and Buddhism are considered pantheistic or atheistic, while Chinese folk religion is often polytheistic.

During the Cultural Revolution in the 1970s, the Communist Party of China viewed traditional beliefs as backwards and Christianity as the tool of Western colonialism. Freedom of belief was suppressed. After the 'opening up' of the 1980s, religious freedoms were expanded for Christians, and traditional beliefs like Taoism and Buddhism were supported as an integral part of the Chinese culture. Nevertheless, the majority of the population of China (60-70%) are agnostic or atheist (Zuckerman, 2007). In the Netherlands, only a quarter of Chinese describe themselves as having a religion. Of these, about half describe themselves as Buddhists and 40% as Christians, while rest mention Taoism or Islam (Huijnk, 2011).

2.4.1 Family

As mentioned earlier, Confucianism and other beliefs are deeply ingrained in Chinese daily life, and have enormous influence in particular on family values. With the passage of time, the structure of modern Chinese families has changed. However, traditional family values still seem to be respected in present-day Chinese-speaking regions as well as Chinese communities overseas.

Family Size

With recent Chinese governments advocating smaller families through family planning campaigns and policy-making (e.g. Attané, 2002; Sun, 1987), large extended families are a thing of the past. In 2012, the fertility rates in Taiwan (1.1), Hong Kong (1.2) and Macau (1.2) were among the lowest in the world. Mainland China (1.5) was ranked below the median (Population Reference Bureau [PRB], 2013). A similar phenomenon is also found among Chinese in the Netherlands: the fertility rate among Chinese women was 1.4 in 2008, which is the lowest among ethnic minority groups (1.7 in the total Dutch population) (Huijnk, 2011). Chinese families have downsized in the modern world.

Lineage system

In traditional Chinese society, marriage brings together families of different surnames and continues the family line of the paternal clan. The merits and demerits of any marriage are important to the entire family, not just the individual couples. In rural regions of modern China, some people still follow the patrilocal tradition that the married couple lives in the man's village.

Son preference

Traditionally, maintaining the lineage is fundamental. Usually only the sons can carry the family surnames. In addition, the main productive assets are passed through the male line, which constrains women's ability to sustain their social and economic level without being attached to a man. As consequence, men are given more status and respect than women; a daughter may be valued lower than a son; and a woman's position in the marriage is mainly valued by her function of procreation. If a man does not have any sons, he may take another wife or adopt a son in order to continue the family line (Gupta et al., 2003).

Choe and Han (1994) suggested that when fertility levels fall in a society with strong son preference, there is heightened pressure to remove daughters. Indeed, when an one-child policy was implemented in China, tolerance of daughters dropped sharply, because the most crucial requirement is to have at least one surviving son in the family (Gupta et al., 2003). Sometimes baby girls were taken to an orphanage and later adopted by Western parents. In the Netherlands, most adopted Chinese children are girls (see Figure 2.3). In addition, many Chinese unaccompanied minor asylum seekers (AMA's) are girls who may not have been registered in China because of the one-child policy (Liu et al, 2008).

Chinese families in the Netherlands show a tendency to maintain Chinese traditional family culture. Besides the preference for sons, many women who came to the Netherlands for family formation or reunification are expected to fulfil the traditional wife role at home and are often isolated from mainstream society (Liu et al, 2008). Little research is available to shed light on the question of how fast these traditions are changing.

Filial piety (孝, xiào)

Through the influence of Confucianism, Confucian concepts of kinship and 'consanguineous affection' are deeply ingrained in Chinese culture. Filial piety (*xiào*), which is extended by analogy to the Five Cardinal Relationships (*wǔlún*), is considered among the greatest of virtues and must be shown towards both the living and the dead. The principle of *xiào* is: to affirm and respect parents' intentions and actions, to be obedient to them, to serve them in all their needs and to honour them by life achievements. After 2,500 years, many Chinese worldwide still share this value in the

family system (Ho, 1996). From birth onwards, a child is influenced by the idea of *xiào*. This notion will be reinforced into daily behaviours through the lifetime.

It is not hard to imagine that the second generation who enter the Dutch education system and grow up in Western society feel a tension in living between two cultures. In school, at work or in public, they are required to actively participate in discussions or activities. On the other hand, they are also expected to show obedience and deference to their elders and higher authorities. They sometimes choose to behave according to Dutch norms in public, but Chinese ones at home (Vogels, 1999; Meeuwesen, 2000; Liu et al., 2008). The same has been noted of Muslim youth growing up in the Netherlands (Phalet, Lotringen, & Entzinger, 2000).

2.4.2 Interpersonal relationships

On the whole, Chinese attitudes towards both the family (in-group) and the out-group are rooted in Confucianism. As described in section 2.3.1, the Five Cardinal Relationships (*wǔlún*) define different types of relationship and specify the behaviour which is appropriate within each of them. The principles of *wǔlún* have gradually developed into a unique Chinese approach to social behaviour in interpersonal relationships.

Social orientation

Hofstede (1984) characterised Chinese society as collectivist compared to Western individualist societies. His arguments for doing so were as follows: that children usually grow up among members of an (extended) family and learn to conceive of themselves as a part of 'we'; that individuals accept and appreciate inequality but feel that the use of power should be moderated by a sense of obligation; that members of Chinese society aim to maintain harmony in the social environment; and that 'high-context' communication prevails in Chinese society. This view has been applied to study interpersonal relationships among Chinese in different contexts by sociologists (e.g. Gelfand & Realo, 1999).

However, Chinese indigenous psychologists (e.g. Ho, 1998; Yang, 1995) have argued that judging by its major characteristics, Chinese culture is not unequivocally collectivistic in nature, because Chinese manifest both individualism and collectivism in different contexts. Other researchers (Baskerville, 2003; Voronov & Singer, 2002) have also argued that Hofstede's cultural Individualism-Collectivism (I-C) scale is not adequate for characterising the culture of some groups, including Chinese.

In response to the shortcomings of Individualism-Collectivism, Yang (2006; 1995) developed the concept of 'Chinese social orientation' to describe and understand Chinese personality and social behaviour. 'Social orientation' comprises four dimensions: 'familistic', 'relationship', 'authoritarian' and 'other'. These are not independent from

each other but interrelated. The concepts of Yang's 'Chinese social orientation' can be briefly described as follows:

Familistic orientation

In Chinese society the family, rather than the individual, is the basic structural and functional unit. Chinese familism has been formed based on undeniable predominance of the family over its members in almost all domains of life. However, the subordination of the self to the family is a primarily a type of in-group behaviour, rather than a general form of collectivism. When facing people outside the family/pan-family group, Chinese may not behave according to collectivism, but tend to show egoism, which is not the concept of individualism used in Western social studies. The conflict between Chinese associations in the Netherlands while establishing the Council of the Chinese Minority (IOC) is an example of this (see *Political participation* in section 2.2.2*).*

Relationship orientation (關係, guanxi)

In Chinese society, *guanxi* describes the basic dynamic in personalized networks of influence, the 'connections (*guan*)' and 'relationships (*xi*)'. Chinese relationship orientation comprises five aspects: relational formalism, relational interdependency, relational harmony, relational fatalism, and relational determinism. A person's identity and behaviours are accordingly based on the relationship with another person defined by the Five Cardinal Relationships (*wǔlún*) of Confucianism. Relationships thus manifest interdependency. To preserve the stability of a group or a society, it is important to maintain interpersonal harmony in relationships. Moreover, under the influence of Buddhism, many Chinese apply the notion of predestination to explain the occurrence, type, and duration of a relationship. Once a relationship is recognised, Chinese further distinguish the interpersonal intimacy and distance and determine their attitude and behaviour in the relationship.

Authoritarian orientation

In traditional Chinese society, the father had the absolute power to rule the entire family. Attitudes and behaviours toward the head of a family as an unchallengeable authority were extended to the heads of larger groups or organisations. Chinese with a traditional orientation manifest a high degree of sensibility and acquiescence to authority of all kinds. They show a tendency to comply with authority with no condition and no time limit. This also has a pragmatic aspect: respectful obedience may be seen as a useful way to ingratiate oneself with the authorities, who are usually the controller of the family or social resources.

'Other' orientation

'Other' denotes those without a specific relationship to a person. The 'other' can be a stranger, an acquaintance, or a familiar person who is not currently involved in a process or a role of interaction. Chinese may be readily influenced by 'other' people on both a psychological and behavioural level. There are four major characteristics of Chinese 'other' orientation: constant worry about others' opinions, strong conformity towards others, deep concern about social norms, and high regard for reputation.

The 'Chinese social orientation' described by Yang (op. cit.) underlies general codes of conduct shared by Chinese to deal with interpersonal relationships in daily life. For example, identifying the type of relationship between oneself and another person is important in order to decide what attitudes or behaviour are appropriate in the relationship.

2.4.3 Communication style

There is no doubt that Chinese communication style is much influenced by their social orientation. Traditionally, studies on communication suggested that 'harmony' as the core of Chinese relationship orientation guides communication behaviour. Intercultural communication scholar Chen (2001) proposed a harmony theory of Chinese communication which asserts that Chinese communication aims to reach a harmonious state of human relationship. Twelve years later he renewed his attention for the dynamics of Chinese communication, claiming that in alongside harmony, there is another face of Chinese communication: power (Chen, 2013). This theory reflects the concepts of Chinese social orientation, such as the closeness of a relationship and the hierarchical positions in a relationship.

According to Chen's theory of Chinese communication (2013), it is essential for Chinese to develop harmonious communications with others in order to maintain the interpersonal harmony of relationships. Courtesy, politeness, respectfulness, taking each other's 'face' (面子, *miànzi*) into account, minimizing emotions, and avoiding confrontations are examples of the strategies used by Chinese to start a communication. On the other hand, to identify the *quanxi* (relationship orientation) is important to Chinese in communication since *quanxi* determines the specific ties of interactants in the hierarchical structure of Chinese social network. In other words, *quanxi* is a resource (power) that Chinese use to pursue, influence and control the interaction in order to reach harmony and competence. When harmony cannot be maintained in interactions, it is possible for Chinese to exercise power in communication. In Chinese society power is usually attributed to older people and those in superior positions. Those with authority are often invited to solve the disharmonious situation between people.

2.5 Dynamics of the Chinese ethnic group in the Netherlands

Chinese overseas usually maintain traditional forms of 'Chineseness', the quality of being Chinese, especially with regard to familial organisation or kin. Chineseness is lived out in the family milieu and expressed in everyday habits, attitudes, idioms and gestures that are rooted in Chinese traditions and transmitted over time. Many traditions are nowadays regarded as backward in China, but provide cultural continuity for overseas Chinese facing the challenge of new environments (Kwok, 2009). This can also be observed in Chinese society in the Netherlands, particularly among the earlier groups of migrants (Liu et al., 2008).

2.5.1 Changing values among Chinese migrants

Chinese living overseas experience Western-led modernity; at the same time, they carry Chinese social experiences and cultural practices with them. Along with the different migration backgrounds, however, 'Chineseness' is sustained in varying degrees. For example, Chinese societies in China or in Taiwan gradually acquire Western ideals and work on equality between genders. Chinese new comers to the Netherlands from these regions are generally more likely to respect Western values such as gender equality. However, Chinese families established in the Netherlands before 2000 seem more likely to hold tightly to traditional ideas – for instance, that men have a higher position than women, that married women should fulfil the traditional 'wife' role in assisting their husband's (family) business, giving birth, bringing up children, and running the household (Liu et al., 2008).

Moreover, ethnic Chinese from former Dutch colonies have been exposed to at least three different cultures. Their degree of 'Chineseness' is likely to be different from that of migrants from Chinese-speaking regions. Compared to the first generation, later generations of Chinese migrants may undergo a form of enculturation in Dutch culture, which guides their ideas and behaviours in daily life. The Chinese community in the Netherlands has different faces. Although this question has not yet been systematically investigated, a start has been made in analysing this diversity.

2.5.2 Different faces of the Chinese community in the Netherlands

Ethnic Chinese in the Netherlands form a heterogeneous group, reflecting historical changes in the composition of migration flows. Generally, it seems an invisible community because of its closeness to the mainstream society, as we noted earlier on the other hand, the success of Chinese on the labour market cannot be overlooked and makes them, at least on the economic level, a model minority in Dutch society. Recent research has attempted to identify different subgroups within this minority in order to obtain a more accurate picture of its characteristics.

Gijsberts et al. (2011) confine themselves to migrants coming from Chinese-speaking areas and distinguish four subgroups: those arriving before 1990, between 1990 and 2000, and after 2000, and in addition the second generation (which may be the offspring of any of these groups). By contrast, Linder et al. (2011) analysed data from the Survey of the Integration of New Groups (SING09) and distinguished three subgroups (again, considering only Chinese from Chinese-speaking areas): those arriving before 2000, those arriving after that date, and the second or later generations. In this study we have opted for the classification scheme of Linder et al., adding a further category of migrants from former Dutch colonies. In what follows we discuss the characteristics of each group in turn: the Pre-2000 Chinese, the 'New Chinese', Chinese from former colonies, and the second or later generations.

Pre-2000 Chinese

The size of this group is at present about 31,000 people. Most of them came to the Netherlands for economic or family reasons, speak Cantonese, and have little or no proficiency in Dutch. Compared to the other three subgroups, their educational level is relatively low. Although their labour market participation is high (70%) they seem to live isolated lives. A large number of them have hardly any social contacts, even within their own community. This is probably connected with the long hours of hard work in the catering industry (Huijnk, 2011; Rijkschroeff 1998). This group of Chinese usually adhere firmly to Chinese culture: for example, the parents have absolute power in the family. Their integration into Western society is low.

The 'New Chinese' (after 2000)

Half of this group came to study. Of the rest, some came for work (including highly-skilled or 'knowledge migrants') and others have migrated for family reasons. Many of them have only temporary residence permits. Their Dutch proficiency is the lowest of all the subgroups discussed here (Gijsberts, 2011). Their educational level is on average high, but their labour market participation is low because most of them are still studying. The highly-skilled workers participate in various industries. It is not common among this group to receive social benefits or assistance. Members of the group may not need such benefits, and in any case they have usually not lived long enough in the Netherlands to be able to claim them (Vogels et al., 2011). They have usually acquired Western ideals before migrating to the Netherlands, and compared to the pre-2000 Chinese they are generally more likely to accept Western values alongside traditional Chinese culture.

Chinese from former Dutch colonies

This group mainly comes from Indonesia and Surinam. They are more likely to be highly educated than the Pre-2000 Chinese. Because of the early exposure to Dutch culture, these Chinese are a well-integrated group in the Netherlands compared to the first generation from Chinese-speaking areas (Li, 2011). Indonesians, indeed, were never an official 'ethnic minority' and are classified as Western migrants.

Chinese from Indonesia are influenced by three different cultures: Chinese, Indonesian and Dutch. Most were brought up in a traditional Chinese family in Indonesian society, and have received Dutch education from an early age (Rijkschroeff et al., 2010). Whereas the family of Chinese from Indonesia may have lived in Indonesia for generations, most the first-generation Chinese from Surinam are also the first generation of migrants from to Surinam from China. Although they have a partly Dutch cultural background, they show 'Chineseness' and sometimes identify themselves by their origins, e.g. as Cantonese of Hongkongese rather than Surinamese (Li, 2011).

The second generation

Most of the second generation have enjoyed a better education than their parents. They also show a higher level of participation in the labour market and make less use of unemployment benefits (Jennissen & Oudhof, 2007). The greater part of them live mainly in the central Randstad region, and they are more satisfied with their living situation than their parents (Jennissen & Oudhof, 2007; Kullberg, 2011). In terms of their social and cultural characteristics they are much closer to native Dutch people than the first generation. They have intensive contact with native Dutch and more than half have a native best friend. The second generation also identify themselves with the Netherlands and focus less on their own ethnic group (Huijnk, 2011). Although they grew up in families with a traditional Chinese culture, many of them have let go of Chinese norms and values.

2.5.3 Conclusion

The Chinese community in the Netherlands is not a homogeneous group in terms of languages, regions of origin, migration motives, generations and even cultures (Li, 2011). It is important to emphasise the heterogeneity of ethnic Chinese in the Netherlands. This group came to the Netherlands in four main waves, from different regions and for different reasons. Their cultural positioning also differs. Studies of Chinese migrants in the Netherlands should pay particular attention to these differences between subgroups. In particular, patterns of illness and of health-related behaviours may differ between them.

Apart from this, we have seen the complicated patterns of norms and values of the Chinese in a changing society. Subgroups of Chinese migrants differ in the norms and values they adhere to: for example, the second generation differs from the first regarding

the need to cope with living in ‘two cultural’ worlds and the ways of bridging them. If Chinese migrants cannot bridge the gap, they seem vulnerable to mental health problems.

Before taking a close look at health care utilisation among Chinese in the Netherlands, the next chapter will review theories concerning migration and health care.

Chapter 3

Approaches to health service delivery for migrants and ethnic minorities

In order to increase knowledge about migrants' health and develop better policies on this topic, much research has been carried out in recent decades. This research has been concerned with two main issues: migrants' state of health and its determinants on the one hand, and health service delivery to migrants on the other. The first issue concerns epidemiological research and the investigation of risk factors. Here, it is customary to distinguish between the risk factors arising in three phases of migration – before migration, during the journey, and after arrival in the host country (see e.g. Gushulak et al., 2010). Research on health service delivery to migrants examines their entitlement to use health services, the accessibility and quality of services available to them, and the take-up or utilisation of these services. These two issues are not necessarily connected. Not all the health service needs of migrants arise from specific risk factors that they face as a result of migration; and even when their health is better than that of non-migrants, special measures may have to be taken to ensure that they receive quality health care. Everybody needs health care from time to time, and migrants are no exception.

Rather than investigating epidemiology, the current study deals with the topic of health service delivery, with special attention for Chinese migrants or their offspring and mental health care services. This chapter describes the development of approaches to health service delivery to migrants, showing how conceptions of 'good practice' in this field have changed in recent decades. Particular attention is paid to the concept of 'cultural competence', which has occupied a central place in discussions of this topic. The chapter shows how the conceptual framework that is used in the empirical studies reported in chapters 5, 6 and 7 came into being.

3.1 The rise of attention to health service delivery for migrants

Attention to diversity and health first arose mainly in the context of the Civil Rights Movement in the United States of America (USA) (ca. 1955-1968). Although this movement initially concerned the struggle for equal rights for the African-American population (which had been present in the USA for around two centuries and consisted largely of the descendents of slaves), its focus subsequently widened to include other racial and ethnic groups. We should note that in the USA, attention for the health of 'migrants' is fairly recent: attention has almost entirely been focused on 'racial or ethnic minorities', and migrants as such were for a long time only considered to the extent that they could be classified as belonging to such minorities.

One of the main targets of the Civil Rights Movement was the inadequacy of health care for African-Americans. The well-known quotation from a talk by Dr. Martin Luther King in 1966, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane," is a reminder of this. Health care for this group was not simply criticised as second-rate and insufficient: there was also criticism of the *appropriateness* of the help given, particularly in the mental health system. Mainstream health care could not cater for the needs of minorities, according to the critics, because it was oriented to those of the (white) majority. From this perspective, the traditional "one size fits all" approach was

regarded as 'institutional discrimination' against people whose needs differ from those of the majority, since such health care provision did not take account of minority patients' cultural backgrounds. Joseph White (1970), in an influential article entitled *Towards a Black Psychology,* stated:

> It is very difficult, if not impossible, to understand the life-styles of black people using traditional theories developed by white psychologists to explain white people… when these traditional theories are applied to the lives of black folks many incorrect, weakness-dominated, and inferiority-oriented conclusions come about (White, 1970, p. 45).

With the success of the Civil Rights Movement, the political and legal foundations were laid for a campaign to adapt health services to diversity and combat inequalities in health care. Title VI of the Civil Rights Act of 1964 protects individuals from discrimination on the basis of their "race, colour, or national origin" in programs and activities that receive Federal financial assistance – which includes many health and social care services.

However, the question of how exactly to adapt health services to the needs of migrants and ethnic minorities has been a topic of continual debate since the 1960s. In the beginning it was above all the concept of 'culture' that gained attention from those working on this topic. Health care professionals were urged to take patients' cultural backgrounds into account. Best practice in health care was defined as 'culturally sensitive' or 'culturally competent' care. For several decades, the concept of 'cultural competence' – "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989, p. 4) – was the unchallenged source of inspiration for efforts in Western countries to adapt health services to diversity.

Although the pioneer in this field was undoubtedly the USA, towards the end of the twentieth century increasing attention was paid to diversity in other countries as well. In the other so-called "traditional countries of immigration" (Canada, Australia and New Zealand), efforts were made to match health services to the needs of ethnic minorities and migrants. Without going into detail about these developments, we can say that the movements for responsive care in these countries were strongly influenced by American ideas. (One reason for this was of course that these countries, like the USA, were mainly English-speaking.)

Turning to North-Western Europe, we find that substantial levels of immigration during the phase of post-war economic expansion from the 1950s to mid-1970s also stimulated increasing attention to the issue of diversity and health care. The UK and the Netherlands were particularly receptive to American ideas on 'cultural sensitivity' or 'competence', but in those two countries as well as France, Germany and Italy, anthropological approaches which had their origins in the colonial history of each country were also

developed. In the following section we will look more closely at the concept of 'cultural competence' and examine how the meaning of this concept has changed in the last 40 years.

3.2 Development of 'cultural competence'

3.2.1 The original concept of 'cultural competence'

In the 1970's and 1980's, the term 'cultural sensitivity' was mainly used to refer to what later become known as 'cultural competence'. Health professionals were expected to be sensitive to cultural factors which might underlie ethnic differences in health status, or attitudes and behaviour regarding health and health care. Gaining knowledge of 'other' cultures (the implicit norm being white, middle class culture) was regarded as the appropriate professional response to the challenges presented by an ethnically diverse population (Culley, 2006). This emphasis on knowledge encouraged the proliferation of cultural 'fact files', checklists and guides to help professionals understand their patients. The dominant assumption was that learning facts about people's cultures would be enough to enable service providers to deliver 'culturally sensitive' care.

The cultural information used to educate service providers focused on the history, traditions, values, family systems and behaviours of minority groups (Adams, 1995). Culture was seen as influencing many health-related behaviours such as the type of advice trusted and the willingness to follow it, conceptions of the body, interpretation of symptoms and ways of coping with illnesses (Kleinman & Benson, 2006). In mental health care, professionals used this knowledge to 'decode' (Van Dongen, 2003) the messages sent by migrant clients. Equipping health care professionals with knowledge about the cultures of different minority groups was regarded as the logical first step to understanding their health needs.

In the USA context, where language support for patients is often mandatory under Title VI of the Civil Rights Act, much effort has also been devoted to the provision of language support services – for example interpretation in clinical settings and written materials in the patient's own language (see Like and Goode, 2012). Lacking this legislative basis, however, action on language support has received much less priority in Europe.

Efforts in the USA to promote 'culturally competent care' were placed on a firmer footing by the publication in 2000 of the CLAS Standards (National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care) (OMH, 2001). Although in fact only the standards relating to language support have mandatory status (and even then only in certain situations), the fact that this document was published by the USA Department of Health and Social Services (Office of Minority Health) gave it considerable authority, and it was influential in shaping the way health services were adapted to diversity. An 'enhanced' set of standards was published in 2013.

During the past three decades, however, the nature of 'cultural competence' has been called in question by many writers, and fundamental criticisms have been made of the original notion. In the first place, criticism was mainly aimed at the concept of 'competence': simply knowing facts about cultures was not enough. Going further, the 'facts' themselves started to be challenged: 'cultures' came to be seen as much less stable and homogeneous than the textbooks suggested. Lastly, the implicit assumption that diversity is above all a matter of 'cultural differences' started to be seen as more of a hindrance than help. These shifts in the notion of 'cultural competence' took place alongside each other rather than in sequence, although a serious challenge to the centrality of 'culture' was only made in the last ten years. In the following sections we will discuss each of these shifts in turn.

3.2.2 The first shift: Changes in the notion of 'competence'

As mentioned above, the earliest strategy proposed for increasing 'cultural competence' focused on providing knowledge about the attitudes, values, beliefs, and behaviours of different minority groups which was regarded as important for the caregiver. For example, training material on caring for 'the Asian patients' would present a list of supposed health beliefs and behaviours among 'Asians', accompanied by a list of "do's and don'ts" for providers (Betancourt et al., 2003).

This interpretation of cultural competence became known as the 'cookbook' or 'fact file' approach and gradually fell into discredit. As Kohn-Wood and Hooper (2014) put it: "The literature on cultural competence has evolved from early cookbook-style approaches, which detailed specific cultural differences, to approaches that focus on cultural processes and dynamics". Betancourt et al. (2005) concluded from results of interviews with experts in cultural competence practice that there has been a shift of emphasis in training interventions from knowledge to attitudes and skills. The use of cultural checklists can result in bypassing the need to engage with the experience and the personal choice of users (e.g. Gunaratnam, 1997; Culley, 2006). Other important issues were neglected, such as the need for empathy and the problem of the caregiver's own prejudices (Betancourt et al., 2003). Finally, major cities in Europe, North America and Australia often harbour migrants with over a hundred different nationalities and mother tongues. To produce a 'fact file' with information over all these different cultures would be an impossibly large undertaking. There is an increasing realisation that it is unrealistic to try to acquire knowledge of all cultures and to apply this knowledge to individual patients (Engebretson et al., 2008; Johnson & Munch, 2009).

Tervalon and Murray-Garcia (1998) proposed that instead of trying to become 'culturally competent', caregivers should practice 'cultural humility' – "a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves" (p. 118). This is not something that can be learned from a book, but has to be practised and be based on a deeply-rooted commitment to valuing and respecting diversity. The importance of developing skills to

improve the quality of care to diverse populations is stressed in more recent cultural competence models (e.g. Kim-Godwin, Clarke, & Barton, 2001). Training should aim not only to enhance health professionals' awareness of cultural issues and health beliefs, but also to give people the ability to elicit, negotiate, and manage this information. In the same vein, Martin and Vaughn (2007) argued that cultural competence comprises four components: (a) Awareness of one's own cultural worldview, (b) Attitude towards cultural differences, (c) Knowledge of different cultural practices and world-views, and (d) Cross-cultural skills, e.g. intercultural communication.

Nobody would deny that basic factual knowledge about the country a patient comes from can be very valuable for a caregiver – if only to show that they are interested in who the patient is, rather than simply what illness they have. However, the notion of cultural competence has moved from being primarily a matter of knowledge to one of knowledge, attitudes, and skills – often referred to by the acronym KAS (Expert Panel on Cultural Competence Education for Students [CCES], 2012).

3.2.3 The second shift: Changes in the concept of 'culture'

Early work on cultural competence tended to assume that each racial or ethnic group had its own specific and stable culture. This static view of culture was derived from classical anthropology. As more experience was gained, however, health care professionals started to realise that ethnic groups are not rigid and monolithic: cultures evolve, while newcomers constantly add new ingredients to them. Since the composition of an ethnic group is complex, it is not safe to assume that members from the same ethnic group all have the same needs. Moreover, migrants in particular inhabit different cultural worlds simultaneously. The static, homogeneous 'cultural knowledge' provided by textbooks was not sufficient to understand the needs of migrants or minorities.

This shift reflected the influence of Clifford Geertz's (1973) dynamic conception of culture. According to Geertz, culture is fluid, heterogeneous and multi-layered. From this point of view, "one size fits all" may have been an inadequate approach to health service delivery, but "five or six sizes fit all" was not really an improvement. Health care professionals started to reconsider whether the original cultural competence approach was capable of providing quality care.

During the 1990's, criticism of the assumed one-to-one relationship between ethnic groups and cultures grew. Researchers argued that this assumption encouraged stereotyping (Like & Goode, 2012) and did not take account of intra-group diversity and the continuous dynamic of cultural transformation (Kleinman & Benson, 2006). The CLAS Standards in 2000 explicitly warned of the dangers of stereotyping in efforts to develop cultural competence.

Faced with the proliferation of new migrant and minority groups and the realisation that these groups could themselves be very heterogeneous, current approaches place much more emphasis on the need to learn from each patient about their culture – cf. the concept

of ‘cultural humility’ (Tervalon & Murray-Garcia, 1998) mentioned above. Instead of trying to become experts on different cultures, health care providers should cultivate openness, self-reflection, respect towards the other, and self-critique (Harrison & Turner, 2010). Rather than aspiring to know in advance what patients are like, caregivers should learn to communicate with them, get to know them, and let them tell us about themselves. The patient is uniquely qualified to help the health provider understand the intersection of race, ethnicity, gender, religion and class that forms his or her identity, and to clarify the relevance and impact of this intersection in relation to the present illness experience.

Through self-reflection and commitment to lifelong learning, practitioners will hopefully become sufficiently humble and flexible to be capable of redressing the power imbalances that exist in the dynamics of doctor-patient communication (Chiarenza, 2012). Accepting the idea that the other is unknown means realising that our knowledge can only be improved by learning from the other. Humility is a prerequisite in this process, as the health provider relinquishes the role of expert to the patient.

As Saha, Arbelaez, & Cooper (2008) and Beach et al. (2006) have noted, this approach has much in common with the ‘patient-centred’ approach which has been put forward by the Institute of Medicine [IOM] (IOM, 2001) and is now recognised as desirable by many accreditation agencies. However, those who advocate an approach of ‘cultural humility’ are not saying that attention for diversity can be reduced to ‘patient-centred’ care, because the latter does not necessarily go beyond the purely individual characteristics of the person. ‘Culture’ has to do with a person’s social context and group membership, and if these dimensions are not taken into account we cannot speak of ‘culturally competent care’ (Ingleby, 2012).

3.2.4 The third shift: Changing views on the importance of ‘culture’

As we have seen above, for about 40 years ‘cultural competence’ has been viewed as the royal road to inclusiveness in health care. In many countries, providing services for people with different backgrounds is actually defined as ‘intercultural’, ‘transcultural’ or ‘cross-cultural’ work. However, lessons learned from research and from the experience of implementing ‘cultural competence’ programmes in practice have led to searching debates about just how important ‘culture’ is.

In Europe the Dutch cultural anthropologists Van Dijk and Van Dongen (2000, p. 48) expressed concern that the concept of ‘culture’ was being used to stigmatise migrants as exotic and strange people. Their criticism was that research on health care for migrants is fragmented and repetitive; it highlights differences and masks similarities. The implicit message is that if people of foreign origin have problems regarding health or health care, this must be because they are ‘culturally different’. This notion presupposes that there are systematic and persisting differences between patients originating from different countries, requiring different ways of tackling their health problems. Van Dijk and Van

Dongen charged that 'culture' was being used to blame migrants for all the problems and to divert attention from the shortcomings of the care being provided.

Moreover, it is not only cultural differences that are to be found within ethnic groups, but many other kinds of diversity. Indeed, the very concept of diversity, which originally related to a small collection of relatively homogeneous 'ethnic groups', has radically changed to include dimensions of difference such as migration or employment status, different degrees of entitlement and inclusion, migration history, religion, gender, age, generation, sexual orientation, and so on (Cattacin et al., 2013; Ingleby, 2012). Vertovec (2000) referred to the 'super-diversity' of some present-day societies and called for a paradigm shift in the way this is responded to.

This implies substantial changes in the way services are designed and delivered. What is required is 'sensitivity to difference' (Renschler & Cattacin, 2007), rather than specifically 'cultural' competence. People are so diverse that developing competence for health and social care professions based on supposed cultural knowledge, or simplified ideas about the health-related beliefs of specific ethnic groups, does not allow for understanding individual diversity; nor does it take into account the historical and political context, practical issues and the effects of socioeconomic differences.

Because people's needs are constituted at the intersection of many identities, there can be no 'culturally unique needs' (Culley, 2006). Kleinman and Benson (2006) recommend asking patients themselves whether their ethnicity is an issue in the healthcare setting; in this way, patients' illness narratives can be located within a context that they themselves define.

This shift has had different effects in the USA and Europe. In the USA, attention is now focused not only on ethnic groups or migrants, but also on equal treatment of people regardless of their gender, education, age, migrant status, geographical region, religion, or sexual orientation. At the same time, 'patient-centred care' is also emphasised. Paradoxically, however, the focus on 'culture' remains unchanged: the concept has simply been extended to cover any kind of variation in human characteristics. The 'Enhanced CLAS Standards' published in 2013 defined 'culture' in terms of "racial, ethnic and linguistic groups, as well as geographical, religious and spiritual, biological and sociological characteristics" (HHS, 2013a).

In Europe, by contrast, this broadening of perspective is seen as implying a shift *away from* 'culture'. As we saw above, European writers redefine the goal of responsive care in terms of 'equity' or 'sensitivity to difference' rather than 'cultural competence' and emphasise the role of other kinds of diversity besides culture.

In both Europe and the USA, we see increasing acceptance of the need to provide responsive care (however it is labelled) to the entire population, rather than only to migrants and ethnic minorities. Nevertheless, delivering health care for migrants and ethnic minorities remains a special challenge, and the ideas of 'cultural competence' and 'diversity sensitivity' are not necessarily in conflict with each other. 'Cultural humility'

acknowledges the dynamic nature of culture, while 'diversity sensitivity' draws attention to the importance of other factors. Both concepts point in the same direction: responsive health care for migrants and ethnic minorities should start from the individual and take account of cultural traditions, personal preferences and values, family situations, social circumstances and lifestyles and whatever else is relevant.

We should also never overlook the fact that in order to benefit at all from responsive service delivery, people first have to have the right to make use of the health care system. In focusing only on changes within service provider organisations, all conceptions of responsive care run the risk of neglecting those who cannot even access care - in particular, those who are left outside the system because they have no health care coverage.

In the past, as Van Dijk (1998) has claimed, the existence of cultural differences has often been used as an 'alibi' to explain away migrants' underutilisation of mainstream health care. Many articles have been written that attempt to demonstrate that cultural factors, such as divergent health beliefs, deter migrants from seeking help from mainstream services when they need it. Other research, however, including the studies undertaken for this thesis, shows that cultural differences are by no means the only source of problems in health service delivery for minorities. Practical obstacles, of which we will provide many illustrations in the following chapters, can be equally important, if not more so. Such obstacles can affect both migrants' ability to access care and their chances of receiving effective care of high quality. In the next chapter we will analyse in more detail the different elements of service delivery and the effect they can have on service utilisation or 'uptake' by migrant groups. This will be followed by a literature review on mental health service delivery to Chinese migrants in Western countries, with special attention to the Netherlands.

Chapter 4

Investigating health service delivery to migrants and ethnic minorities

In past decades, Western countries receiving large numbers of migrants have faced new challenges, such as increased diversity of the population and new patients with different health profiles and needs. This inevitably impacts on the day-to-day work of health professionals. Approaches to protecting and maintaining the health of migrants need to be developed. To do so, it is first necessary to understand what their health needs are and what factors have to be taken account of when providing services to them. In this chapter we first explain the two basic concepts that are used in connection with the second of these issues: access to health services and quality of service delivery. Next, the issue of health service utilisation by migrants is discussed. At the end of the chapter, a review of studies on overseas Chinese and mental health care is given to illustrate the application of these concepts.

4.1 Health service delivery: basic concepts

In order to assess the adequacy of health service delivery to migrants and minorities, it is necessary to distinguish between access to services and their quality. In this section we first explain what is meant by access, and then analyse the possibilities and limitations of measuring access from data concerning health service utilisation. This is followed by a discussion of the concept of quality in service provision.

4.1.1 Access to health services

In the words of Gulliford et al. (2002, p. 186), "Facilitating access is concerned with helping people to command appropriate health care resources in order to preserve or improve their health". Many different models have been put forward to analyse the factors that determine access (e.g. Yeo, 2004; Ku & Matani, 2001; Andersen, 1995; Weissman, 1991; Whitehead, 1992; Aday & Andersen, 1974). In the present study we focus on two main factors, the entitlement to use health services and their accessibility for the user.

While 'entitlement' has to do with the financial barriers that may prevent a person from reaching services, the 'accessibility' of a service refers to other kinds of barriers. Yet even when a person is entitled to use services and these are accessible, there may be other barriers which inhibit them from seeking help: they may not think they need it, even though other people are convinced that they do. In our research, we treat this as a question of 'health behaviour' – how a person perceives their health and what they consider to be appropriate measures for dealing with it. Although health behaviour is usually considered to be a 'demand-side' factor, it is possible for service providers to influence it. A provider can encourage use of its services by giving information and creating a feeling of trust, in such a way that a person comes to see their problem as one requiring help which the provider is able to give. Thus, 'psychological' or 'cultural' barriers to seeking help are not just 'demand-side' factors: they can also be affected by the policies of the service provider. Similarly, language barriers can be regarded as coming from the user, but they can also be seen as a result of the service provider's failure to provide language support.

Equally, a long and difficult journey from the user's home to the hospital or clinic can be regarded as arising because the user lives in the wrong place – or because the location of the service provider was poorly chosen.

Entitlement

The most fundamental element of access is entitlement to use health services. In fact, the issue of entitlement does not relate to obtaining the desired help, but being able to pay for it. Nearly all industrialised countries have developed systems of risk-sharing (insurance-based or tax-based, and often a mixture of both) which, in return for compulsory contributions, protect individuals against the risk of catastrophic medical costs. The rules governing entitlements are usually not laid down by service providers, but by governments and/or insurance companies (Ingleby, 2011, p. 201). In general, entitlement to use health services is restricted to legal residents who have paid the compulsory health insurance contributions. Entitlement can be assessed in two ways – in terms of coverage or affordability. Coverage refers to the range of health services which are included in the statutory system of risk-sharing; affordability refers to the difficulty for an individual users of paying the regular contributions (plus any 'out-of-pocket' costs that may be demanded).

Accessibility

When health services are available and a person is entitled to use them, the accessibility of the services is the next factor affecting whether they will be utilised. In this research, 'accessibility' refers to the ease with which people can actually utilise the health services to which they are entitled. As we saw above, factors undermining the accessibility of a service can come from the user (demand-side factors) or the provider (supply-side factors), but this distinction is often hard to make. These factors can be roughly categorised into language barriers, practical barriers, beliefs, values and attitudes, discrimination, and mistrust. In the case of mistrust, poor (perceived) quality of care may as it were work backwards to impede access: if a service provider gains a bad reputation, whether deservedly or not, this will act as a barrier to accessing it. The barriers just mentioned often arise in combination, and access may be affected by a complex interaction between them (for example, when a migrant with limited language proficiency has difficulty finding the right service provider and is then unable to discover how to reach it by public transport.)

4.1.2 Health service utilisation

Statistics relating to health service utilisation are often used as an indicator of access (Nørredam & Krasnik, 2011; Hernández-Quevedo & Jiménez-Rubio, 2009; Lindert et al., 2008; Sundquist, 2001). Differences in health service utilisation between groups are then

used to indicate possible barriers to access. However, disparities in health care utilisation between groups can arise from quite different sources: either from differences in the health needs of each group, or from differences in their access to care. Unless one has information about one of these two factors, it is impossible to use figures on utilisation to estimate the other one. For example, migrants as a group probably utilise geriatric services less that non-migrants do, but the main reason for that is likely to be that they are usually younger – not that they have poorer access.

There are also problems in collecting and interpreting data on both utilisation and health status among migrants. First, the collection of such data faces several serious obstacles (Ingleby, 2009), such as the lack of consensus about the categories which should be used and the unwillingness of some staff to note the ethnic information. In addition, in some countries there is political concern about the possible misuse of such data. Second, there are problems of cross-cultural validity and representative sampling which may affect epidemiological data. An accurate estimate of the health status of an ethnic minority group has to be based on population surveys, not on clinical data (because we know that clinical data will often be affected by differences in access). Population surveys are often simply not available: for example, in relation to the present study there are no epidemiological data on mental illness among Chinese which could be used to interpret differences in service utilisation. However, even in the absence of good statistics about population health, it can still be possible to infer whether barriers to access exist. Other indicators such as delay in seeking care or higher severity of symptoms at presentation (which may indicate such delay) are a good indicator of access problems (Nørredam & Krasnik, 2011). In the case of Chinese patients, a higher severity at presentation is often reported (Geense, 2003), as it is for several other ethnic groups in relation to mental health care (e.g. Selten, 2001).

To sum up, data on health service utilisation – where it is collected – can be a useful indicator of access problems, but only as long as we have some idea about underlying rates of illness. After all, low rates of utilisation might simply reflect a lower incidence of health problems among the group in question. Nevertheless, access problems can sometimes be inferred from higher severity at presentation – and, of course, from qualitative data obtained by asking people what barriers they experience, as has been done in this thesis.

4.1.3 Quality of care

Even when there is reasonably equitable access to health care, barriers to receiving good-quality care may still exist for migrants and ethnic minorities. Researchers in this field typically measure the quality of care by examining its effectiveness in terms of outcomes, the satisfaction of both users and health care workers, and the extent to which the treatment process was properly carried out, avoiding therapy noncompliance and dropout (Priebe et al., 2011; Derose, Bahney, Lurie, & Escarce, 2009; Harmsen, Bernsen, Bruijnzeels, & Meeuwesen, 2008). A literature review concerning immigrants to the USA

(Derose et al. 2009) showed that migrants are generally less satisfied with the care received than nationals; nevertheless, perceptions and experiences vary among migrant subgroups.

A Finnish study reports that clients with a migrant background are often perceived by professionals as making inappropriate, incoherent, or ill-formulated requests, while from the point of view of these clients the professional listens poorly, lacks insight into the problem, and proposes inappropriate or irrelevant solutions (Dayib, 2005). The origin of such problems often lies in poor communication (Derose et al., 2009; Harmsen et al., 2008; Flores, 2006; Schouten & Meeuwesen, 2006; Green et al., 2005). Other issues mentioned by migrants concern staff helpfulness, timeliness of care and discrimination (Weech-Maldonado et al., 2003; Lauderdale, Wen, Jacobs, & Kandula, 2006).

Limited language proficiency and cultural differences in views concerning care are considered by many to be the main factors that affect the communication between migrants and professionals (Meeuwesen, 2012; Derose et al., 2009; Harmsen et al., 2008). For example, low language proficiency can create pitfalls in the treatment situation which constitute a threat to patient safety: patients can experience adverse effects of medications because they do not understand the instructions for taking them properly. Furthermore, patients with a culturally different background may evaluate the received health care and outcome differently. Saha et al. (2003) pointed out that barriers in the patient–physician interaction contribute to racial disparities in the experience of health care.

Research shows that interpretation services and the availability of a language-concordant provider can improve migrants' care (Meeuwesen, Ani, Cesaroni, Eversly, & Ross, 2012; Wilson, Chen, Grumbach, Wang, & Fernandez, 2005; Green et al., 2005). As we saw in the previous chapter, the notion of 'cultural competence' implies that professionals need certain knowledge, attitudes and skills in order to deliver high-quality care to patients from diverse backgrounds. At the same time, the approach of 'diversity sensitivity' calls attention to factors other than culture which need to be taken into account, such as socioeconomic position, education, migrant status, language proficiency, age, and gender.

4.2 Factors undermining access to care and quality of care among migrants

We will now illustrate the concepts that have been described in the previous section by showing how they have been applied to analysing shortcomings in health service delivery for migrants. First, we examine the issue of entitlement to care: lack of entitlement is perhaps the most fundamental of all barriers preventing access to care. Then we examine a range of factors which can either impede access, or lower the quality of care, or both.

4.2.1 Entitlement to health care

Although the Affordable Care Act of 2010 represented a great step forward in terms of bringing entitlement to health care within the reach of millions more Americans, there is a

still a very great difference between the USA and Europe in this respect. In the USA the government does not provide universal health care insurance. Many employees may receive employee-paid medical insurance coverage; otherwise, people may purchase their own health coverage privately. The government-run systems Medicare and Medicaid also subsidise health services for certain categories of people who cannot afford them. However, many low-wage earners do not have incomes low enough to qualify for Medicaid, but still cannot afford private insurance. Lack of insurance coverage is the primary obstacle to using health services among migrants and ethnic minorities.

'Racial and ethnic minorities', which constitute about one-third of the USA population, are considerably less likely than the rest of the population to have health insurance. They made up more than half of the 50 million people who were uninsured in 2007 (James et al., 2007, p. 13). A long-running battle over health care has characterised American politics since the early 20th century. In recent times proposals have been put forward by both major political parties, including the 'Clinton health care plan' in 1993 and a series of initiatives during G.W. Bush's presidency. However, health care reform did not succeed until President Obama signed the Affordable Care Act in 2010. The act requires insurer coverage of preventive services without cost to patients and increases health insurance access for millions of previously uninsured Americans. Everyone who is 'a citizen or national of the United States or is lawfully present in the United States' is subject to the rights and duties defined by this act. Thanks to these changes, many legal immigrants now qualify for affordable health insurance coverage, although the 11 million undocumented migrants still have none.

By contrast, most European countries have achieved close to universal coverage of their population for the majority of health care services; even undocumented migrants have certain (albeit usually minimal) entitlements (Nørredam & Krasnik, 2011). On the other hand, the entitlements for migrants vary considerably from country to country. Legal migrants from another EU country enjoy practically the same coverage as they would in their home countries; for third-country nationals entitlements vary widely, though in many EU Member States such migrants are allowed to use the same system of health insurance (or national health service) as nationals. Gaps in coverage, however, may arise for unemployed migrants as well as asylum seekers and undocumented migrants. Health care for asylum seekers is provided free of charge in most countries, but the services available may be limited – in the least favourable case restricted to emergency services only (Nørredam & Krasnik, 2011). Provisions for undocumented migrants vary widely; for example, undocumented migrants in the Netherlands have in principle the same entitlements to general and mental health care as nationals, while those in Sweden may only access emergency care in return for payment of the full cost (Cuadra, 2012; Sandhu et al., 2012). Even where entitlements are reasonable, undocumented migrants may not have access to information about what they are, and may also be reluctant to seek help for fear of being reported to the authorities. Moreover, many service providers are unfamiliar with the rules and some fail to comply with them (Chauvin, Parizot, & Simonnot, 2009).

4.2.2 Other barriers to access and quality of care

Language barriers

Limited proficiency in the official language(s) of the host country is often the most serious barrier affecting migrants' access to care (O'Donnell et al., 2013; Perreira et al., 2012; Yeo, 2004). Conservative estimates for Europe suggest that 25% of migrants are affected by language barriers, which means that 1 in 4 migrants are in need of an interpreter. This equates to around ten million people in Europe: the true figure may be even higher (Meeuwesen et al., 2012).

Language is the means by which an individual accesses the health care system, learns about services, and makes decisions about her or his health behaviour (Woloshin, Schwartz, Katz & Welch, 1997). It is also the instrument by which an individual communicates health needs and related issues (e.g. attitudes toward illness and treatments) with professionals, and understands diagnoses and advice (Yeo, 2004). Limited language proficiency affects both the ability of migrants to find information about health and health services, and the quality of communication between them and care providers which is so essential to providing good care (Harmsen et al., 2008; Flores, 2006). Worries about being able to communicate with care professionals are also reported as a reason for delay in seeking help from mainstream services (Nørredam & Krasnik, 2011).

Lack of health literacy

Health literacy is defined as "the degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions and services needed to prevent or treat illness" (HHS, 2013b). Low health literacy implies lack of knowledge about health, illness and the health care system. It leads to the following difficulties in accessing healthcare: not knowing the connection between risky behaviours and health, not being able to locate providers and services, not knowing the meaning of application forms, notices, and brochures, not being able to fill out complex health forms, or be able to share medical history with providers. Sometimes, low language proficiency can be an obstacle for migrants to acquire sufficient health literacy.

Practical barriers

Aside from language barriers and lack of knowledge about the health care system, other practical barriers may impede migrants' access to care and sometimes also undermine the quality of care. These barriers can occur at the level of patients, providers and the health system (Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006). For example, does the care user have time to seek professional help? Is there a long waiting list for appointments with providers? Does the system require a referral in order to access specialised care? Such barriers may of course affect non-migrants as well as migrants (Perreira et al., 2012; Harris, Furler, Mercer, & Willems, 2011; Nørredam & Krasnik,

2011). However, the barriers may have a greater impact on migrants, who will probably be unfamiliar with them.

The most frequently mentioned practical barriers for migrants include health status, mobility, transportation and logistical barriers, available time and stress constraints, as well as administrative burdens such as complicated registration or admission procedures (Perreira et al., 2012; Nørredam & Krasnik, 2011; Derose et al., 2007; Scheppers et al., 2006; Field & Briggs, 2001). For example, migrants tend to be more dependent than nationals on public transport and often live in areas without good services (Scheppers et al., 2006). The location of the service provider is thus a common problem for them. Regarding time, institutions have to be open at times when the migrant can manage a visit – and the employer must be willing to allow him or her to do so in work time.

Beliefs and attitudes

Kleinman's theory of 'explanatory models' (1978) explained the relationship between beliefs about health, illness and healing methods and the action of seeking help or using care. Such models reflect social class, cultural beliefs, education, occupation, religious affiliation, and past experience with illness and health care (Kleinman et al., 1978). Based on a literature study, Scheppers et al. (2006) gave a list of health beliefs and attitudes which are regarded as barriers to using health care: time orientation and concepts of achievement, values concerning health and illness, perceptions and attitudes towards health services and personnel, knowledge about physiology and disease. They suggest that patients from non-Western countries may have different sets of beliefs or explanatory models from Western ones and that these might inhibit them from seeking help from Western medical systems.

For example, some writers (e.g. Aragona et al., 2005; Lipowski, 1988) have suggested that non-Western migrants often have a divergent understanding of mental illness and are likely to 'somatise' the symptoms of psychological problems. Somatisation (the tendency to experience and communicate psychological distress in the form of somatic symptoms) is regarded by such authors as a factor that complicates the detection and treatment of mental illnesses among migrants (e.g. Pottie et al., 2011). By contrast, other researchers have found somatisation to be common in all cultural groups and societies, rather than being characteristic of specific groups. It has also been pointed out by Kirmayer and Young (1998) that the way complaints are expressed ('idioms of distress') is influenced not only by cultural beliefs and practices, but also by familiarity with health care systems and pathways to care.

At the same time, the stigma attached to certain illnesses can also impede access. Not only health beliefs, but also other cultural beliefs such as the value of self-reliance, hard work, and family support, can influence migrants' utilisation of health services (Perreira et al., 2012). For example, a Spanish study showed that migrant workers were more likely to report 'sickness presenteeism' than nationals (Agudelo-Suárez et al., 2010). (Presenteeism

is the opposite of absenteeism, i.e. going to work when one is sick; see Johns, 2009.) This, however, may have more to do with job security than culture: migrants may continue working when they are sick because they need the money and cannot afford to take time off, or because their employer does not allow them to do so.

Discrimination

The report of a European project on minorities and discrimination (European Union Agency for Fundamental Rights [FRA], 2011) showed that stereotypes (which may be based on culture, sex, age, ethnicity, migrant background, religion or a combination of these characteristics) can lead to unequal treatment of certain groups of health service users. Such discrimination can be 'direct' or 'indirect'. Direct discrimination is aimed at individual members of a group, while indirect discrimination targets a characteristic which is often found among the group's members. For example, a health system that offers better access to people with higher socioeconomic status will indirectly discriminate again migrants, because their socioeconomic status tends to be lower.

Discrimination can also be divided into 'institutional' or 'personal' kinds. Institutional discrimination resides in the written or unwritten rules of a system or organisation; even individuals who are not themselves prejudiced may be subject to these rules. For example, institutional discrimination against migrants is shown by services which fail to provide language support when it is necessary. For many patients with a migrant background, diagnostic tests and therapy (for example) need to be carried out in the patient's mother tongue. Individual discrimination, by contrast, is carried out by persons who have the choice of doing otherwise.

All these forms of discrimination have been found in service provision for migrants. Institutional and indirect discrimination is present when services are organised in a way that is non-optimal for migrants: this is almost inevitable when – as is so often the case – nothing is done to adapt the services to their needs. Direct and individual discrimination has also been found. Lee, Ayers, and Kronenfeld, (2009) studied migrants in the USA and found that (perceived) discrimination affects migrants' willingness to seek help from mainstream care services. Based on an American health care quality survey with a sample of 6722 respondents, Blanchard (2006) also concluded that health care professionals may associate particular minority groups with certain illnesses (stereotyping).

Mistrust

Another important barrier to access is lack of trust in the health services. Research has shown that the quality of available health services (whether assumed, perceived or experienced) can influence users' willingness to seek help from them (Dayib, 2005). Mistrust of the services or fears of poor treatment deter migrants from seeking help. People who lack trust will be inclined to seek help only when absolutely obliged to – for

example in an emergency or in advanced stages of illness (Manfellotto, 2003). They may suppress or hide their problems, resort to traditional healers and self-medication, or return to their home country for treatment (Stronks, 2001). Moreover, undocumented migrants often have a generalized fear of authorities because of the risk of deportation; they may avoid seeking public assistance of any kind (Perreira et al., 2012).

Although as we have seen, factors undermining access to care and the quality of care may be both cultural and practical in nature, there has been a strong tendency in the literature to focus on the cultural ones – explanatory models, treatment preferences, help-seeking traditions, stigma, ways of expressing illness (e.g. somatisation), or preferences for alternative medicine (see Scheppers et al., 2006). This tendency is especially noticeable in discussions about migrants' use of mental health services (Lindert et al., 2008; Snowden & Yamada, 2005).

As mentioned in Chapter 3, although cultural explanations have received most attention, some researchers (e.g. Scheppers et al., 2006; Snowden & Yamada, 2005; Wu et al., 2005; Kung, 2004) have warned that this tendency may lead to biased or false conclusions. For instance, Jenkins, Le, McPhee, Stewart, and Ha (1996) found that even though Vietnamese migrants in the USA adhere to different traditional health beliefs and practices from those of the general population, this does not act as a barrier to accessing Western health services. Researchers often overlook the fact that some barriers impeding migrants' access to health care, such as long waiting times for appointments, may also affect non-migrants.

This review of the literature has shown that diverse and persistent barriers impede migrants' access to health services. Many factors may also impair the quality of the services provided, and this may lower migrants' motivation to use them still further. Up to now our focus has been on migrants and health care in general: in the next section, we will narrow the focus in two ways, by examining the extent to which these problems have been reported in research on Chinese migrants in the West and mental health services.

4.3 Chinese migrants and mental health services

Forty-five million people of Chinese birth or descent live outside the China, Taiwan, Hong Kong and Macao, regardless of citizenship. These so-called 'overseas Chinese' constitute approximately one-fifth of the world's migrant population (Zhuang, 2011). The population of overseas Chinese in the West is about 10 million, of which more than 100,000 people live in the Netherlands (OCAC, 2013).

Systematic studies on health issues among Chinese migrants in the West started in the late 1960s and 1970s. The utilisation of mental health services by this group was of particular theoretical interest because Chinese migrants were seen as having a strong attachment to their culture of origin, including traditional notions about health and illness (Ma, 1999;

Tabora & Flaskerud, 1997; Sue et al., 1976; Sue and Sue, 1971). These notions were generally regarded as incompatible with Western ones. For example, there is no straightforward equivalent to 'mental health' in Chinese medicine, and there is no dualism of mind and body (Bond, 1996; Lin, 1981). The relationship between Chinese migrants and Western health systems was assumed to be an area in which 'cultural factors' played a very important role. This section reviews the key findings to date relating to mental health care needs, service utilisation, and barriers to access and quality of mental health care among this group. This is followed by a review of research on these topics among Chinese in the Netherlands.

4.3.1 Chinese migrants' utilisation of mental health services

Health service utilisation and health needs

Research on the health service utilisation of Chinese migrants in the West shows that in general, Chinese are less likely to use mental health care services than other ethnicities, including the majority ethnic group (Chu & Sue, 2011; Schellingerhout, 2011; Chen, Kazanjian, & Wong, 2009; Gill, Kai, Bhopal, & Wild, 2007; Abe-Kim et al., 2007; Chen & Kazanjian, 2005; Kung, 2003). The low uptake of mental health care could be explained by the hypothesis that Chinese migrants have better mental health than other groups, but it is also possible that they experience particularly strong barriers to accessing the mental health care they need.

Do Chinese have better mental health than other ethnic groups? An examination of the limited number of epidemiological studies indicates that lower service utilization by Chinese in the West does not necessarily result from a lower need for services. Though some studies show lower rates of certain mental disorders for Chinese migrants (US Office of the Surgeon General, 2001; Nazroo, 1997), others show similar or even higher rates of some mental disorders (Takeuchi et al., 2007; Abbott, Wong, Williams, Au, & Young, 1999; Cheung & Spears, 1992). Research also shows that the differences may depend on gender, age and generation (e.g. US Office of the Surgeon General, 2001; Abbott et al., 1999). Because most studies on Chinese migrants' needs for mental health care rely on data from self-reported health assessments or questionnaires, Sue & Chu (2003) argued that a lack of cross-cultural validity can create bias. They argued further that among Chinese migrants, mental distress may be somatised and may not fit easily into Western diagnostic categories. Therefore, if culture-bound syndromes such as neurasthenia are included within the estimates of the prevalence of mental disorders, then it is difficult to contend that Chinese have significantly lower prevalence rates than other groups.

Given the problems of the world-wide shortage of population-based studies of prevalence rates among Chinese migrants, as well as the issues of cross-cultural validity, the possible occurrence of culture-bound syndromes, the heterogeneity of the Chinese migrant group

and conflicting results concerning prevalence, it is difficult to draw definitive conclusions on whether Chinese migrants have better mental health than other groups.

Even though research gives no clear answers to this question, Chinese migrants' needs for mental health care have been recognised in by many studies (e.g. National Alliance of Mental Illness [NAMI], 2011; Gill et al., 2007; Kumar, Tse, Fernando, & Wong, 2006; Geense, 2003). First, research has shown that migration-related factors, especially social isolation, culture shock and cultural adjustment difficulties, are significant predictors of psychiatric symptoms among Chinese migrants in the USA (Yeh, 2003; Abbott et al., 1999; Sodowsky & Lai, 1997; Kuo, 1976). Second, while Chinese are under-represented in mental health services, those who do access these services often present more severe symptoms than other groups, because professional help is often sought only as a last resort (Chu & Sue, 2011; Yeung & Kam, 2006; Chen, Sullivan, Lu, & Shibusawa, 2003). This is one more reason for believing that barriers to access, rather than lack of need, explain the low uptake of services by Chinese migrants.

Help-seeking and service utilization behaviours

To gain a better understanding of health care utilisation among Chinese migrants, researchers have also investigated their help-seeking and service utilization behaviours in relation to general and mental health. Ma (1999) studied Chinese migrants in the USA and found several patterns among them, including high rates of self-treatment and home remedies (special diets and alternative medicines); medium rates of combined utilization of Western and traditional health services, including travel to the country of origin for care; and low rates of exclusive utilization of either Western or traditional Chinese treatments. Chinese with mental health problems were likely to try self-treatment and home remedies first and to delay seeking help from professionals. However, a study in New Zeeland (Scragg, 2010) reported that family practices and GP clinics were the health care providers most often visited by Asians, including Chinese, when they first become ill (≥ 90%). However, they were less likely than other ethnic groups to see their family doctor for mental health reasons. Particular barriers seem to exist to their use of mental health care.

What these factors might be can be gathered from several studies, which mention the following factors: socioeconomic status, gender, entitlement to care, acculturation, linguistic discordance and communication barriers, self-medication and use of traditional treatment, health-related beliefs, mental health literacy, severity of illness, restriction in daily activities, cultural competency of health systems, stigma, confidentiality concerns, service constraints and discrimination in the health care setting (Clough, Lee, & Chae, 2013; Ye, Mack, Fry-Johnson, & Parker, 2011; Spencer, Chen, Gee, Fabian, & Takeuchi, 2010; Chen et al., 2009; Lee et al., 2009; Blignault, Ponzio, Rong, & Eisenbruch, 2008; Abe-Kim et al., 2007; Wynaden et al., 2005; Kung, 2004). Cultural factors such as health-related beliefs are frequently claimed to be important barriers to Chinese migrants' mental health care utilisation.

Experiences of mental health care

The experiences of those who seek mental health care also have an impact on readiness to utilise services. Negative experiences can deter users from seeking care again. Chinese migrants often report worse health care experiences and lower satisfaction with care than other ethnic groups (Clough et al., 2013). Abe-Kim et al. (2007) found that more than a quarter of Chinese American respondents were not satisfied with the mental health care they received. A study of mental health service use among Chinese Americans found that negative attitudes towards regular services were associated with the use of traditional medicine and other sources of informal care (Spencer et al., 2010).

Leong and Lau (2001) reported that the factors impeding the quality of mental health services among Asian American patients, including Chinese, include lack of cross-cultural validity of diagnostic tests and assessments, cultural variations in symptom expression, communication barriers and lack of access to culturally competent services. Green et al. (2005) go on to say that the availability of language-concordant providers or interpreters can improve both clinician-patient communication and quality of care for Chinese patients, especially in mental health care.

The studies reported above have strengthened the general impression that that the relationship between Chinese migrants and the health services of the Western countries they migrate to is often problematic. This seems particularly true for mental health services. In section 4.2.2 we outlined a number of barriers that impede access to care and undermine the quality of care, which have been shown to exist for migrants in general. We will now examine more closely the findings concerning such barriers in the specific case of Chinese migrants and mental health care.

4.3.2 Barriers to access and quality of care

To structure this discussion we have grouped barriers into two kinds: 'practical' and 'cultural'. Practical barriers are not only material in nature, but also cognitive (e.g. lack of knowledge). We include (direct) discrimination in this category, because apart from being an unpleasant experience it is usually accompanied by unhelpfulness. 'Indirect' discrimination mainly takes the form of a failure to adapt services, which is the topic of this whole thesis. Cultural barriers are those which can be related to customs, beliefs or values that characterise 'overseas Chinese' as an ethnic group.

Practical barriers

Entitlement

Lack of health care coverage is frequently identified as a barrier to access in the USA, because there is no system of universal health care coverage such as is found in European countries, Canada, New Zeeland and Australia. Clough et al. (2013) found that Asian

Americans, including Chinese, are less likely to be eligible for public health insurance or to purchase private insurance. Being uninsured is a barrier to accessing health services of all kinds. More detailed data show that in 1997 about 20% of Chinese Americans were uninsured compared to 14% of Caucasian Americans. The uninsured were less likely to have a regular source of care (Brown, Ojeda, Wyn, & Levan, 2000).

Knowledge of the health care system

Lack of knowledge of the (mental) health care services that are available and the way to access them is regarded as an important barrier to using health care among Chinese in the West (Blignault et al., 2008; Lai & Chau, 2007; Kung, 2004; Li, Logan, Yee, & Ng, 1999). Many Chinese migrants have limited knowledge of the health care systems in the West, which may be very different from those in their countries of origin. In many Western countries, mental health care has to be accessed through primary care. Chinese migrants need to get past the GP (family doctor) or a community health centre in order to obtain a referral to mental health care. By contrast, in Chinese speaking regions (China, Taiwan, Hong Kong and Macau) care users can access health services without appointments and approach specialists without a referral. Blignault et al. (2008) further pointed out that Chinese migrants might assume mental health care is expensive on the basis of their knowledge about health care in their country of origin. They do not use mental health services because they do not realise that their health insurance will cover the cost.

Linguistic and communication barriers

Limited proficiency in the official languages of host countries, as well as other kinds of communication problems, seem to be regarded as the most important factor interfering with access to, and quality of, mental health care (Chen et al., 2009, Blignault et al., 2008; Green et al., 2005; Wynaden et al., 2005; Kung, 2004; Chen et al, 2003; Leong & Lau, 2001; Li et al., 1999; Sue & Sue, 1977). Within mental health services, language has a key role to play in assessment and treatment, community engagement, service development and capacity (Blignault et al., 2008).

Discrimination and mistrust

We are mainly concerned here with direct discrimination, because 'indirect' discrimination mainly takes the form of a failure to adapt services to Chinese migrants' needs – which is the topic of this whole thesis. Experiences of direct discrimination in health care have detrimental consequences for both the use and quality of services. An Australian study found that being belittled by the doctor for their poor English and treated rudely by reception staff affected Chinese migrants' willingness to use mental health services (Blignault et al., 2008). Clough et al. (2013) point out that perceived

discrimination can affect the quality of care, cause a delay in seeking treatment, and lead to mistrust of the health care system. Chinese Americans who experienced discrimination because of their poor language ability were more likely to discontinue their treatment (Spencer et al., 2010). Regarding mistrust, Blignault et al. (2008) report that some Chinese do not seek mental health care because of concerns about confidentiality: they do not trust professionals to keep confidential information to themselves.

Other practical factors

Not only may Chinese migrants wrongly assume that mental health care will not be covered by their health insurance, they may also not be in a position to undertake time-consuming forms of psychotherapy. Both worries may be connected with employment conditions (being self-employed or in low-paying jobs (Sue, 1994).

Cultural barriers

As we saw in Section 4.2.2, 'cultural differences' have been strongly emphasised in many studies of migrants' relationship with regular health services. In relation to Chinese and mental health care, the factors most often mentioned have been the holistic Chinese view on health, somatisation, stigmatisation, spiritual explanations, and the supposed lack of psychological and psychiatric understanding in Chinese culture (Simich, Maiter, Moorlag, & Ochocka, 2009; Snowden & Yamada, 2005; Kung, 2004; Abbott et al., 2003; Furnham & Li, 1993; Lin, Carter, & Kleinman, 1985). We will discuss each of these in turn.

Holism

Some authors regard the traditional holistic Chinese view of health and illness, which stresses the interrelatedness of mind and body, as a barrier to using Western health services (e.g. Wong & Tsang, 2004; Ma, 1999). Those with holistic view of health may want to have body and mind attended to together, rather than going to a mental health centre for the mind and a hospital for the body (Tabora & Flaskerud, 1997). Lai and Chappell (2007) also reported that Chinese migrants who were more convinced of Chinese health beliefs are more likely to use Traditional Chinese Medicine (TCM) for both physical and mental illness.

Stigma

It is frequently claimed that mental illness is heavily stigmatised in Chinese culture. One reason for this is said to be that Chinese tend to equate 'mental illness' with 'madness' (e.g. Green et al., 2006). In addition to the tendency to regard only serious disturbances as mental illness, Chinese cultural norms hold the family responsible for the individual's

behaviour and welfare. Having a family member with mental illness is regarded as failure of the family to take care of its member properly. The stigma of mental illness targets primarily the family, rather than the affected individual (Lin, 1981). Thus, Chinese migrants may regard seeking professional mental health care as risking shame for their family as well as (or even more than) for themselves (Green et al., 2006; Mak & Chen, 2006; Kung, 2003). This worry may also make them less likely to take the initiative in discussing personal problems with counsellors and expressing emotions in the counselling session (Mak, Poon, Pun, & Cheung, 2007).

Somatisation

A long line of research in North America has been devoted to the finding that Chinese migrants are more likely to emphasise physical symptoms than psychological ones in the case of mental illnesses, in particular depression (Dere et al., 2013; Mak & Zane, 2004; Tabora & Flaskerud, 1997; Lin et al., 1985; Tseng, 1975). This 'Chinese somatisation' is often regarded as a cultural trait which could reduce the utilisation of specialised mental health services. Lin (1980) pointed out that the idea that internal organs perform both physiological and psychological functions can easily lead Chinese patients suffering from psychological difficulties to redirect their attention to the supposed physiological functioning of the related organ. At the same time, Cheung, Lau, & Waldmann (1980) stated that mental illness is heavily stigmatised in Chinese communities. Patients in their study were found to be aware of psychological distress, but chose to suppress it; instead, they presented somatic symptoms.

Spiritual explanations

When it comes to the explanation of mental illness, supernatural beliefs – stressing 'fate' and spirit possession as the cause of mental illness – are sometimes ascribed to ethnic Chinese (Yip, 2004; Parker, 2001; Leung & Lee, 1996; Kleinman & Kleinman, 1985; Lin, 1980; Kleinman & Sung, 1979). Many researchers have claimed that the resulting tendency to resort to shamans, religious rituals, folk healers, home remedies, self-treatments, acupuncture or herbal treatment among Chinese migrants (Hsiao et al., 2006; Kung, 2003; Ma, 1999; Tabora & Flaskerud, 1997) can reduce utilisation of mainstream mental health services. However, such 'supernatural' beliefs are more related to folk traditions than to TCM.

How important is the role of cultural factors in creating barriers to utilising Western health services?

Researchers' views on Chinese migrants' utilisation of mental health care have been strongly influenced by Kleinman's series of studies on mental illness beliefs and health-seeking behaviour in Chinese societies during the 1970s and 1980s (e.g. Kleinman & Lin,

1981). In particular, Kleinman's work on somatisation and indigenous treatments (Kleinman & Kleinman, 1985; Kleinman, 1982; Kleinman, Eisenberg, & Good, 1978; Kleiman, 1977) has been widely used to interpret the way in which Chinese migrants understand, experience and deal with mental illness (Simich et al., 2009; Snowden & Yamada, 2005; Kung, 2004; Abbott et al., 2003; Furnham & Li, 1993; Lin et al., 1985). Consequently, the low uptake of Western mental health services among Chinese migrants is explained by their 'non-western' cultural beliefs regarding the nature, manifestations and causes of mental illness, as well as the appropriate help.

In the past decade, however, there has been a shift from cultural interpretations of care utilisation problems to ones that have to do with the immediate context (socioeconomic factors or other practical barriers). Kung (2004) showed that when sex, age, marital status, education, family income, employment status, medical insurance coverage, acculturation, and symptom severity were controlled for, practical barriers significantly reduced the likelihood of service use but cultural barriers did not. The following variables had a significant positive effect on utilisation of mental health services: severity of symptoms, level of acculturation, having insurance coverage and being older or unmarried.

Other recent studies have also addressed the importance of practical barriers to mental health care among Chinese migrants, such as language barriers and communication problems, financial barriers, not knowing how to get hold of care, lack of time and opportunity to undergo treatment, and perceived discrimination (Kim, Jang, Chiriboga, Ma, & Schonfeld, 2010; Spencer et al., 2010; Lee et al., 2009; Blignault et al., 2008). Researchers further emphasise that Chinese migrants are not a homogeneous group and that wide differences in health beliefs, health care access and utilization exist among them (Chung, 2010; Liu et al., 2008; Wong & Tsang, 2004).

Influence of Chinese health beliefs on mental health service utilisation

Another important argument undermining cultural explanations of low service utilisation concerns the influence of health beliefs and TCM (HHS, 2001). According to Clough et al (2013), although many Chinese remain attached to traditional health beliefs and medicine this does not seem to preclude the use of Western health services. Studies have shown that Asian immigrants, including Chinese, regularly use Western health services at the same time as employing traditional methods of dealing with illness. Such immigrants tend to regard Western health care as being best for serious, acute issues, while traditional care with fewer side effects may be preferred for chronic ones (Ngo-Metzger et al., 2003). Lin (1985) stated that that Chinese adopt a pragmatic attitude to the usefulness of treatments and are willing to try any approach which appears to work.

A second argument concerns the idea that traditional Chinese health beliefs do not recognise the existence of mental health problems. In fact, TCM is basically holistic and pragmatic: it does not make a hard-and-fast distinction between psychological and physiological processes, not does it prioritise either one of them. It is certainly concerned

with psychological issues, because it relies on behaviour and experience as well as physiological observations for diagnosis and therapeutic action.

Furthermore, emotions are regarded as important etiological factors for illness (Wang et al., 2010; Lin, 1981). Chinese generally consider only severe disturbances such as psychosis to be diseases; mood disturbances or other deviations are regarded as departures from an optimal state of balance (Luk & Bond, 1992). At the same time, TCM places a high value on the moderation and inhibition of affective expression as a way of maintaining balance. It advocates the use of meditation to learn how not to respond to disturbing stimuli with excessive emotions. In combination with Confucianism, TCM stresses equanimity and legitimates suppression of emotion as an adaptive coping mechanism. Under the influence of these traditional cultural values, Chinese may be inclined to seek harmony with their environment and to strive to avoid excesses of emotions (Lin, 1981). This tendency may give the impression that Chinese are 'not psychologically-minded' (Russell & Yik, 1996; Lin, 1980; Tseng, 1975).

However important 'traditional' beliefs may remain, we should not overlook recent social and cultural changes and medical developments in the formation of Chinese health beliefs. Most importantly, alongside folk traditions and TCM, Western medical practices took root in China in the nineteenth century and have become the mainstream medical care system in some Chinese-speaking regions – China, Taiwan and Hong Kong (Leung & Lee, 1996). In present-day China and Taiwan, traditional and modern systems of health care exist side by side and are used in conjunction or alternation with each other (Ministry of Health and Welfare Taiwan [MHW], 2013; State Administration of TCM, 2011). Luk and Bond (1992) found that modern Chinese regard environmental, hereditary and social or personal factors as the main causes of mental illness, which does not fundamentally differ from the Western 'biopsychosocial' perspective. The study by (Yang et al., 2009) showed that Chinese Americans viewed psychiatric conditions as distinct from physical disorders; TCM use was regarded as less effective for psychiatric illnesses when compared with physical illnesses.

Influence of 'Chinese somatisation' on mental health service utilisation

Another argument relates specifically to the issue of 'Chinese somatisation'. As we saw above, the holistic Chinese conception of mind and body, the tendency to suppress emotions and the assumed lack of vocabulary to express emotions have all been regarded as contributing to the 'somatisation' of mental distress. However, the following two Canadian studies found that Chinese respondents did not show a tendency to mask psychological or emotional distress through somatisation, as many other studies have suggested. Dere et al. (2013) reported that while Chinese Canadians reported more somatic and fewer psychological depression symptoms than Euro-Canadians, they also spontaneously reported 'depressed mood' at similar levels as Euro-Canadians. The finding is contrary to prevailing ideas about Chinese unwillingness to discuss depression. Wong and Tsang (2004) argued that in the literature regarding somatisation among Asian

groups, researchers start from a Western perspective and overlook messages conveyed in ways that are appropriate or idiomatic in Asian cultures. At the same time, Mak and Zane (2004) suggested that somatisation might be a physical stress response evoked by increased distress severity and psychosocial stressors rather than a cultural response to express psychological problems in somatic terms.

Influence of acculturation on mental health service utilisation

Last but not least, some researchers have claimed that acculturation to Western culture is linked with favourable attitudes toward psychological treatments among Chinese migrants. Those with higher levels of acculturation may be more inclined to accept Western beliefs about mental health (Chen & Mak, 2008; Lai & Chau, 2007; Zhang & Dixon, 2003). However, Kung (2004) did not find a significant relation between acculturation level and perceived cultural barriers to mental health care utilisation. On the other hand, a higher level of acculturation was associated with fewer practical barriers, such as language problems, not knowing how to access mental health care and lack of insurance coverage. In other words, acculturation was not an advantage because it changes people's health beliefs, but because it reduced practical barriers to accessing care.

4.3.3 Chinese in the Netherlands and mental health care

Although the Chinese community has existed in the Netherlands for a hundred years, very little information is available about their state of health. The only national survey concerning Chinese and their health was carried out by the Netherlands Institute for Social Research (SCP) (Gijsberts, Huijnk, & Vogels, 2011). This survey reported that average levels of self-reported physical and mental health among Chinese were similar to those reported by the ethnic majority Dutch population (see Table 4.1). However, these figures were not age-standardised; and within the older age group (45-64), mental health was reported to be somewhat less good. Because these results were based on self-reported health levels, which may be subject to problems of cross-cultural validity, we do not know whether this result would also be found if other methods of measuring the prevalence of health problems were used. Hardly any data based on other methods are available. In contrast to the main minorities (Turkish, Moroccan, Surinamese and Antillean), research has only been conducted so far on the Chinese minority's health-seeking behaviour and health service utilisation, mainly with respect to mental health (Blaak & Huijbregts, 2004). Nonetheless, the limited amount of research that has been carried out indicates that there is a need for mental health care among Chinese and that service delivery for them is far from optimal.

Table 4.1 Self-reported physical and mental health in 2009. Scale from 1 to 100; the higher score, the better health (Schellingerhout, 2011)

	Physical health		Mental health	
	Chinese	Native Dutch	Chinese	Native Dutch
15-24 years old	93,1	89,9	84,4	96,4
25-44 years old	90,0	88,2	91,4	91,9
45-64 years old	77,2	80,6	87,8	93,8

Several actors may impair mental health among ethnic Chinese in the Netherlands. The long hours of work and the isolated working environment in the Chinese catering business can bring risks to mental health (Liu et al., 2008; Rijkschroeff, 1998). Gambling addiction among Chinese is also a problem: after the long working hours, going to the casino for gambling is often the only entertainment available. Casinos are often a social meeting point. This tradition may be passed over from the older generation to younger family members. Gambling addiction can also lead to family problems (Liu et al., 2008; Ministerie van Volksgezondheid, Welzijn en Sport [VWS], 1999; Vogels, 1999, p. 168). Moreover, in the traditional Chinese family married women are expected to raise children and to focus on the household. These women often speak little Dutch and have very few social contacts with outside world. In addition, traditional parenting styles and the value attached to 'filial piety' (see also Chapter 2, p. 30) can cause communication problems or conflicts between generations (Liu et al., 2008; Tang & Tjon, 2006).

According to the SCP report mentioned above, while Chinese migrants' self-reported physical and mental health is on the same level as that of the native population, those in the age group 45-65 years old felt mentally less healthy and less happy than Dutch nationals (Schellingerhout, 2011). Studies also show that Chinese make less use of Dutch health services in general, such as general practitioners or Community Health Services (Gemeentelijke of Gemeenschappelijke Gezondheidsdienst; GGD), than the native population (Schellingerhout, 2011). Although there are no separate studies of mental health service utilisation, Chinese patients have been found to present more serious symptoms at the first appointment in clinics (Geense, 2003). There seem to be barriers to utilisation of both general and mental health care services among Chinese in the Netherlands, preventing them from reaching professional help or causing them to delay seeking it. At the same time, mental health professionals also report difficulties in the care of Chinese patients (Liu et al., 2008).

Regarding the potential factors affecting general and mental health care among this group, Smits, Seeleman, Van Buren, and Yuen (2006) interviewed elderly Chinese and found indications that more knowledge about mental health and better services were needed. In addition, language barriers and cultural beliefs seemed to undermine the use of mental

health services (Liu et al., 2008). Lack of financial resources and time has also been identified as a barrier to seeking help among Chinese in the Netherlands, who are often self-employed or in low-paid jobs (Rijkschroeff, 1998). The Trimbos Institute has further suggested that fear of losing face is an important factor deterring Chinese from seeking help for gambling addictions (Algra, 2001). Unlike the Chinese community in the USA or Canada, the Chinese community in the Netherlands does not contain many physicians of Chinese descent, especially psychiatrists. Very few social workers or psychologists can speak Chinese. Although mental health care professionals working with the Chinese community may recommend using an interpreter or a mediator with Chinese background (Liu et al., 2008), the interpreter may be unable to translate the dialect which the client uses because of the diversity of languages and dialects used by Chinese migrants. The shortage of appropriate interpreters or mediators often means that contacts with professionals turn out to be a wasted opportunity, since health professionals cannot rely on the quality of the interpretation. Often children or other family members are burdened with the interpretation work (Liu et al., 2008). However, some Chinese of the second generation have completely lost their mother tongue – one out of five does not speak Chinese (Gijsberts, 2011a). The quality of their interpretation skills is doubtful (see e.g. Zendedel & Meeuwesen, 2013).

The research described above implies that mental health service delivery to this group is far from optimal. However, there is not much insight into the exact nature of this problem. What factors are discouraging this group from using mental health services? What are the experiences of those who do use the services? Are they satisfied with them? If not, what are the reasons? Are the barriers which impede the use of mental health services cultural or practical in nature?

The present thesis sets out to answer these questions. The empirical studies reported focus on the adequacy of Dutch mental health service delivery to Chinese in the Netherlands. The following three chapters examine in turn barriers to using health care in general, beliefs about mental illness, and the experience of using Dutch mental health care.

Chapter 5

Barriers to health care for Chinese in the Netherlands

This chapter is co-authored by David Ingleby and Ludwien Meeuwesen. This chapter has been published as:

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Abstract

This study examines utilisation of the Dutch health care system by Chinese people in the Netherlands as well as their attitudes to the system, paying special attention to mental health. Information was gathered by semi-structured interviews (n=102). The main issues investigated are access, help-seeking behaviour, and quality of care.

Results showed that most respondents used Dutch health care as their primary method of managing health problems. Inadequate knowledge about the system and lack of Dutch language proficiency impedes access to care, in particular registration with a General Practitioner (GP). Users complained that the care given differed from what they expected. Results also showed that the major problems are to be found in the group coming from the Chinese-speaking region.

Western concepts of mental health appear to be widely accepted by Chinese in the Netherlands. However, almost half of our respondents believed that Traditional Chinese Medicine or other methods can also help with mental health problems.

The provision of relevant information in Chinese appears to be important for improving access. Better interpretation and translation services, especially for first generation migrants from the Chinese-speaking region, are also required.

Keywords: access to health care, acculturation, Chinese, culture, family doctor, general practitioner (GP), health care utilisation, help-seeking behaviour, mental health, quality of care.

5.1 Introduction

The Chinese population in the Netherlands, as in many other countries, has increased greatly in the last ten years. This population is currently approaching 100,000 (CBS 2010; Liu et al., 2008), making it the fourth largest ethnic minority in the country as well as one of the longest-established. In this article we include in the category 'Chinese' not only persons originating from the Chinese-speaking region (mainland China, Hong Kong, Macau and Taiwan), where Chinese culture is dominant, but also those coming from overseas Chinese communities in (for example) Indonesia or Surinam. We also include children of migrants who were born in the Netherlands, i.e. the second generation.

Traditionally, Chinese have had a reputation for keeping themselves to themselves; they are often assumed to solve their problems within their own community. Language barriers have also hampered contact with Dutch society (Liu et al., 2008; Vogels, 1999). For all these reasons, Chinese remain an invisible minority to most Dutch people and up to now little research has been done on them, in particular regarding their health. This article reports an investigation into the attitudes of this group towards the Dutch health care system and the factors influencing their willingness to make use of it.

In the Dutch health care system, the general practitioner (GP) functions as a 'gatekeeper' to specialist services (Ministry of Health, Welfare and Sport, 2009). Our main interest in this study was in mental health care, but since this is fully integrated within the general health care system and is only accessible through the GP, we also asked questions about health care in general.

Mental health services in the Netherlands are financed from the social health insurance system, in which participation is compulsory for all residents. For some treatments, a partial contribution from the patient is required. Out-patient services are provided by a network of community mental health care centres, backed up by in-patient services.

Research in many countries has shown that Chinese people are less likely than other ethnic groups to utilise mainstream health services and has identified some of the barriers to uptake (Chen, Kazanjian, & Wong, 2009; Ministry of Health, Welfare and Sport, 2009; Chen, Kazanjian, & Wong, 2008; Tiwari & Wang, 2008; Fung & Wong, 2007; Quan et al., 2006; Chen & Kazanjian, 2005; Gary, 2005; Li, Logan, Yee, & Ng, 1999). In the Netherlands, however, very little is known about the use of health services in general, and mental health care in particular, by this group. Geense (2003) and Liu et al. (2008) reported that while it is unclear whether Chinese use mental health care less than other ethnic groups, there are indications that care delivery for them is far from optimal. To be able to provide more appropriate care for this group it is first necessary to understand the factors which may impede their use of the existing services.

The aim of this exploratory study was therefore to gain insight into the attitudes of Chinese in the Netherlands to the Dutch health care system, paying particular attention to mental health. What factors influence their willingness to make use of the system? What are their beliefs concerning mental health? Information was gathered by semi-structured

interviews. Before describing the study we will briefly discuss the main issues it deals with: access, help-seeking behaviour, and quality of care.

5.1.1 Access

Access to health services has two main ingredients: entitlement to use the services, and the accessibility of services in terms of how easily they can be located and how many barriers to their use are experienced. Entitlement to use Dutch health services is restricted to legal residents who have paid the compulsory health insurance contributions. Undocumented migrants, although not allowed to join the insurance system, may receive government-subsidised health care if they are unable to pay costs themselves. However, many appear not to know this.

Accessibility can be broken down into several components. To start with, people must identify themselves as having a problem that can be helped by the available services. Differences in health-seeking behaviour may thus result from divergent beliefs concerning illnesses, their causes and treatment; Kleinman's concept of 'explanatory models' (1978) was developed to explore such beliefs. Explanatory models among Chinese may be strongly influenced by Traditional Chinese Medicine (TCM). Secondly, people need knowledge about the health care system and skills for obtaining help from it ('health literacy'). For example, those who are unfamiliar with the system may have difficulty getting past gatekeeper agencies such as general practitioners, resulting in over-utilisation of crisis or emergency services (Harmsen et al., 2008; Wachtler, 2005).

Another important barrier to access is lack of trust. If people do not trust the services, they will be inclined to seek help only when absolutely obliged to – for example in an emergency or in advanced stages of illness (Manfellotto, 2003). They may suppress or hide their problems, resort to traditional healers and self-medication, or return to their home country for treatment (Engelhard, 2007; Stronks, 2001).

Perhaps the most serious barriers to access are formed by communication problems (Meeuwesen, Twilt, ten Thije, & Harmsen, 2010). Unless health services provide effective ways of overcoming such problems they can lead to inaccurate diagnoses, non-compliance with treatment and inappropriate use of services (Harmsen et al., 2008; Liu et al., 2008; Pachter, Auinger, Palmer, & Weitzman, 2006). It is important that both parties understand not only each other's words, but also their perspectives and expectations.

5.1.2 Help-seeking Behaviour

Help-seeking behaviour will be influenced by the barriers to access which migrants encounter. Chinese in the US and UK show several different patterns of health-seeking behaviour (Green et al., 2006; Ma, 1999): either self-treatment and home remedies, or combinations of Western and traditional health services, or exclusive utilisation of either Western or traditional Chinese treatments.

Regarding mental health, Fang and Schinke (2007) found that a high percentage (84%) of Chinese migrants in the US attending a community mental health service used complementary therapies. Research on Chinese migrants in British Columbia has reported that demographic characteristics (age, place of origin, educational level and marital status) influence the utilisation of mental health care (Chen, Kazanjian, & Wong, 2008). Chen et al. (2009) found an association between language proficiency and mental health care utilisation. Chung (2010) mentioned shame and stigma as important barriers to help-seeking, while Fung & Wong (2007) suggested that explanatory models of mental illness and the perceived availability of appropriate services determined the readiness to use mental health services.

In the Netherlands, Liu et al. (2008) found that language barriers and lack of knowledge about the services available were major factors discouraging Chinese from using mental health services. Other cultural barriers were the pervasive stigma attached to mental health problems, differences in communication style, the tendency to conceal problems, different ideas about appropriate help, and distrust of mental health care professionals.

Hsiao et al. (2006) suggested that Chinese-Americans lacking English proficiency were more likely to use complementary and alternative medicine than Chinese-Americans who were proficient in English. At the same time, Chinese-Americans who immigrated more than 10 years ago were less likely to use complementary medicine alongside Western health care than Chinese-Americans who were born in the USA. Like Ying and Miller (1992), these researchers suggested that acculturation was an important predictor of help-seeking behaviour. In the present research, we examined the effect of length of residency in the Netherlands and three other acculturation-related factors: self-labelling of ethnicity, Dutch language proficiency, and social contacts with Dutch people.

5.1.3 Quality of Care

The perceived quality of available health services is another factor influencing the readiness of users to seek help (Andersen, 2008). Research into the quality of health care for migrants and ethnic minorities (Fortier & Bishop, 2003; Harmsen et al., 2008; Lasser, Himmelstein, & Woolhandler, 2006) studies its effectiveness in terms of outcomes, the satisfaction of both users and health care workers, and the extent to which the treatment process was properly carried out, avoiding therapy non-compliance and dropout. All these aspects of good care are undermined by poor communication (Flores, 2006; Green et al., 2005). Clients with a migrant background are often perceived by professionals as making inappropriate, incoherent, or ill-formulated requests – while from the point of view of these clients the professional listens poorly, lacks insight into the problem and proposes inappropriate or irrelevant solutions (Dayib, 2005).

Using the concepts discussed above, the following research questions were formulated: What is the respondents' level of acculturation? How easy is their access to health care?

What are their help-seeking tendencies? What are their attitudes to Dutch health care and to issues concerning mental health?

5.2 Methods

5.2.1 Subjects and procedure

The present study can be characterised as 'mixed-methods' research because quantitative data were supplemented by qualitative data from open-ended questions. We examined both the statistical associations of behaviour and attitudes, and the reasons or explanations given by respondents. The semi-structured questionnaire used in this study was prepared in both Chinese and Dutch versions and contained six sections: demographics, acculturation, access to health care, help-seeking tendencies, opinions about Dutch health care, and mental health issues. Before use, the questionnaire was tested and fine-tuned in a pilot study with 10 Chinese respondents.

Five interviewers were employed (including the researcher), each of whom was proficient in at least one of the following: Dutch, Mandarin and Cantonese. In this way it was possible to interview all respondents in their preferred language or dialect. Although the questionnaire was self-administered, the interviewers were available to assist the respondents with difficulties in understanding or answering the questions.

The sample consisted of Chinese residing in the Netherlands and originating from the Chinese-speaking region (defined here as mainland China, Hong Kong and Taiwan) or overseas Chinese communities. The latter group are recognised by the Council of the Chinese Minority in the Netherlands (Inspraakorgaan Chinezen) as members of the Chinese minority in the Netherlands (Inspraakorgaan Chinezen [IOC], 2010).

Respondents were recruited in shopping areas of 'Chinatowns' or in the vicinity of large Chinese supermarkets in Amsterdam, The Hague, Rotterdam and Utrecht (the cities in which half the Chinese in the Netherlands live) (Kullberg, 2011). These areas are visited by Chinese people, even those living in other parts of the Netherlands, for shopping and social events. Interviewers approached potential respondents on the street and 53% were willing to cooperate (n=102). To ensure a reasonably representative sample, researchers approached equal numbers of men and women and aimed at a wide age range. Each interview took 10 to 15 minutes and data were collected anonymously.

5.2.2 Measures

The topics covered in the six sections of the interview are described here in more detail.

Demographic information

Background variables included age, gender, civil status, education, region of birth, mother tongue, migration generation, reason for migration, age of migration to the Netherlands and length of residence.

Civil status: This comprised five categories: married, partnered, single, separated and widowed. This was recoded as 'partnered' (including married or partnered) and 'not partnered' (single, separated or widowed).

Education: This was determined by the highest education completed either in the Netherlands or in the region of origin. The answers were grouped into three categories: (1) primary school or lower, (2) secondary or lower vocational education, and (3) higher education.

Region of birth: This included 9 categories (China, Hong Kong, Taiwan, the Netherlands, Indonesia, Suriname, Malaysia, Singapore and 'other regions'). China, Hong Kong and Taiwan are defined as the Chinese-speaking region, while Indonesia and Suriname are former Dutch colonies. The variable was recoded into four categories: Chinese-speaking region, former Dutch colonies, 'other regions' and the Netherlands.

Mother tongue: This question was open-ended. When the mother tongue of the respondent was Chinese, details of the dialect were asked for.

Migration generation: Two groups were formed: (1) First generation (born outside the Netherlands) and (2) Second generation (born in the Netherlands). None of the respondents were from the third or later generations.

Reason for migration: Answers to this open-ended question were grouped into five categories: family reunification or formation, economic migration, study, political factors, and 'other reasons'.

Length of residence in the Netherlands: this was measured in years.

Acculturation factors

Three aspects of acculturation were measured: self-labelling of ethnicity, Dutch language proficiency and social contacts with Dutch people.

Self-labelling of ethnicity: Respondents were asked which ethnicity they used to describe or introduce themselves to other people. Answers were coded as Chinese, Dutch, mixed ethnicity or other ethnicity. Mixed ethnicity could combine Chinese, Dutch or other ethnicities.

Dutch language proficiency: Respondents assessed their own proficiency in reading, writing and speaking Dutch. Answers were coded using a 4-point scale: none (0), poor (1), moderate (2) and good (3). Because of the high degree of intercorrelation between

these three variables (α=0.97), a summary variable (Dutch proficiency) was created using the mean of all three.

Social contacts: Two questions were asked: "Which ethnic background do most of your friends have?" and "What is the frequency of your contact with native Dutch?" Answers to the first question were coded as Chinese, Dutch, mixed ethnicity or other ethnicity. The options for the frequency of contact with native Dutch were 'seldom', 'sometimes' and 'often', based on the respondents' self-perception.

A positive correlation was found between the variables 'Dutch language proficiency' and 'frequency of contact with native Dutch' ($r = 0.56$, $p < 0.01$).

Access to Health Care

Questions on this subject related to entitlement, accessibility and utilisation of Dutch health care.

Entitlement: Respondents were asked if they had health insurance. If the answer was 'no', interviewers asked what the reason was.

Accessibility of Dutch health care: Two items were included: (1) whether respondents had received information about the Dutch health care system, (2) whether they were registered with a general practitioner (GP).

Utilisation of Dutch health care: Respondents were asked whether they had ever used Dutch health care.

Help-seeking tendency

Respondents were asked which form of care they usually used for regaining health. The options were: Dutch health care, TCM, both of these, or other kinds of care. Respondents who used other kinds of care were asked to give further details. A new variable 'Tendency to seek help from the Dutch care system' was made, contrasting positive attitudes to seeking help from the Dutch system (whether or not in conjunction with other forms of treatment) with negative ones.

Opinions about Dutch health care

Respondents were asked whether or not they had difficulties in using Dutch health care. An open-ended question asked for their opinions about Dutch health care and the ways in which it could be improved for Chinese migrants.

Mental health issues

This section comprised three questions: (1) Is Dutch (Western) health care helpful for problems related with mental health? (2) Are there other ways of dealing with mental health problems? (3) What kind of care would you suggest for family or friends who have mental health problems? The response alternatives were 'Yes', 'No' and 'Don't know/not applicable'. Respondents were asked to give further details to clarify their answers.

5.2.3 Analysis

Relationships between the quantitative variables were examined using parametric and non-parametric tests of bivariate association. Because of the moderate sample size, only limited multivariate analyses could be used. In the presentation of results only significant differences will be mentioned.

5.3 Results

5.3.1 Demographics and migration background

Table 5.1 shows the characteristics of the research sample. Four groups are identified: three first generation groups (born in the Chinese-speaking region, former Dutch colonies or other regions) and the second generation (born in the Netherlands). Eighty-two percent of respondents belonged to the first generation and 18% to the second. The majority (69%) came from the Chinese-speaking region.

Respondents' ages varied widely, from 17 to 79 (M = 39, SD = 16). The mean age of the four groups varied considerably; the average age of migrants from former Dutch colonies was 59, while second-generation Chinese who had grown up in the Netherlands were less than half as old. Women comprised the majority of the latter two groups, while the second generation was better educated than the first. Comparing these data with figures for the Dutch population revealed a increased proportion with the lowest and the highest levels of education, with fewer in between ($X^2 = 28.11$, df = 3; $p < 0.01$).

For most respondents (83%) Chinese was their mother tongue. Five different dialect groups were spoken: Mandarin (official spoken Chinese), Yue (Cantonese), Wu, Hakka and Min. Other mother tongues were Dutch (11%) and Indonesian (5%).

About half the respondents (47%) had lived in the Netherlands for more than 20 years. People who had lived in the Netherlands for less than five years comprised 18% of the research group. The main reasons for migration were family reunion or formation (48%) and economic migration (24%). Four percent had migrated because of the political situation in their country of origin.

Table 5.1 Characteristics of different subgroups

		First generation			Second generation	
		Chinese-speaking region* (N=70)	Former Dutch colonies (N=9)	Other (N=5)	The Netherland (N=18)	Whole sample (N=102)
Demography	Mean age	40	59	44	28	39
	% female	50	78	60	67	56
	% partnered	39	56	40	89	49
	Education (1–3)	2.0	2.1	2.2	2.5	2.1
	% mother tongue: Chinese	100	11	60	61	83
Acculturation factors	Dutch proficiency (0–3)	1.2	2.6	2.3	2.9	1.7
	Contact with Dutch (1–3)	2.2	3.0	2.6	2.9	2.4
Access	% with health insurance	90	100	100	100	93
	% received information about health care	40	56	40	67	46
	% registered with GP	79	89	100	100	84
Utilisation	% used Dutch health care	77	89	100	94	82
	% seek help Dutch care	80	100	100	94	85
Opinions on health care	% difficulty using care	49	11	40	17	40
	% thinks room for improvement**	82	60	100	50	75
Attitudes towards mental health	% confidence Mental Health care**	77	75	80	89	79
	% belief in alternatives**	60	50	60	75	62
	% recommend Mental Health care**	84	100	80	88	86

* Includes China, Hong Kong, and Taiwan
**Percentage of saying “yes” among the respondents who gave a “yes/no” answer.

Half of those arriving since 2000 came in order to study. None of those who migrated to the Netherlands before that year came for this purpose. The average educational level of those arriving since 2000 was also considerably higher than that of earlier migrants (means: 2.39 vs. 1.79, t (79) = 3.85, p <0.001). These findings reflect a marked change in the character of recent Chinese migration to the Netherlands.

5.3.2 Acculturation factors

Most respondents born in the Chinese-speaking region described their own ethnicity as Chinese (91%), while most born in the Netherlands or former Dutch colonies described it as mixed (42% and 52%). Whereas 82% of the respondents from the first generation referred to themselves as Chinese, only 20% from the second generation did so.

Considerable differences in mean Dutch proficiency scores were found between the different regions in which respondents were born, ranging from 1.16 for the Chinese-speaking region to 2.94 for the Netherlands. Respondents from former Dutch colonies scored almost as well (2.62) as those born in the Netherlands. The 5 respondents born in other countries also had fairly high scores (2.27). The scores of respondents born in the Netherlands were significantly higher than those born in the Chinese-speaking region (t (85.9) = 14.8, p <0.001). Table 5.2 shows the intercorrelations between the variables relating to demographics, acculturation factors and utilisation of health care.

What determines the level of Dutch language proficiency among the group born in the Chinese speaking region? Stepwise multiple regression analysis showed that gender, educational level, age, and the length of time people had been living in the Netherlands did not significantly affect language proficiency. A higher age on arrival in the Netherlands, as well as coming to the Netherlands for purposes of study, had a negative influence on Dutch language proficiency; the frequency of contact with Dutch had a positive influence. The main determinant was the age at which respondents had migrated to the Netherlands (ß = -.047, p <0.001). The second most important factor was whether they had come for study or for other purposes. Students appeared to make little effort to learn Dutch, perhaps because they did not expect to stay in the country (ß = -.800, p <0.001).

Finally, the frequency of contact that respondents had with native Dutch also increased their language proficiency (ß = .329, p = 0.002), though this influence was probably in both directions. These results should, however, only be regarded as tentative, as the sample on which they are based (N = 70) is relatively small.

Table 5.2 Intercorrelations (Pearson) between the demographic, acculturation and utilization of health care (n=102)

Variables	Age	Gender	Partnered	Education	Migration generation	Age on arrival in NL	Dutch proficiency	Contact with Dutch	Information received about Dutch care	Registration with a family doctor (GP)	Use of Dutch healthcare	Difficulty in using Dutch healthcare
Age	1.00											
Gender (1 = M, 2 = F)	.13	1.00										
Partnered (0 = no, 1 = yes)	.44**	−.08	1.00									
Education	−.48**	.04	−.30**	1.00								
Migration generation	−.34**	.09	−.36**	.27**	1.00							
Age on arrival in NL	.58**	.08	.36**	−.20	.32**	1.00						
Dutch proficiency	−.20*	.23*	−.31**	.23*	.59**	−.44**	1.00					
Contact with Dutch	−.40**	.10	−.32**	.30**	.33**	−.34**	.56**	1.00				
Information received about Dutch health care	.07	.23*	.00	.04	.19	.15	.21*	.08	1.00			
Registration with a GP	.17	.21*	.01	−.12	.21*	−.09	.47**	.16	.24*	1.00		
Use of Dutch care	.27**	.21*	.11	−.22*	.10	.02	.25*	.02	.27**	.51**	1.00	
Difficulty in using Dutch health care	.30**	.02	.28**	−.08	−.25*	.34**	−.35**	−.32**	.10	−.12	.04	1.00

* P < 0.05 (2-tailed).
** *P* < 0.01 (2-tailed).

5.3.3 Access to health care

Entitlement

Only seven respondents had no health insurance. All were men who had migrated from the Chinese-speaking region since 1990. Compared to other men in this category, they were less well educated ($t(42) = -2.00$, $p = 0.05$). One of them mentioned financial reasons for not taking out insurance, while another considered insurance unnecessary because he seldom used Dutch health care. The remaining five were undocumented and not allowed to take out insurance.

Accessibility of Dutch health care

Knowledge of the Dutch health care system: Less than half of the respondents (46%) had received information about how to use the Dutch health care system. Sources of information included health insurance companies, health care providers (including municipal health centres), official brochures, school, work or the media.

Female respondents were significantly more likely than males to report having received information (56% vs. 33%; $X^2 = 5.27$, $df = 1$, $p < 0.05$). Respondents who grew up in the Netherlands or a former Dutch colony were also more likely to have received information than those coming from the Chinese-speaking region or other countries (62% vs. 40%; $X^2 = 4.17$, $df = 1$, $p < 0.05$). Interestingly, there were no associations with any acculturation variables.

Registration with a GP: Sixteen percent of respondents reported that they had not registered with a GP. Reasons given included lack of insurance; lack of information about how to find a GP and get registered; no idea about the function of the GP (using emergency care instead). In some cases the workplace or school had organised a clinic centre for primary care.

Those who registered with a GP were slightly more likely to have received information about the use of Dutch health care than those who did not (51% vs. 19%; $X^2 = 5.70$, $df = 1$, $p < 0.05$). The Dutch proficiency of those who did not register was very low (0.48 vs. 1.88; $t = -5.33$, $p < 0.01$).

Utilisation of Dutch health care

Eighteen percent of respondents ($N = 18$) had never used the Dutch care system. There was a high degree of overlap with the group who had not registered with a GP; however, 21% of those who had registered with a GP had never used health care.

Using the system was more common among elderly people ($r = 0.27$, $p < 0.01$), among women rather than men (73% vs. 90%; $X^2 = 4.51$, $df = 1$, $p < 0.05$) and people with more education ($r = -0.22$, $p < 0.05$). People who had been in the Netherlands longer ($r = 0.42$,

p <0.01), had better Dutch proficiency (r = 0.25, p <0.05), and had received information about the system (82% vs. 55%; X2 = 7.61, df = 1, p <0.01) were more likely to use Dutch health care as well.

5.3.4 Help-seeking tendency

Most respondents (73%) sought help only from the Dutch health care system, 4% used only TCM and 13% used both. The other respondents (11%) said they preferred to help themselves, for example by buying medicines over the counter. There were no significant associations with demographic or acculturation variables.

A new variable was made contrasting those with positive attitudes to seeking help from the Dutch health system (perhaps in conjunction with other forms of treatment) with those who had negative attitudes. Only 15% of the sample had negative attitudes. Their Dutch proficiency was extremely low in comparison with those who had positive attitudes (0.56 vs. 1.85, t (25.5) = 6.06, p >0.001). Moreover, a lower percentage had health insurance (60% versus 99%, p < 0.001 by Fisher's exact test) and was registered with a GP (40% versus 92%, p <0.001 by Fisher's exact test).

5.3.5 Opinions about Dutch health care

A substantial proportion of the respondents (40%) said they had difficulties in using the Dutch care system. They named problems such as language barriers, long waiting times and procedures, diverging health concepts and discrimination. A few people reported that due to their lack of Dutch proficiency, GP's did not want to take the time to explain the diagnosis or treatments to them. All respondents who mentioned language barriers had labelled themselves as Chinese, and most of them (71%) originated from the Chinese-speaking region. Respondents from the second generation (X^2 = 6.31, df = 1, p <0.05) and those with better Dutch proficiency (r = -.35, p <0.01) were less likely to report difficulties.

Seventy-five percent of those who gave yes/no answers believed there was room for improvement in Dutch health care for Chinese. Half of them mentioned the provision of interpretation or translation services. Other suggestions included reducing waiting lists, offering walk-in services, increasing the cultural sensitivity of health workers and providing information for Chinese people about Dutch (Western) medical concepts.

Some of those who did not think there is room for improvement said they thought it unlikely that the system would be adapted just for the benefit of a small group of users. A female respondent from Indonesia suggested that Chinese health care users should try to improve their Dutch proficiency instead of asking for additional language facilities.

5.3.6 Mental health issues

When asked if they had confidence that Dutch (Western) mental health care could help people with mental illness, 20% of the respondents said that they did not know or that the question was not applicable. Of those who did give a definite answer, 79% said 'yes'. Second-generation Chinese were more likely to say 'yes' (90%) than first-generation (76%).

Sixty-two percent of those giving yes/no answers thought that there are alternative methods of helping with mental health problems besides Dutch mental health care. These methods included both traditional Chinese remedies and general ones such as social support.

Regarding the willingness to recommend seeking help for mental health problems (not necessarily from Dutch mental health care), 86% of the 89% who gave a definite answer said they would suggest their relatives or friends seek help if they thought it was needed. Those answering 'yes' to this question had a higher level of education than those answering 'no' ($t(87) = 2.19$, $p < 0.04$).

Fifty-seven percent of respondents had relatives or friends with mental health problems or had themselves experienced issues related to mental health problems in the Netherlands.

5.4 Discussion and conclusions

This study set out to examine the utilisation of health care services by the Chinese minority in the Netherlands and this group's attitudes concerning health, paying particular attention to mental health.

Table 5.1 shows that there are three groups of first-generation migrants, originating from the Chinese-speaking region, former Dutch colonies and other countries. The latter group was too small for statistical analyses, but there was a clear difference between the first two in terms of age and acculturation variables. Migrants from former Dutch colonies were older and had better Dutch language proficiency than those from the Chinese-speaking region. They were also more likely than the latter group to identify themselves as being of mixed ethnicity. Many of them would have made acquaintance with Dutch language and culture before migrating.

A fresh wave of young migrants from the Chinese-speaking region, with a higher average level of education, arrived from 2000 onwards. Half of them came for purposes of study. The second generation, born in the Netherlands, had the highest level of education and were mostly very well acculturated. These findings reflect the immigration patterns described by Cheung and Lam (Cheung & Lam, 2006).

5.4.1 Access to health care

Data on health care utilisation and attitudes showed that the major problems are to be found in the group coming from the Chinese-speaking region. This group contains all of those with no health insurance, as well as most of those who had received no information about Dutch health care, were not registered with a GP, and did not use the Dutch health system. All these characteristics were associated with low levels of Dutch language proficiency (cf. Liu et al., 2008). This proficiency, in turn, was associated with the age at which migrants had arrived in the Netherlands, their frequency of contact with native Dutch, and whether or not they had come to study.

Lack of information about the Dutch health care system was also a barrier to utilisation. Particularly for newcomers, better provision of information about health and health care in Chinese would appear to be important for improving access. Vogels et al. (1999) emphasise that learning Dutch is crucial for the integration of Chinese immigrants.

Despite these problems of entitlement and health literacy, most respondents stated a preference for Dutch health care as their main way of managing health problems. There was no evidence of differences in health-seeking tendencies as a function of age, sex, education level or length of residence in the Netherlands.

Nevertheless, 39% of respondents reported difficulties in using the system. These were mainly associated with lack of Dutch proficiency. Language barriers need to be addressed energetically (Harmsenet al., 2008; Bischoff et al., 2003). Chen et al. (2009) suggested that language is functioning as an indicator of cultural differences and go on to discuss possible cultural barriers to service uptake. However, the findings we report suggest that the main barrier to access in their study may simply have been lack of language proficiency.

Many of those affected are relatively old and not well equipped to improve their language skills. Better interpretation and translation services are clearly required; the employment of more Chinese health workers would go some way to reducing both linguistic and cultural barriers. Respondents also complained about long waiting time and discrimination. Waiting lists are a problem that affects everybody.

5.4.2 Attitudes towards mental health care

It is certainly not the case that Chinese do not recognise the existence of mental illness. Nevertheless, it is known (Mak, Poon, Pun, & Cheung, 2007) that mental illness is associated with stigma for Chinese people and this may present a major obstacle to receiving help. In the present study, however, we did not get the impression that mental health problems were heavily stigmatised by our respondents. Most of them seemed to feel comfortable talking with us about mental health and said they were willing to talk about it with relatives and friends.

Western methods of treating mental illness appear to be widely accepted by Chinese in the Netherlands, as indeed they are in the Chinese-speaking region itself. However, 62% of the respondents who answered the question believed that there are also other ways of dealing with mental health problems. This 'health pluralism' is a common phenomenon in developing countries, but it is also found in Western societies, where 'alternative therapies' and self-help account for a large proportion of all health expenditure (Bodeker & Ong, 2005).

This study suggests that Chinese with a higher level of acculturation – in particular, better Dutch language proficiency – have better access to Dutch health care and make more use of it; however, this does not necessarily mean that they abandon a belief in traditional Chinese or other forms of help. This is in line with the USA study of Hsiao et al. (2006), and the British study of Green et al. (2006), which showed that acculturated Chinese mostly drew upon two medical systems, conventional medicine and TCM.

5.4.3 Limitations of this study

In this study it was not possible to compare Chinese with any other ethnic groups. Nor was any information collected on the nature or prevalence of health problems (mental or otherwise).

The recruitment of respondents on the streets of Chinatowns frequently visited by Chinese for daily shopping and social events may have deprived us of the opportunity to gather ideas from people working during the daytime, especially those working in the restaurant business. In addition, it will have led to under-representation of those who do not visit Chinatowns, who may be more acculturated than those who do.

Finally, although the sample size was large enough to reveal many significant effects, a larger sample would make it possible to use more advanced multivariate analyses (e.g. path analysis) in order to disentangle the relationships among variables. In-depth qualitative studies of how Chinese deal with their mental health problems are also required in order to shed more light on the question of how to provide more accessible and appropriate services for this group.

5.4.4 Conclusion

Despite its limitations, the present study shows that access to health care for Chinese in the Netherlands is closely linked to their proficiency in Dutch. The 'Chinese community' comprises several different populations with different demographic and cultural characteristics. The group with the greatest problems of access to health care are those who have migrated from the Chinese-speaking region during the last two decades.

Cultural differences in relation to health certainly exist, but a belief in Chinese traditional remedies does not necessarily form a barrier to using Dutch care. A lack of cultural

competence among health care workers, on the other hand, does. Barriers were not confined to mental health care services but concerned access to health care in general.

For migrants with a low level of Dutch proficiency, better interpretation and translation services are urgently required; the employment of more Chinese health workers would help to improve both access and the quality of care. Our results suggests that special measures to overcome language barriers need to be taken with migrants from the Chinese-speaking region who arrive later in life, those who seldom have contact with native Dutch, and students not intending to stay permanently. Finally, to overcome the lack of knowledge about health care, activities to improve health literacy are clearly needed, carefully targeted and adapted so as to have maximum impact on the groups who need them most (Netto, Bhopal, Lederle, Khatoon, & Jackson, 2010).

Chapter 6

Beliefs about mental illness among Chinese in the West

This chapter is co-authored by Ludwien Meeuwesen, Floryt van Wesel and David Ingleby. This chapter has been published as:

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Abstract

Purpose

This study was carried out to test the widely-held assumption that underutilisation of mental health services by Chinese living in Western countries is due to their different beliefs regarding mental illness.

Design

Qualitative data were analysed from in-depth interviews with 23 Chinese respondents, who gave a total of 30 accounts of a Chinese person they knew who had experienced mental health problems in the Netherlands. Analysis focused on the way these problems were described and explained, as well as the kinds of help regarded as appropriate.

Findings

The beliefs expressed about mental illness did not seem to differ from those current in the West in ways that would form a major barrier to seeking help from mainstream services.

Research limitations

The study was exploratory and the limited sample size did not make it possible to analyse sources of variation in beliefs. Generalisation to other countries would need to take into account the specific characteristics of the Chinese population in those countries.

Practical implications

Simply knowing that a person is of Chinese origin is likely to tell us little about their beliefs concerning mental health. Moreover, traditional Chinese beliefs are not necessarily incompatible with Western ones. Service providers should pay more attention to issues such as communication barriers, entitlement to care, knowledge of how the health system works and discrimination.

Originality

The paper challenges widely-held notions about ethnic Chinese that are seldom empirically tested. It is the first study of its kind in the Netherlands.

Keywords: mental health problems, mental illness, health beliefs, explanatory models, health care utilisation, transcultural mental health, ethnic Chinese, Chinese migrants, access to care, qualitative research.

6.1 Introduction

The Chinese have a history of emigration stretching back many centuries (Pan, 1999). Most emigration has been to the South Asia region, but from the nineteenth century onwards large numbers of Chinese have also settled in the West. Following waves of emigration in the late 1970s and early 1990s, numbers have again been on the increase in recent years: in 2008, Chinese were the second largest group of migrants to the European Union [EU] (European Commission, 2011). In this article we use the term 'ethnic Chinese' to refer to people of Chinese ancestry living outside Chinese-speaking regions.

Many researchers have reported that ethnic Chinese living in the West tend to underutilise mainstream health services (Liu, Ingleby, & Meeuwesen, 2011; Quan et al., 2006; Ma, 2000), particularly in the mental health sector (Chu & Sue, 2011; Blignault et al., 2008; Abe-Kim et al., 2007; Chen et al., 2003; Lin & Cheung, 1999). Those who do access mental health services tend to present more serious problems, because professional help is often sought only as a last resort (Liu et al., 2008; Yeung & Kam, 2006; Chen et al., 2003; Geense, 2003). The few studies that have been carried out on the use of mental health services by Chinese in the Netherlands indicate that there is also a tendency to underutilisation in this country (Liu et al., 2008; Geense, 2003).

Cultural factors are often put forward to explain this reluctance to use Western mental health services – in particular, beliefs concerning the nature, manifestations and causes of mental illness, as well as the appropriate ways of dealing with it. The aim of the present study is to investigate beliefs among Chinese in the Netherlands concerning mental illness in order to assess the merits of this explanation. First, we will review the literature concerning cultural variations in beliefs about mental health and their influence on mental health care service utilisation.

6.1.1 Cultural variations in health beliefs

Medical anthropologists (Helman, 2007) and transcultural psychiatrists (Kirmayer, 2007; Kleinman, 1977) have shown that there are marked cultural differences in the perception and social meaning of 'mental illness'. Mental illness as a medical concept is mainly prevalent in Western societies from the nineteenth century onwards (Porter, 2003); other cultures do not always relate abnormal behaviour or experience to illness. Culture also influences the way symptoms are expressed through specific 'idioms of distress' (Chu & Sue, 2011; Kleinman, 1991; Nichter, 1981).

Kleinman et al. (1978) introduced the concept of 'explanatory models' to capture the way in which people understand and experience illnesses. This concept has been widely used by researchers studying health care in multicultural settings (Hark & DeLisser, 2009; Bhui & Bhugra, 2002; Williams & Healy, 2001; Callan & Littlewood, 1998; Jacob, Bhugra, Lloyd, & Mann, 1998). 'Explanatory models' do not only relate to the presumed cause of a problem, but also to the way it is experienced, its social and personal consequences, the treatment that is regarded as suitable and the outcome that is expected. Discrepancies

between patients' and professionals' explanatory models are regarded by many authors as an impediment to successful treatment (Scheppers et al., 2006; Bhui & Bhugra, 2002; Callan & Littlewood, 1998).

6.1.2 Beliefs about mental illness attributed to ethnic Chinese

Many investigators have written about the mental health beliefs of ethnic Chinese: much of this research has been carried out in North America since 2000. In this literature, low rates of service utilisation are frequently ascribed to the divergence between these beliefs and those current in the West.

Often, however, it is unclear what assumptions authors are making about Western beliefs. For example, researchers often mention the fact that mental illness is stigmatised in Chinese culture (Kramer, Kwong, Lee, & Chung, 2002; Tabora & Flaskerud, 1997; Kleinman, 1982) – yet stigma is also a major barrier to service utilisation in Western countries (HHS, 1999). Similarly, Chinese are said to regard deviant behaviour or experience as signs of illness only when it impairs individual functioning or disrupts the social environment (Lin & Lin, 1978); again, it is unclear how this differs from Western notions (cf. Wakefield, 1992). Ideas such as that mental illness is related to a lack of resilience, a failure of self-control, or a lack of family support (Simich et al., 2009; Kramer et al. 2002; Lin & Lin, 1978) are also hardly unique to Chinese. The same applies to the tendency not to associate negative feelings and emotional difficulties directly with mental illness, but more often with personal problems or general emotional distress (Hsiao et al., 2006; Tung, 1985), and to the wish to avoid 'morbid thoughts' (Sue, Wagner, Ja, Margullis, & Lew, 1976).

An important issue here is whether we should be concerned with divergences from the beliefs of Western professionals, of from those of Western laypeople. Although both are relevant, what has to be explained is the difference in utilisation rates from Western laypeople: these should therefore form the comparison group. It is known (Jorm, 2000) that although ethnic majority populations in the West often use mental health services, their beliefs may diverge widely from those of professionals.

Although differences are sometimes reported in the way psychological disturbances manifest themselves ('idioms of distress') among Chinese, the notion of mental illness itself is clearly one that is recognised in Chinese-speaking regions. In his research in China and Taiwan, Kleinman (1985) found a tendency to stress somatic rather than psychological symptoms in the presentation of such disorders: he ascribed this to the shame and stigma attached to psychological problems. However, 'somatisation' is a common phenomenon in many countries, and as mentioned above, shame and stigma are also widespread responses.

When it comes to the explanation of mental illness, supernatural beliefs are sometimes ascribed to ethnic Chinese – for example spirit possession, the effects of past lives, or divine punishment due to failure to comply with rituals of ancestor worship (Yip, 2004;

Parker, 2001; Leung & Lee, 1996; Kleinman & Kleinman, 1985; Lin, 1980). However, it is not known to what extent the prevalence of supernatural beliefs differs from that in the West.

Many studies have shown that ethnic Chinese often have considerable trust in Traditional Chinese Medicine (TCM). TCM comprises an empirical and systematically synthesized healing tradition, developed over thousands of years. Although TCM is largely devoid of supernatural components (Lin, 1980), the unique conceptual framework within which it views health and illness is also regarded by many researchers as a barrier to using services. For example, TCM avoids the familiar Western dichotomy between body and mind (Lin, 1980): mental and physical disorders are regarded as intimately connected. According to traditional Chinese philosophy, nature is always in a continuous process of rebalancing. The difference between health and illness is understood in terms of concepts such as 'balance' and 'imbalance', the correspondence between 'microcosm' and 'macrocosm' and disturbed flows of energy or 'chi'.

However, belief in one framework does not necessarily rule out belief in another. For the most part it would seem more appropriate to regard TCM and Western medicine as 'incommensurable paradigms', i.e. as ways of interpreting phenomena which cannot easily be translated into each other's terms – which is not to say that they contradict each other. Moreover, where translation is possible, there often seems to be agreement between Western notions and TCM. For example, the holistic Chinese approach of considering simultaneously body, mind and environment is entirely compatible with the 'bio-psycho-social' model favoured by many Western mental health professionals – an approach that "considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery" (Engel, 2011).

Another issue that is supposed to create barriers is the type of treatment regarded as appropriate. A tendency to resort to folk healers, shamans, religious rituals, home remedies, self-treatments, acupuncture or herbal treatment (Hsiao et al., 2006; Kung, 2003; Ma, 1999; Tabora & Flaskerud, 1997) is sometimes thought to reduce utilisation of mainstream services. A discrepancy is said to exist between what ethnic Chinese expect and what Western services have to offer. However, this argument overlooks the fact that alongside folk traditions and TCM, Western medical ideas and practices took root in China as long ago as the nineteenth century (Leung & Lee, 1996). In present-day China and Taiwan, ancient and modern systems of health care exist side by side and are used in conjunction or alternation with each other (DOH, 2012; State Administration of TCM, 2011). Whether living in Chinese-speaking regions or in the West, most Chinese are accustomed to draw on both medical systems for care (Green et al., 2006; Hsiao et al., 2006; Ma, 1999). Indeed, this 'medical pluralism' is a feature of many, if not most, societies (Agdal, 2005).

An important misconception underlying much of the literature concerning the mental health beliefs of ethnic Chinese is that the ideas of this group mainly reflect the ideas that are current in their country of origin. Migrants, however, are exposed to many different

cultural influences; they do not simply reproduce the notions they were brought up with. Moreover, the offspring of Chinese migrants to the West grow up surrounded by Western culture. Authors often make statements about the beliefs of ethnic Chinese which are derived from knowledge (often incomplete) about the regions in which these groups originate, rather than from any systematic empirical studies of ethnic Chinese themselves. Oversimplified and stereotypical notions about 'Chinese culture' are reproduced which ignore both the complexity of this culture and the enormous diversity, in terms of educational level, religion, occupation and years of residence in the West, of ethnic Chinese. By contrast, several researchers (e.g. Chung, 2010; Chau, 2008; Chen and Mak, 2008) have stressed this complexity and heterogeneity.

Thus, a critical examination of the existing literature raises doubts about idea that divergent explanatory models form the major barrier to utilisation of Western mental health services by ethnic Chinese. Instead, it is possible that the barriers have more to do with immediate practical difficulties – such as language barriers and communication problems, formal and financial barriers, not knowing how to get hold of care, lack of time and opportunity to undergo treatment, and (last but not least) perceived discrimination. This view is supported by other studies (e.g. Liu et al., 2011; Spencer et al., 2010; Blignault et al., 2008; Kung, 2004; Tabora & Flaskerud, 1997). Viewing cultural differences as the main cause of underutilisation may be an illustration of what Van Dijk (1998) termed 'culture as excuse': the tendency to depict the culture of minority users as something alien and exotic, in order to explain away problems caused by the failure of the health services to respond to the needs of minority users.

Against this background, the present study was carried out to study the beliefs of ethnic Chinese living in the Netherlands. The main research questions were as follows: (1) What kinds of problems are perceived by this group as mental health problems? (2) What is regarded as the cause of these problems? (3) What kind of help is considered appropriate? In this way we hoped to shed light on the question of whether divergent beliefs about mental illness are the major cause of low service utilisation in the Netherlands.

6.2 Method

The research was exploratory in nature and focused on the views, opinions, and concepts of ethnic Chinese. For this reason, a qualitative approach was adopted. Because of the practical difficulties and ethical objections involved in directly approaching Chinese with mental illness, we opted for an indirect method in which ethnic Chinese were invited to tell us about one or more Chinese persons in their social environment whom they regarded as having (had) mental health problems (精神問題). We used the term 'mental health problems' rather than 'mental illness' because we were not primarily interested in medical diagnoses but in lay beliefs. Moreover, 'mental health problems' is a more discrete term,

which respondents would probably be more willing to use in relation to the people they discussed.

Twenty-three semi-structured in-depth interviews were carried out. Four spoken languages (Mandarin, Cantonese, Dutch or English) were used in the interviews, depending on which language was preferred by the respondents. Recruiting from different language groups enabled us to make the sample more representative of the current diversity of Chinese in the Netherlands.

Before collecting the data, five interviewers (including the first author) were trained in the skills necessary for carrying out in-depth interviews. Each of them was proficient in at least one of the languages listed above. In what follows we refer to the interviewees as 'narrators', who gave accounts of 'protagonists' they knew with mental health problems.

6.2.1 Sample and procedure

From a larger sample recruited in our earlier study (Liu et al., 2011) we approached a group of 26 Chinese respondents who had told us that they knew Chinese living in the Netherlands who had experienced mental health problems, and had agreed to tell us the stories of these people in an interview. Nine of those approached were not able to be reached or to participate due to time constraints. Two interviews were omitted because they contained practically no material answering the question about mental health problems. To increase the number of participants, we added 8 new respondents using a 'snowball' sampling technique.

This procedure yielded a total of 23 respondents ('narrators'). The interviews were conducted in their preferred language (14 in Mandarin, 4 in Cantonese, 4 in Dutch and 1 in English). A topic list was used to ensure that the stories told addressed the three main research questions listed in the previous section. Each interview lasted between 60-90 minutes. Interviews were audio-taped and transcribed verbatim: in addition, two Chinese transcripts were translated into English in order to compare the coding between researchers. In this article, all quotations have been where necessary into English. In cases where there is room for doubt about the equivalence between Chinese and English terms, the Chinese expressions used by the narrator are given in brackets.

As some narrators were able to give accounts concerning more than one protagonist, a total of 30 stories about protagonists were collected from the 23 interviews. Five narrators told their own story; in these cases, narrator and protagonist are the same person.

6.2.2 Background of the narrators

The ages of the 23 narrators spanned a wide range (22-80); the median age was 37. Most of the narrators (70%) were female. Nineteen (83%) belonged to the first generation and the rest were from the second generation. Fifteen narrators had higher education, 4 had

completed secondary education and 2 had only reached primary education level. Eight were single; 8 were married or partnered, 5 were divorced and one widowed. Some narrators did not provide all of the personal data requested.

The period for which the first-generation narrators had resided in the Netherlands ranged from 2 to 56 years, with a mean of 22 years. Twelve of these narrators had a permanent Dutch residence permit. The majority came from a Chinese-speaking region, while 3 came from former Dutch colonies. Half of the 18 first-generation narrators stated that their main motive for migration had been 'family reasons'. Six of them had come to the Netherlands to study, while 3 had come in search of economic opportunities.

6.2.3 Ethical issues

We followed the applicable ethical guidelines to protect respondents' rights and interests while participating in this study. Prior to the interview, the researchers met respondents to explain the aim of the research and the procedure. The respondents were given written information about the study and gave their informed consent to participate. They were assured that they had the right to withdraw from the study at any time. All data they provided would be treated confidentially and only used for the research aim. Results would be reported anonymously and details modified where necessary to prevent any individuals from being identified.

6.2.4 Data analysis

In order to analyse the data of these interviews we followed the open, axial and selective coding procedure described by Boeije (2010), which is briefly set out here. This procedure is based on analysis techniques stemming from grounded theory (Corbin and Strauss, 2008). Nvivo 9 software for qualitative data analysis (QSR International, 2010) was used for data management, analysis and processing.

(1) Open coding: 30 mental health-related stories were identified from 23 transcripts. Twenty-two of the stories were in Chinese; 6 were in Dutch, and 2 in English. Eight stories in English, of which six were translated from Chinese, were reviewed by the first author to identify the main themes and sub-themes. Data were broken down, examined, compared, conceptualised and categorised following the principles of grounded theory (Corbin and Strauss, 2008). The stories and the identified themes were then reviewed by the three other authors independently of each other. The team discussed the major themes and the sub-themes and ways of relating these to each other in a coding framework, until consensus was reached. In this way a provisional code tree was formed. All 30 stories were then coded by the first author using this provisional code tree. The Dutch and English transcripts were checked by native Dutch-speaking and native English-speaking team members. If a new code was needed, the code tree was modified. Throughout the

procedure, the research team discussed the interpretation of the texts with each other and exchanged views. In some cases this led to modification of the code tree. After 25 stories the coding reached the stage of 'saturation', i.e. it was not found necessary to add new codes.

(2) Axial coding: After the 'open coding' phase, the first author put back together the unravelled data, identified relationships between categories, related the codes to each other, and refined the definition of the codes. The team once again checked whether each text fragment was coded properly and if the codes covered the data sufficiently. At the end of this stage a final code-tree was established in which all codes had a clear definition.

(3) Selective Coding: After the axial coding procedure the identified codes were put into context by creating a hierarchical structure of main codes and sub-codes. To answer the research questions, we further analysed the data by integrating codes into concepts and connecting these concepts. We used queries of matrix coding with Nvivo9 to organise the information. Data integration was a spiral process. Concepts were re-organised if it was considered necessary. The results were discussed and re-analysed constantly until all researchers reached agreement.

This process enabled us to give a focused description of protagonists' mental health problems as described by the narrators, the explanations that were offered for these problems, and the kinds of help that were considered appropriate.

6.3 Results

6.3.1 Mental health problems

Problems described could be grouped into six categories, which we labelled as follows: emotional disturbance, physical complaints, suicidal feelings or acts, bizarre behaviour, isolation or withdrawal, and compulsive behaviours (addictions or obsessions). They are listed below in order of frequency.

The type of problem most often described as a 'mental health problem' fell into the category we labelled as emotional disturbance. This included being easily emotional, anxious, depressed, angry, fearful, sad, unhappy, crying, feeling lonely, hopeless, having low self-esteem, or being suspicious. For example, protagonist ID20-1 was a woman whose husband had died of cancer. Along with the loss, she was shocked to discover that their son was homosexual. This discovery triggered her negative emotions.

[ID20-1] She was very angry (生氣) about this incident. Later, she suppressed her feelings about it. Because of the suppression, she became quiet. Her mood was down (情緒低落). She became pessimistic about life. To her, there seemed to be no hope.

Physical complaints such as sleeplessness, fatigue and feeling frail, were also frequently described as mental health problems. Narrator ID05 (42 years old) had come to the Netherlands when he was a teenager. He talked about his own experience and described his problems as sleeplessness and fatigue:

[ID05-1] I sometimes could not sleep well. I didn't know how to face tomorrow. I felt tired at work as well. However, I still needed to work. I had asked for sick leave, all I had done is sleeping at home…

Suicidal feelings or acts were also described. Protagonist ID15-1 is a second-generation female migrant, who without any known reason, attempted suicide in a Chinese restaurant:

[ID15-1] After working here for a while, there seemed to be something wrong with her mentally (精神). She went to the second floor of our restaurant and tried to commit suicide by jumping off the building (跳樓). Several male cooks restrained her and held her down.

Some protagonists showed bizarre behaviour which did not make sense to other people. Narrator ID11 described such behaviour in a married woman:

[ID11-3] She wouldn't use sanitary pads during her periods and walked around the house. The blood dripped everywhere. The husband cleaned it up and she messed up, again and again.

Others showed signs of isolation or withdrawal from society. Narrator ID24 was an overseas female student who, in her own account of herself, avoided contact with other people:

[ID24-1] I found out that I was very different from others. For example, if I had to be at work at 12 o'clock, I couldn't commit myself to being there. Thus, I started to avoid them, I told lies to them in order not to work. I felt my life to be meaningless.

Compulsive behaviours (addictions or obsessions), including gambling, excessive drinking or other compulsive behaviours were also reported as mental health problems. For example, narrator ID08 described the obsessive behaviour of an overseas student (ID08-1) staying in the Netherlands who worked for a Dutch company.

> [ID08-1] …He always felt insecure. He had groundless fears (杞人憂天) …He was nuts (神經兮兮的). He needed to check if the lights were off several times before going to bed. He always locked himself in his room, in his own house.

More than half the protagonists (18 out of 30) were described as having two or more mental health problems.

Considering all the problems reported, narrators seemed to regard a problem as a 'mental health' issue if the protagonists' functioning in daily life was seriously affected because they could not think rationally, could not cope with their own emotions, or could not control their own behaviour in a way generally regarded as normal. In some cases the disruption was caused not only to the person themselves, but also to those in their social environment.

6.3.2 Explanations of protagonist's mental health problems

In 22 of the 30 stories, explanations of the causes of the protagonists' mental health problems were given by the narrator, sometimes quoting the protagonist. These explanations could be grouped into two general categories - external and endogenous.

External factors related to social or environmental threats, such as life events. They could be immediate stressors such as divorce, death of a close family member or friend, changing or losing one's job and studying abroad or changing schools. They could also be chronic stressors, for instance, an unhappy marriage, work pressure or stress caused by unmet social or cultural expectations. In the view of narrators, prolonged exposure to chronic stressors could induce personality changes.

An example of an immediate stressor is seen in protagonist ID01-1, who came to the Netherlands for higher education. She used to be an outgoing girl, who was active and performed well at school. After her failed application for a job in the Netherlands, the narrator related that her behaviour became 'not normal' (不正常):

> [ID01-1] She asked the company why they had turned her down. Probably, they answered her that women show a lower level of ability to handle stress (承受力). Eventually, she really could not bear this

> setback (打擊). Her grades were very bad at that time. She was always online during the nights. Sometimes, she took her PC mouse to knock on the doors of other rooms and talked about nonsense in the middle of the night.

Chronic stressors often resulted from the migration itself. An example is provided by a young woman (ID24) who came to the Netherlands to study and decided to stay. She described the emotional problems created by the resulting financial strains:

> [ID24-1] The financial pressure is too huge. The cost [of studying in the Netherlands] is around €15.000 per year. In the beginning, my parents supported my study abroad. However, while I was studying in the Netherlands, things went wrong between my parents. I lost the financial support. I must earn my own living here. My boyfriend planned to help me by applying for Dutch residency for me… Because the application for a residence permit takes a long time, I became very pessimistic in that period. I didn't want to see anybody. I didn't want to talk to people. I didn't have an ID. I didn't have money [income]. It was difficult. It was really hard for me.

The second type of explanation, in terms of *endogenous factors*, could be further broken down into biological disturbances and personality dispositions. The biological disturbances mentioned in the interviews included neurological disorders, effects of alcohol, hormonal imbalance and biological clock disturbance. Narrator ID05, who suddenly felt faint at work, considered brain damage to be the cause:

> [ID05-1] He [the doctor] said the possible reason for it is that some nerves in my brain were damaged when I was hit by a car in my childhood when I was in Hong Kong.

Narrator ID25 described her brother, who was hospitalised because of being suicidal. His doctor told the family that his unstable emotions were the result of having had meningitis:

> [ID25-1] The doctor said it [the cause] was the meningitis that he got in childhood. … The doctor had taken his spinal fluid to test. The doctor already knew what had happened to him after the first test.

Personality dispositions included protagonists' temperament, character, beliefs and world-views. These could be formed or influenced by long-term stress such as the effects of psychological trauma suffered in childhood, an important early loss of a loved one, or unfavourable parenting styles. Protagonist ID08-1, a young man who showed obsessive

and compulsive behaviours (mentioned above), provided an example of personality dispositions regarded as causes in themselves. He always felt insecure and had groundless fears. These were described as character traits formed by early experiences:

> [ID08-1] His parents were apart when he was little… He lived with his mother. His mother was very strict with him. He said that his [fearful] personality was developed under this situation.

ID23-1 was a woman who came to the Netherlands for family reunion. She was depressed and had a gambling habit. The narrator indicated that this protagonist suspected that her parents were deliberately ignoring her:

> [ID23-1] I don't know if they [her family] realised it was a kind of psychological problem… I know that there probably was a difficulty causing her situation… such as, she felt her parents didn't love her enough.

Narrators sometimes described personality dispositions as causing mental health problems, but such a disposition could also moderate (mitigate or exacerbate) mental health problems resulting from endogenous factors. For example, narrator ID06 suggested that the following protagonist's lack of resilience aggravated the stress of studying abroad:

> [ID06-1] It mostly came from three kinds of pressures. Academically, too many experiences of failure. Secondly, culture shock; there were a lot of things she couldn't accept. Thirdly, the language barrier. The combination of these three ultimately caused her mental health problem… She was 21. She should have the ability to resist the pressure and situation by herself, but I can't see those things in her [our italics].

Narrators noted that a person's physical condition could affect their mental condition, or vice versa, while they were dealing with life events or experiencing stress. Two main patterns of explanations of mental health problems can be discerned. In the first, a protagonist is faced by one or more environmental threats and is unable to cope with them. The stress or shock leads to a mental health problem. The second pattern of explanation concerns physical impairments or changes. Brain dysfunctions are used to explain complaints like sleeplessness or abnormal behaviour. When brain functioning is disturbed, abnormalities of cognition, self-control, reasoning and emotion occur, which may be manifested after a time or triggered by life threats.

Protagonist ID01-1, an overseas Chinese student who failed to get a job in the Netherlands (mentioned above), provides a good example of the first pattern:

> [ID01-1] …I think it was a kind of mental health problem. There was mental stress (心理上有壓力). Could not let things go (想不開). It led to the mental health problem. [As a result] it could not be solved by just releasing the stress.

The second pattern is illustrated by Protagonist ID07-1. After the migration to the Netherlands he became even quieter than he had been before, but also showed outbursts of temper at home. His mother (Narrator ID07) felt that her son's emotional disturbance resulted from the combination of migration stress, his introvert character, and possibly his brain impairment as well:

> [ID07-1] He has epilepsy. (We have known it) since he was a child. When we came to the Netherlands, the environment changed… When he had just arrived here, he didn't talk much because of his introvert character and the change of environments… I asked the doctor if he was affected by epilepsy. However, the doctor didn't give me a direct answer…

These patterns show again that it was common for respondents to invoke multiple factors, as well as interactions between them, in their explanations of mental health problems.

6.3.3 Appropriate help

Most protagonists (or their close relatives) regarded the regular Dutch health care system as the appropriate source of help for dealing with mental health problems. Forms of complementary care were also mentioned by some. One in four protagonists coped with mental health problems by other strategies, such as looking for social support from family or friends or spiritual support from religion.

Use of regular mental health care

In three-quarters of the cases, regular health care was considered as the first resort for dealing with mental health problems. For instance, a Chinese overseas student accepted the advice of a teacher to see a counsellor:

> [ID06-1] She tried to talk to a teacher during this time and was advised to seek psychological counselling …She knew from the beginning that she needed a psychologist…

Various pathways were described in the stories of protagonists who voluntarily sought help from regular mental health services – for example, consulting a family doctor and receiving treatment in primary care, referral to specialised mental health services, or direct contact with psychological counselling services organised by employers or educational institutions.

For protagonists considered to be incapable of performing daily tasks, regular mental health care was also regarded by family or friends as the most appropriate form of help to seek. The story of protagonist ID11-3 (see above) is an example. Confronted with her bizarre behaviour, her husband contacted social workers and asked for professional help.

> [ID11-3] She wouldn't use sanitary pads during her periods and walked around the house… she felt that she's OK… It was her husband and the social workers from the women's organisation; they found a psychiatrist to visit her, to learn more about the situation…

Besides making use of mainstream care, a substantial number of protagonists also looked for complementary care when they felt the regular treatment was not working well enough. This mainly involved seeking a second opinion and starting other treatments. Some used care services in other countries. For example, ID11-5 had sought help from Dutch health care, and also asked advice from both mainstream services and TCM:

> [ID11-5] She went to see a [family] doctor [and was referred to a mental health specialist]. But her sickness didn't get better in the Netherlands. So she went to Hong Kong and the United States to seek help… According to the TCM doctor [in Hong Kong], she suffered from menopausal syndrome… [The doctors in the US] said that there were three intervertebral discs wearing out too much…

Only in three stories was TCM considered as an option by protagonists, and only in two was it actually used. Other complementary activities included Qigong[1], diet therapy, searching for information via helplines or media, and spiritual support from religion (Buddhism).

> [ID12-1] I don't know if that [illness] was helped by xxx [a regional mental care institution]. I think it [the improvement] was because of the practice of Tai Chi and [other sorts of] Qigong, because she felt herself more relaxed and better. This would have a [positive] effect on her mental health problems.

[1] Qigong is an ancient Chinese health exercise that integrates physical postures, breathing techniques and meditation. For example, Tai-Chi is one school of Qigong practice.

Help without considering mainstream health care

Apart from the forms of care described so far, one in four protagonists or their close social contacts did not consider using Dutch health care. They sought emotional and social support from family and friends, or spiritual support from religion. Narrator ID24 (also mentioned above) described how her friend helped her to get through a difficult period:

> [ID24-1] When I looked for jobs, I asked A to accompany me… Later when I started to work, she always guided me and checked what I was doing… I realised that her character urged me to keep walking, to go through the difficult period. I now appreciate her a lot.

The reasons given for not using regular mental health care included lack of knowledge about how and where to seek help, the presumed cost of specialised mental care, fears of being labelled as mentally ill, and worries about not being able to communicate with professionals.

6.4 Discussion and conclusion

In this study we examined the ways in which Chinese in the Netherlands perceive and explain mental health problems, as well as the help they regard as appropriate. Although researchers in many Western countries have claimed that the health beliefs of ethnic Chinese in the West are incompatible with Western ideas about mental illness and that this leads them to underutilise mental health care, the results of this study do not support this view. We found little evidence of strongly divergent beliefs about mental illness or of rejection in principle of mainstream health care.

Regarding the nature of mental health problems, the type of problems identified did not seem to differ from those which are regarded in the West as signs of mental illness. The common denominator seemed to be that the protagonist's functioning in daily life, or the lives of people in their immediate environment, were seriously affected because of their inability to act rationally or cope with their own emotions, and to control their behaviour in a way regarded by others as normal.

Second, the explanations of mental health problems were sought in external factors (e.g. life events) and/or endogenous ones (biological factors or personality dispositions); these factors could also interact with each other. Levels of social support and personal resilience could moderate the development of mental health problems. Such ideas are also the basis of the 'biopsychosocial model' (Engel, 1977) which is widely accepted within mental health care (Frankel et al., 2003). Third, most respondents regarded forms of regular health care as appropriate help for mental health problems. Other forms of help, including TCM, could be used as complementary or alternative care. When regular mental health care was not used, this appeared to be mainly for practical reasons.

We did not find any examples of mental health problems not recognized in the West, or explanations in terms of supernatural forces, spirit possession, etc. Perceptions and explanations of mental health problems did not differ noticeably from those common in the West, and regular mental health care was accepted as the main source of appropriate help for mental health problems.

These findings can be interpreted in different ways. Firstly, respondents might have 'acculturated', i.e. exchanged their original (divergent) cultural beliefs for Western ones (cf. Chen and Mak, 2008). This may indeed have happened to some extent, but as discussed earlier, 'Western' ways of thinking about mental health could also have been acquired before the migration. Moreover, TCM's multifactorial approach to mental health problems is quite compatible with the Western biopsychosocial model (Hsu, 1981).

A second explanation is possible in terms of 'medical pluralism': the type of care sought is mainly a pragmatic choice, based on what is available and what seems to work. Other researchers have found that Chinese migrants in Western countries tend to draw upon multiple medical systems for care (Green et al., 2006; Hsiao et al., 2006) – as, indeed, do Chinese living in China. Moreover, participation in other activities such as Qigong does not imply a rejection of Western medical ideas and practices.

6.4.1 Methodological reflection

This study was exploratory in character, which limits the possibility of generalising its results. Although the sample was not intended to be representative in statistical terms of the Chinese population of the Netherlands, its composition reflects well the diversity of the population (Gijsberts et al., 2011). The fact that saturation was reached before all stories had been analysed suggests that a larger sample would have added little new information.

It could be argued that by asking respondents to discuss 'mental health problems', we might have encouraged them to selectively report problems that fit within Western notions about mental illness. However, most of the interviews were conducted in Chinese, and the term we used to refer to 'mental health problems' (精神問題) did not have specifically Western connotations.

6.4.2 Conclusion

Despite its limitations, the present study suggests that the ideas of ethnic Chinese about the nature and causes of mental health problems are not markedly different from those that are common in the West. The ethnic Chinese studied here mainly sought help from mainstream mental health services; only two used TCM. If, as other research has suggested, there is underutilisation of mental health services by Chinese living in the Netherlands, this does not seem to be due to divergent 'explanatory models' but to other

factors. And if this is true in the Netherlands, it may also be the case in other countries where underutilisation has been reported.

These other factors may include such issues as entitlement to care, the ease which it can be located and used, language barriers, communication problems, discrimination and lack of knowledge about the health system. Some of these barriers, such as language and communication problems, can be considered as 'cultural' ones. However, our findings suggest that barriers to utilisation of mainstream health services may have more to do with practical difficulties than with culturally determined health beliefs.

Chapter 7

Why do ethnic Chinese in the Netherlands underutilize mental health care services? Evidence from a qualitative study.

This chapter is co-authored by Ludwien Meeuwesen, Floryt van Wesel and David Ingleby. An adapted version of this chapter has been published as:

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Abstract

Chinese in the Netherlands are less likely than other ethnic groups to utilize mainstream mental health care services. This study investigated the experiences of Chinese with mental health problems, with a view to recommending measures for making services more responsive to the needs of this group. Qualitative methods of analysis were applied to interview data in order to explore ways of finding help, barriers to accessing mainstream mental health care, experiences in care, factors jeopardizing the quality of care, and views on the services. Rather than recruiting Chinese with mental health problems, an indirect method was used in which ethnic Chinese were invited to tell us about one or more Chinese persons in their social environment whom they regarded as having (had) mental health problems (精神問題). Although most Chinese regarded mainstream Dutch care as the appropriate resource for dealing with mental health problems, many barriers to access and threats to care quality were reported. In contrast to the widely accepted view that cultural differences in health beliefs underlie the low take-up of mental health services by Chinese in the West, the main obstacles identified in this study concerned practical issues such as communication problems and lack of knowledge of the health system. Respondents also described concerns about entitlement to care and discrimination (actual or anticipated). Measures suggested by respondents for improving care included more use of interpreters and cultural mediators, encouraging migrants to increase their language proficiency, and better dissemination of information about the health system. The article concludes with a discussion of the policy implications of these findings.

Keywords: mental health care utilization, migration and health, ethnic Chinese, access to care, quality of care.

7.1 Introduction

Although Chinese form the oldest and fifth largest non-Western minority in the Netherlands and their numbers are rapidly increasing, little research has been carried out on their health. There are indications that they are less likely than other groups to utilize mainstream mental health care services (Schellingerhout, 2011; Liu et al., 2008; Geense, 2003). In a survey carried out in 2009, only 2% of Chinese respondents had used mental health care service in past year, compared to 8% of native Dutch (Schellingerhout, 2011). The present study used interview data to investigate the kinds of help that are sought by Chinese with mental health problems, the difficulties that are experienced along the way, users' experiences of receiving care and their views on the services.

The Chinese population in the Netherlands is very diverse (Gijsberts et al., 2011), and can be divided into four main groups. Firstly, migrants from Chinese-speaking regions who arrived before 2000: this group tends to have the lowest levels of education and language proficiency. Secondly, migrants from former Dutch colonies: many of these arrived during the period of decolonization, and they tend not only to speak good Dutch but also to have good educational qualifications. Third, migrants arriving after 2000: most of these come from Mainland China and many are well-educated (a considerable proportion being students or business people). Nevertheless, they often have a poor command of Dutch. Finally there are the Dutch-born children of all these migrant groups (the 'second generation'), who are native-speaking Dutch with (on average) high educational achievements.

7.2 The Dutch mental health care system

In the Netherlands, mental health services are incorporated in both primary and secondary care (Schäfer et al., 2010). The general practitioner (GP) has the role of 'gatekeeper' for specialized health services and makes the initial assessment of patients' needs. For mental health problems the GP may provide counselling or refer a patient to a psychologist working within the GP's own practice, and may also prescribe medication. Often, however, the GP will refer the patient on to a specialized mental health care provider for diagnosis and treatment. Within certain limits, the costs of mental health care are reimbursed under the Dutch system of coverage.

Occasionally, students or employees are able to access care directly through services provided by educational organizations or workplaces. Treatment by a psychiatrist or psychotherapist in private practice can also be accessed directly by those who can afford to pay for it themselves. Otherwise, it is not normally possible to get an appointment for specialized care, or at least to obtain reimbursement of the costs, without a GP's letter of referral.

In theory, undocumented migrants in the Netherlands have the same entitlements to mental health care as nationals (Sandhu et al., 2012). However, such migrants may not know about these rights. According to Doctors of the World (Médecins du monde/MdM)

(Chauvin, Parizot, & Simonnot, 2009), many service providers are unfamiliar with the rules and some fail to comply with them.

7.2.1 Mental health care utilization by ethnic Chinese in the West

Lower utilization of mental health services by Chinese living in the West has been widely reported (e.g. Chen et al., 2009; Abe-Kim et al., 2007; Kung, 2003). Almost all of this research has been carried out in English-speaking countries such as North America, Australia, New Zealand and the United Kingdom; very few Dutch studies have investigated the issue (exceptions are Schellingerhout, 2011; Liu et al., 2011; Liu et al., 2008; Smits, 2006). A simple explanation of low utilization could be that Chinese have fewer mental health problems, but epidemiological evidence does not seem to support this idea. Moreover, it is often found clinically that Chinese entering treatment have more serious problems (e.g. Chu & Sue, 2011; Chen et al., 2003, Geense, 2003).

Many authors have related low utilization to culture-bound beliefs concerning the nature, manifestations and causes of mental illness. Chinese are often said to be skeptical about the value of Western treatment methods and to prefer seeking help from Chinese traditional healers or using traditional remedies (Yang et al., 2009; Hsiao et al., 2006; Yip, 2004; Kung, 2003; Parker, 2001; Ma, 1999). It is also frequently suggested that Chinese tend to equate 'mental illness' with 'madness' and to regard seeking professional help as bringing shame to the family (Green et al., 2006). Of course, such stigmatization also exists in the West (Sareen et al., 2007), but it is assumed to be more serious among the Chinese (cf. Chen & Mak, 2008; Tabora & Flaskerud, 1997).

However, the idea that culture-bound beliefs explain underutilization of mental health services by Chinese is open to a number of criticisms. Many researchers (e.g. Sun, 2013; Chung, 2010; Yang et al., 2009; Chen & Mak, 2008) have pointed out that 'Chinese culture' is not a homogenous entity. A variety of different health beliefs can be found among ethnic Chinese in the West, and these beliefs may be complex and many-layered; they may also change over time, as migrants take root in the host countries. Many researchers also seem unaware of the fact that Western approaches to psychiatry have long been incorporated in Chinese health care (Koran, 1972).

Another weakness of this explanation is that although the mental health beliefs of ethnic Chinese may differ from those of Western professionals, they may not differ much from those of most lay people in the West (see Jorm, 2000). Likewise, research on stigma among ethnic Chinese does not usually include a comparison with the native population.

'Health pluralism' (Bodeker & Ong, 2005) is also a commonly reported phenomenon. Chinese living in the West may simultaneously adhere to different health beliefs and practices (Hsiao et al., 2006) – for example, seeking treatment from Western medical practitioners and at the same time using traditional Chinese medicine (TCM) (Chau & Yu, 2004).

Thus, there are many reasons for questioning explanations of low service uptake by this group in terms of cultural beliefs. Indeed, Van Dijk (1998) suggests that such explanations may function primarily as an alibi for the health system's failure to provide good services. On the basis of a survey of 1747 Chinese American respondents, Kung (2004) proposed that it is mainly practical barriers, rather than cultural beliefs, which lead to low uptake of services. Below we list the main practical barriers that have been identified in the literature. (It should be noted that few of these studies make allowance for variations in sample characteristics in terms of variables other than ethnicity.)

Communication problems. Communication barriers between Chinese users and health professionals are reported very frequently (Liu et al., 2011; Chen et al., 2009; Kung, 2004). Cross-cultural communication is not just a matter of understanding words, but also of appreciating idioms and cultural or social references. Inadequate communication can be especially detrimental to good mental health care.

Lack of knowledge about the health care system. This reason for underutilization is frequently cited by researchers (e.g. Liu et al., 2011; Wang, 2011; Blignault et al., 2008; Chan & Quine, 1997). Poor language proficiency may make it harder for Chinese to acquire the knowledge they need.

Financial concerns. These include lack of affordable treatment and/or insurance coverage (Kung, 2004; Ma, 2000; Lin & Cheung, 1999). The seriousness of this barrier will vary depending on the group in question and the country they live in. However, when people are ill-informed about the health system, simply expecting high costs may be enough to deter them from seeking treatment (Liu et al., 2011; Blignault et al., 2008).

Lack of time and opportunity. Like many migrants, Chinese often have jobs (for example in the catering industry) characterized by long hours of work and restricted possibilities to take time off for medical consultations (Liu et al., 2008). 'Sickness presenteeism' – the tendency to carry on working despite being ill (Johns, 2010) – is a common phenomenon among migrant groups with 'precarious' employment (cf. Agudelo-Suárez et al., 2010).

Service constraints. These may include long waiting times for an appointment, complicated administrative procedures, and the limited time allocated for consultations (Liu et al., 2011; Blignault et al., 2008; Kung, 2004).

Discrimination. Discrimination against Chinese users in health services is reported in many studies (e.g. Chu & Sue, 2011; Spencer & Chen, 2004). Such experiences include being given different treatment or being belittled by health service workers due to poor language proficiency or ethnic background. Spencer and Chen (2004) found that discrimination in health care is associated with greater use of informal services among Chinese Americans.

Low quality of care. Chinese often report worse health care experiences and lower satisfaction with care than other ethnic groups (Clough et al., 2013). Disappointing experiences can deter users from seeking care again and can contribute to a negative image of services in the Chinese community. The same factors which impede access are often responsible for undermining the quality of care and patient satisfaction.

7.3 Method

7.3.1 Sample and procedure

The 25 respondents in this study consisted mainly of participants in an earlier questionnaire study (Liu et al, 2011). These participants had been recruited on the streets in shopping areas heavily frequented by Chinese in the four major Dutch cities – Amsterdam, The Hague, Rotterdam and Utrecht. About half of those approached in this way agreed to cooperate. When the questionnaire had been completed, the participants were asked if they were willing to be interviewed in more depth at a later date about one or more Chinese people they were acquainted with, who had experienced mental health problems while living in the Netherlands. Twenty-six of the 102 participants volunteered. To replace those who later could not be reached or were unable to participate, nine new respondents were recruited using a snowball technique. Material from two respondents had to be discarded because it contained hardly any information relevant to mental health, leaving a total of 23 respondents. The reason for not recruiting people with past or present mental health problems directly was to avoid the practical and ethical problems associated with recruiting and interviewing such a group.

Semi-structured in-depth interviews were carried out using respondents' preferred language (14 in Mandarin, four in Cantonese, four in Dutch and one in English). The five interviewers (including the first author) were trained in the skills necessary for carrying out in-depth interviews. Each of them was proficient in at least one of the languages listed above.

Respondents were invited to give accounts of one or more Chinese persons in their social environment whom they regarded as having (had) mental health problems (精神問題). A topic list was used to ensure that respondents addressed the three main themes of the study: experiences of getting into mainstream mental health care, experiences while in care, and views on the system. For a full description of the method readers are referred to an earlier publication (Liu et al, 2013), which analysed the beliefs about mental health expressed in these accounts.

Interviews were audiotaped and transcribed verbatim. In this article all quotations have been translated into English when necessary. In cases where there was room for doubt about the equivalence between Chinese, Dutch and English terms, the Chinese or Dutch expressions used by the respondent are given in brackets.

In what follows we refer to the respondents as 'narrators', who gave accounts of 'protagonists' they knew with mental health problems. As some narrators were able to give accounts concerning more than one protagonist, a total of 30 stories about protagonists were collected from the 23 interviews. Five narrators told their own story: in these cases, narrator and protagonist were the same person. In all five cases, they offered spontaneously to discuss the difficulties they had experienced with mental health care services.

Data collection was based on the applicable ethical guidelines to protect respondents' rights and interests. These concerned explanation of the aims of the research, the procedures used, consent to participate, withdrawal and confidentiality.

7.3.2 Background of the narrators

The ages of the 23 narrators spanned a wide range (22-80, median = 37). Sixteen of them (70%) were female. Nineteen (83%) belonged to the first generation of Chinese migrants and the rest to the second generation. Fifteen narrators had higher education (four of these being overseas students); four had completed secondary education; and two had reached primary education level. Eight were single; eight were married or partnered; five were divorced and one widowed. Some narrators did not provide all of the personal data requested.

First-generation narrators had resided in the Netherlands for between two and 56 years (median = 22). Twelve of these 19 narrators had a permanent Dutch residence permit. The majority (16) came from a Chinese-speaking region, while three came from former Dutch colonies. Ten stated that their migration motive had been 'family reasons'; six of them had come to study, while three had migrated in search of economic opportunities. The ages of the five second-generation narrators ranged between 22 and 37 years: their education level was high, four of the five having completed higher education.

7.3.3 Data analysis

Data analysis followed the open, axial and selective coding procedure described by Boeije (2010), which is based on grounded theory (Corbin & Strauss, 2007). Nvivo 9 software for qualitative data analysis (QSR International, 2010) was used for data management and analysis.

Throughout the procedure, the research team exchanged views with each other about the interpretation of the texts. Data coding was carried out using a spiral process until the codes covered the data sufficiently. The results of analysis were discussed and re-analyzed repeatedly until all researchers reached agreement.

7.4 Results

7.4.1 Ways of finding help

Help-seeking behaviour. About three-quarters of the protagonists (23) sought help from Dutch mental health services. Six of them also used complementary care or undertook specific activities to regain mental health, such as TCM, Qigong or religious practices. These activities could be undertaken before, during or after treatment by mainstream services.

The other seven protagonists did not seek mainstream help. Among them, two patterns could be observed: three did not seek help of any kind, while the other four used other methods to cope with their problems, for example by seeking emotional or social support from family and friends or spiritual support from religion. However, it is noteworthy that nobody in this group sought help from a professional healer outside the regular system – i.e. 'alternative' care.

Pathways to mainstream care. In the 19 accounts which gave information on this topic, four pathways could be distinguished: mental health care given by the GP (4), onward referral by the GP (6), direct access to mental health services (2), and non-voluntary help seeking (7). Although it is also possible in the Netherlands to obtain treatment privately from an independent psychologist or psychiatrist, no accounts in this study described using this pathway to care.

Protagonist ID05-1, who went to his GP after suddenly fainting at his office, illustrates an onward referral to specialized mental health care:

> [ID05-1] The doctor thinks the fact that I lost control of myself and fainted was due to the stress and the anxiety. He said, it was possibly a consequence of the brain impairment which was caused by a car accident in my childhood. So he suggested to me to see a psychiatrist.

The protagonists who directly contacted psychological counselling services offered at school or work could recognize their mental health problems and wished to obtain professional help. "Her grades slipped lower and gradually she lost interest in the subject. She talked to a teacher during this time and was advised to seek psychological counselling" [ID06-1].

Professional help was sometimes sought on behalf of protagonists by other people ('non-voluntary help seeking') because the protagonists did not consider themselves in need of treatment, had refused to seek help themselves, or were regarded as a suicide risk. An example is protagonist ID11-3:

> [ID11-3] She felt she was OK… She wouldn't go to see the doctor… It was her husband and the social workers from the women's organization; they found a psychiatrist to visit her, to learn more about the situation…

It is notable that the proportion of non-voluntary users among the protagonists who received mental health care is quite high (7 out of 23). Suicide attempts were involved in 4 of these cases; 6 persons were hospitalized. We were unable to ascertain how many people were the subjects of a compulsory admission order.

7.4.2 Barriers to accessing mainstream care

Insufficient language proficiency. Sometimes protagonists were discouraged from using Dutch care services because of low language proficiency. Protagonist ID10-1 was aware of his drinking problem and related violent tendencies. However, he was reluctant to see a doctor:

> [ID10-1] He realized there was something wrong. I suggested him to see a doctor accompanied by me. When he was in a good mood, he said okay… After two days, he didn't want to go any more. He said, "I cannot communicate [with the doctor]"... It was, of course, because of the language… if [a person] doesn't know how to speak the language, how to see a doctor?

Lack of knowledge about the health system. Chinese migrants often lack adequate knowledge about the Dutch health care system. Protagonist ID22-1, for example, recognized her mental health problems but gave the following reasons for not seeking mainstream help: "I didn't know where these institutes are, whom I should call… I am not sure if I am able to pay the medical expenses."

A common misunderstanding concerned the GP's 'gatekeeper' function in health care. Many protagonists came from countries where users can directly access specialist services. Protagonist ID06-1 was aware of her mental health problem but seemed not to know that visiting a GP was necessary to get help for it: "We know she should go to a family doctor. But in her belief, family doctors are for physical ailments. Psychological problems need psychologists."

Entitlement to use care services. Issues concerning entitlement were mainly related to legal status and financial resources. Sometimes undocumented migrants are not aware of their right to health care or avoid using services because they are worried that they will be reported to the authorities, as the following quotation illustrates: "But they won't go.

Without legal status, they don't believe they should… The issue is about whether they trust the organization, and if there are police waiting, trouble brewing" [ID06-2].

For some regular Chinese migrants, the cost of mental health care was their central concern. They could not use the health system without health insurance, and some saved money by not taking out insurance. Even those with insurance sometimes assumed – incorrectly – that mental health services were not covered.

Unawareness of the need to seek help. Not realizing that problems were signs of mental illness sometimes delayed or deterred seeking mental health care. For example, for a long time protagonist ID24-1 could not sleep well. Only when she realized that her personality had also changed did she go to see the GP.

> [ID24-1] By that time, I didn't realize that I was sick because I thought it was a kind of modern illness that [I] could not fall in sleep until the early morning due to the stress. Later on I discovered that my personality was totally different from what it used to be. I had good temper in the beginning [of my sleep disorder]. Thereafter I got angry easily.

Stigma. Concern was sometimes expressed about being labelled as mentally ill. However, only three protagonists' help-seeking behaviour seemed to be affected by fear of stigmatization. Narrator ID21-1 perceived this as a reason for his sister turning to seek support from religion instead of looking for psychological help: "She didn't turn to healthcare… when you go that way you also give yourself the label that there's something wrong in your mind and not a lot of people like to do that." Another narrator mentioned that it was acceptable to talk about her mother's mental illness in the family; however, the family would not talk about it in front of others in order to avoid gossip.

Negative attitudes towards Dutch health care. Some accounts expressed dissatisfaction about complicated procedures, long waiting lists, discrimination and professionals' inappropriate attitudes. For example, narrator ID09-1 talked about how the required procedures discouraged foreign students from using health care:

> [ID09-1] As foreign students, we don't have personal GPs… If something is wrong, we have to go to a hospital. And our insurance policy is, for foreign students, we have to pay the cost in advance, and get reimbursed by submitting receipts later. So it's troublesome. Furthermore they (the health institute) will ask us to show our visas when we have to make appointments and registrations. Very bothersome. On top of this, [getting into] the Dutch health system takes a long time.

At the same time, when ID22-1 talked about her reluctance to seek help from a professional, she exemplified worries about being discriminated against because of low Dutch proficiency or not being treated 'sincerely' by Dutch professionals. In such cases, Dutch proficiency is not just an issue about communication – it is also linked to prejudice: "When they see that I am a foreigner and my Dutch is not good, they probably will look down me, and they won't help you sincerely by thinking for you from your situation."

7.4.3 Experiences in mental health care

Diagnoses. These are mentioned in 10 of the 23 accounts relating to protagonists who used Dutch health care; only five accounts described the nature of the diagnosis. Most of these 10 protagonists accepted the diagnosis given, while two showed doubts about it. Two narrators felt doctors were unwilling to answer questions about the diagnosis. For example, ID07-1 accepted the doctor's diagnosis of her son's illness, but when she asked questions about it, she received no answers:

> [ID07-1] I don't know (what the illness is about). I have asked the doctor if the illness can be cured. However, the doctor didn't want to answer.

Treatment. The treatments most frequently described were psychotherapy and medication. Two protagonists were referred for physiotherapy, while some received advice regarding their lifestyle.

Accounts often provided little information about the precise nature of the psychotherapy received, so we use the term to refer to any treatment based on verbal interaction between professionals and clients (e.g. counselling, behaviour therapy, family therapy etc.). Sixteen out of 23 protagonists received some form of psychotherapy, 13 of them in combination with medication.

The narrators' and protagonists' comments about psychotherapy were generally positive. One narrator indicated that the talks with therapists provided an 'objective' opinion which helped him and his wife to see their problems differently. Some protagonists found it difficult to talk about their problems with their families: narrator ID02 commented on her mother's story, "I think that the person is more open, and more likely to talk to an unknown (person) than his or her family"

Fifteen protagonists received medication. In most accounts, however, the type of medication was not mentioned, or its purpose was not known.

Two protagonists who presented with somatic complaints were first referred for physiotherapy. In both cases the results were unsatisfactory and they were eventually referred by the GP to specialized mental health care.

In four accounts the professional gave protagonists advice about changing their life-style, for example by taking life easier, getting exercise, and participating in social activities. Three protagonists were given additional social support from a social worker or home care service.

Adherence. This was mentioned in 12 accounts. In five of these, protagonists complied with the treatment. Three of them followed the treatment without problems, though two did not really feel comfortable about it. Among the seven accounts which reported non-adherence, four protagonists discontinued medication, two terminated or dropped out of psychotherapy, and one refused the recommended hospitalization.

Reasons for non-adherence included side-effects of medication, lack of effect of the treatment, doubts about the diagnosis or treatment, fear of the unknown effects of the treatment, feeling there was no need to follow the treatment, and practical problems. Some protagonists had more than one reason for non-adherence. For example, ID05-1 had three reasons for rejecting the proposed hospitalization:

> [ID05-1] I was a bit afraid when I went there [psychiatric care] the first time. Because he [the psychiatrist] said, I had mental health problems [was mentally ill]. Also, when I was there, I saw a group of retards playing. Then I said [to him], 'I am not a retard; I am normal'… He still suggested to me to stay in the hospital for 5 weeks in order to take some tests. I considered myself a normal person; it was not necessary to stay there. Eventually I refused [his suggestion]. I couldn't bear to miss my daughter. I was also afraid. I didn't know what would happen there during the nights.

ID12-2 discontinued the medication because of doubts about the diagnosis and treatment and lack of trust in the psychiatrist.

> [ID12-2] He (the doctor) prescribed me pills. I took them, but later I got really sick. I went back to the doctor and told him that I didn't want to take them, they made me sleepy, and I did not think I was really depressed. He still wanted me to keep swallowing them. At one point I got a phone call from the doctor's assistant: the psychiatrist was overworked and had had a breakdown. I immediately stopped taking the pills and felt ultimately relieved. I also believe that you need to use your own strength to overcome all problems.

Conversely, family support can be important for adherence, as shown by protagonist ID03-1:

> [ID03-1] She did not take the pills and lied to her husband. She hid the pills in the hand and only swallowed the water… Later she started to accept the situation and take the medicine… Her husband deserved the credit. She later learned to take the pills obediently.

Outcomes. Fourteen accounts provided information about the outcome of mental health care. In 11 accounts the symptoms were relieved or brought under control, but three protagonists were not helped. In most accounts, we only had the narrator's reflection about the treatment received by protagonists. Some accounts contained very positive comments on Dutch mental health care. For example, narrator ID23-1 spoke of the care received by his daughter:

> [ID23-1] I think they [mental health care professionals] have done a good job. To solve it [the illness] is actually a great job… After a time, she [my daughter] still regularly visited the same doctor. But she didn't take the pills any more, and no more therapy. [She] only kept normal appointments as controls.

In other cases, however, narrators and/or protagonists had reservations about the treatment even though it seemed to be effective. Narrator ID11 mentioned that her friend had to keep taking the pills in order to stay well:

> [ID11] She got better after taking medications from the psychiatrist… She's been taking them for nine months. Her psychiatrist recommended her to stop… But whenever she stopped [the medication], her symptoms kept coming back frequently… she might have to take them for a long time.

Two of the three unsuccessful treatments were related to overseas students. Eventually both of these went back to China for further treatment, since Dutch care did not help them sufficiently.

7.4.4 Threats to care quality

Poor communication with professionals. This was the most frequently mentioned difficulty. It was mainly associated with limited Dutch proficiency, but also with differences in communication style and cultural background.

Communication problems could make it difficult for protagonists to obtain a referral for specialized treatment, could lead to low adherence and dropout, and could deter protagonists from using Dutch health care in the future. Protagonist ID06-1 is an example:

> [ID06-1] She did 3 to 5 sessions of counselling. Because their communication was half with words and half with gestures, there was not much effect… she encountered a language barrier during the counselling, and no one was able to translate for her. How can others translate your personal emotions? ...Especially when we are trying to express feelings, it's already hard to express ourselves correctly… She was thinking about seeking [further] psychological therapy in the Netherlands. But when she thought about her previous experience, she lost confidence in doing this.

Sometimes the communication barriers did not so much concern language as cultural background and social context. Because professionals were not familiar with the background of Chinese culture, protagonists could experience frustration in trying to make them understand their mental health problems, while professionals might be unaware of core issues while treating the patients. The story of ID05-1, who had lived in the Netherlands for more than 30 years, illustrates that communication problems can exist even when the professional and the care user speak the same language:

> [ID05-1] He [the doctor] didn't ask me if I needed an interpreter… He said he understood what I said completely… I understood what he talked about. However, I found it difficult to express myself to him. I didn't know if the doctor really understood what I have said or he pretended that he understood… Sometimes I said this and he said something else, or I said that and he replied with something irrelevant.
>
> [Regarding the stress at work]… In the end, we are still Chinese. We are more conservative. We keep everything inside our heart. He [the psychiatrist] advised me to talk to my boss openly. Do you think I was a Dutch? To open yourself to a person by just saying it?

Protagonist ID18-1 dropped out from psychotherapy because she thought that the psychologist would not be able to understand the difficulties she had gone through:

> [ID05-1] I had a feeling that he could not help me at all. I talked him about my situation. Then he advised me, you shouldn't think like this way. I think this doctor didn't understand me. If you use Dutch mentality to treat me, you are not suitable (qualified; 適合) to treat my illness.

Discrimination. The experience of discrimination also had a negative effect on the quality of treatment. ID12-1 was a Chinese woman from Indonesia. Her treatment (psychotherapy) remained a struggle until she got help from a psychiatrist originating from the same country: there is a strong suggestion that discrimination played a role.

> [ID12-1] She [the protagonist] thought it [the care] was terrible. They [the professionals] made a clear distinction between people from the East and full-blooded Dutch. I think it had to do with the clash between cultures… What struck me is that she said at one point it went better when she had an Indonesian psychiatrist.

Practical matters. Sometimes the demands of everyday life, such as working hours or lack of time for treatment, affected protagonists' ability to receive treatment. For example, ID11-5 still had to work when she was very ill:

> [ID11-5] She is very sick and she has to work… But she is really ill and cannot work. She needs to ask for sick leave often. Even she only works 3 days a week… If she doesn't need to work, she will be able to take a real rest. That will make a lot of difference.

7.4.5 Respondents' suggestions for improving care

Some narrators, including a few who were also protagonists, expressed their opinions about the kinds of support which could help Chinese to overcome factors which undermined the quality of care. Most suggestions focused on improving communication.

Better interpretation and translation services were seen as necessary to overcome communication barriers. It seems that many Chinese were not aware of the interpretation services that are available. In some situations family members were invited to interpret for the patient. However, narrator ID11-1 pointed out the disadvantage of this:

> [ID11-1] Our kids have to make a living; they might not have time to go with us. Some of our kids can't speak Chinese that well either. For example, my hand was bitten by a dog recently. It seems like it was sprained (拗傷). They [kids] weren't sure what it [the Chinese word] means. If you ask them to go to the doctor's with you, they don't know how to tell the doctor about your situation. This is a huge headache for us.

Employing more Chinese health workers was also seen as a measure that could reduce both linguistic and cultural barriers.

> [ID05-1] It's better to hire Chinese people who have knowledge in this field [medical specialty]. It will be helpful to us, the older generation. At least we won't be confronted with the communication problem.

More *help from educational institutions or workplaces* was felt to be desirable to help newcomers access available services. Narrator ID08 talked about how his university assists overseas students to access care:

> [ID08] When we arrived, our school had arranged a family doctor for us. If we were in another city, we needed to find one by ourselves. We can also find the nearest psychologist on the web… Our teacher will distribute the information. Our school gives support about living. Friends and colleagues also exchange relevant information.

Compared to the overseas students in other schools, he felt lucky because his university not only provided the necessary information about Dutch health care to foreign students, but also helped them make use of the care.

7.5 Discussion

7.5.1 Main findings

Ways of finding help. Regarding *help-seeking behaviour,* mainstream Dutch health care was seen by three-quarters of the protagonists as the appropriate resource for dealing with mental health problems. The same proportion was found in an earlier questionnaire study on Chinese in the Netherlands (Liu et al., 2011).

When we examine *pathways to care,* most protagonists first consulted their GP; some of them were referred on by the GP to a specialized mental health service provider. Other protagonists sought help directly from services provided by schools or employers, or were pressed to receive care by people in their immediate environment. These pathways are the same as those used by the majority Dutch population, with one exception: no accounts mentioned seeking help from a psychologist of psychiatrist paid for entirely out of their own pocket. A few protagonists undertook other activities in addition to seeking mental health care from the regular services, but there were no examples of Chinese with mental health problems seeking other kinds of professional help as an alternative to mainstream Dutch care.

Barriers to access. These were experienced by many protagonists. However, culture-bound health beliefs hardly ever seemed to deter protagonists from seeking care. This result also agrees with the findings of the questionnaire study mentioned above (Liu et al.,

2011). Although fear of stigmatization was mentioned as a barrier in the present study, there were no indications that this obstacle to seeking professional help is greater among the Chinese community than in the general population.

The most serious barriers described concerned practical issues. Virtually all the issues identified in our review of the literature regarding Chinese in the West (above) were also found in this Dutch sample: communication problems (including language barriers), lack of knowledge about the health care system, concerns about the costs of care, service constraints and discrimination. Negative opinions about the quality of Dutch health care, whether or not based on personal experience, also deterred some people from using the system.

Experiences of mainstream care. In the 10 accounts that provided information about diagnosis, eight protagonists accepted the diagnosis given, but two expressed doubts about it. Psychotherapy and medication were the most commonly described treatments, usually given in combination. Some protagonists received physiotherapy or advice regarding their lifestyle. In seven of the 12 accounts providing information about adherence, the protagonists dropped out of treatment or refused it from the beginning.

Threats to care quality. Although positive outcomes were described in many accounts, difficulties in using the services were described in almost all of them. This suggests that the services are far from optimal for Chinese users. Factors which impaired the quality of care included poor communication, discrimination and practical matters.

Poor communication was seen as a major threat to care quality. Chinese reported that their problems in mastering the Dutch language made it harder for them to obtain knowledge about health and health care and to communicate successfully with professionals. As well as protagonists' limited language proficiency, the inability of professionals to appreciate their cultural background and social context was felt to make communication difficult if not impossible.

Opinions about the services and recommendations for improvement. Many protagonists expressed a need for interpreters, but they did not seem to be aware that interpretation services were provided free of charge by the Dutch government at the time the interviews were conducted. Though health professionals did not make much use of these services, it is likely that some protagonists in our study would have asked for professional interpretation had they known it was available. Other recommendations concerned the employment of more Chinese health workers and more help from educational institutions or workplaces.

7.5.2 Limitations of the study

The results of this qualitative study are in agreement with the main findings of the quantitative study that preceded it (Liu et al., 2011). The rich detail of these accounts gives additional insight into the nature of factors undermining the accessibility and quality of care. However, caution should be exercised in extrapolating these results to the entire Chinese population in the Netherlands. Firstly, the sample size is limited. Secondly, although like the Chinese population itself the sample contains a great deal of diversity (in terms of country of origin, date of migration, age etc.), no attempt was made to make the sample representative by matching the proportions. Thirdly, the method of recruitment and interviewing could have introduced biases, and most information about the experiences of people undergoing treatment was obtained at second hand. On the other hand, the fact that saturation was reached in the construction of codes (Liu et al., 2013) suggests that using a larger sample would not add much to the range of issues identified. The main value of such research is to show in concrete detail what respondents mean when they talk about (for example) barriers to access or problems in communication. A much larger study would be needed to track down all the possible sources of variation in the results.

Two other limitations that should be borne in mind are that the interpretation of the concept 'mental health problem' was left up to the respondent: no precise criteria were given. In addition, because data in different variables were not collected and the sample size was small, it was not possible to identity groups or characteristics that were associated with having problems in using Dutch mental health care. The results should not be assumed to apply without distinction to all Chinese in the Netherlands.

7.5.3 Conclusion

These results show that much needs to be done to improve the accessibility and quality of mental health care services for Chinese in the Netherlands. Cultural differences exist and can create barriers to mutual understanding, but they are not such as to prevent Chinese from accepting and benefiting from Dutch health care. The main barriers have to do with low language proficiency, lack of knowledge of the health system, lack of cultural competence among professionals, and the failure of the health system to take steps to overcome these.

Although of course it is important for all migrants to acquire a certain level of proficiency in the language of the host country, many find Dutch difficult to learn and some - for example students - do not intend to stay for long. Information about the health system in migrants' own languages is badly needed and should be incorporated in integration programs. From 1986 onwards the Dutch government organized a program entitled "Health information in migrants' own languages and cultures" (Singels, Drewes, & van der Most van Spijk, 2008), but in recent years the Health Ministry has withdrawn support

for all programs in foreign languages. For irregular migrants, effective dissemination of information about their entitlements to health care is also needed.

Service providers should be enabled to provide professional interpretation services without creating financial barriers for patients. Unfortunately, in 2012 the Dutch government withdrew financial support for these services (VWS, 2011), so that the problem of language barriers for Chinese and other ethnic groups is likely to have become even more serious. The position of the Dutch Health Minister is that informal interpretation by friends or family members can fill the gap (VWS, 2013), but much research has demonstrated that this is a highly unsatisfactory solution (Mikado, 2012; Priebe et al., 2011; Meeuwesen et al., 2010; Liu et al., 2008).

It is also clear from these results that health workers' skills in intercultural communication need to be enhanced. This has implications for the training of medical staff and the formulation of quality standards. The use of 'cultural mediators' is another strategy that can be employed to bridge the gaps in language, knowledge, and culture between care users and professionals (Chen et al., 2009; Green et al., 2005).

In comparison with the four largest non-Western ethnic groups in the Netherlands, very few research studies on health care or health promotion programs have focused on the Chinese minority. Given the increasing size of this group and the barriers to access and threats to health care quality that have been demonstrated by this and earlier studies, it is high time that more attention was paid to the health needs of ethnic Chinese in the Netherlands.

Chapter 8

Summary, discussion and conclusions

8.1 Introduction

Dutch research has suggested that compared to other ethnic groups in the Netherlands, Chinese are less likely to use mental health care yet present more serious symptoms at the first consultation (Schellingerhout, 2011; Liu, 2008; Geense, 2003). However, the reason for these differences is unknown, because most studies of ethnic minorities in the Netherlands are confined to the four main groups – Turkish, Moroccan, Surinamese and Antillean.

This research set out to fill this gap in our knowledge and to shed light on mental health care utilisation among Chinese in the Netherlands. It further examines the adequacy of Dutch mental health care services for this group. Recommendations are made for improving health service delivery and for refining existing theories on the basis of the results. These proposals regarding 'good practice' can contribute more generally to mental health service delivery in a multicultural setting.

The aim of this study is to answer the following research questions:

1. Who are the Chinese in the Netherlands? (Chapter 2)
2. How has attention for health service delivery to migrants and ethnic minorities arisen, and what developments have taken place in the main approaches? (Chapter 3)
3. What are the basic concepts used to analyse health service delivery to migrants and ethnic minorities? What is known about (a) problems in mental health service delivery to these groups in Western countries, and (b) problems concerning Chinese living in the Netherlands? (Chapter 4)
4. What patterns of help seeking are found among Chinese in the Netherlands? How easy is their access to health care? What are their attitudes concerning mental health problems and Dutch (mental) health care? (Chapter 5)
5. What role do beliefs about mental health play in mental health care utilisation among this group? What kinds of problems are perceived as mental health problems? What is regarded as causing them and what kinds of help are considered appropriate? (Chapter 6)
6. What are the experiences of using mental health care among Chinese in the Netherlands? What light do these experiences shed on their underutilisation of mental health care? (Chapter 7)

This research embraces a range of disciplines in medical and social sciences, such as psychiatry, clinical and health psychology, medical anthropology, social history and sociology. Both literature reviews and empirical studies were carried out.

Literature reviews provided the basis of chapters 2, 3 and 4. In chapters 3 and 4 the articles and books examined ranged from general to specific: from publications on migrant health care, health service delivery, and health care utilisation in general, studies concerning such topics among Chinese in the West, to specific articles on the Chinese community in NL.

In chapters 5, 6 and 7 empirical studies were carried out on the use of mental health care among Chinese in the Netherlands. A mixed-method approach was applied in data collection and analysis.

In phase I of this empirical research, quantitative data were collected by administering a structured questionnaire in street interviews to a sample of Chinese in the four main Dutch cities or *Randstad* (Amsterdam, The Hague, Rotterdam and Utrecht). The questions referred to their help-seeking behaviour, access to Dutch health care and opinions of the quality of care, with a special focus on mental health care. The software package SPSS 10 was used for data analysis.

In phase II, rather than recruiting Chinese with mental health problems, an indirect method was used in which qualitative data were collected using 23 semi-structured in-depth interviews with Chinese who were willing to give an account of one or more Chinese persons in their social environment whom they regarded as having (had) mental health problems (精神問題). These interviews yielded 30 such accounts. Qualitative data analysis using the software programme NVivo 9 focused on the way these problems were described and explained, the kinds of help regarded as appropriate, experiences in Dutch mental health care, factors impeding the quality of care, and respondents' reflections on care utilisation.

8.2 Main findings

8.2.1 Findings of literature reviews

Chapter 2 Ethnic Chinese in the Netherlands

With their different migration patterns and origins, ethnic Chinese in the Netherlands form a heterogeneous group. There are important differences in terms of socioeconomic status, migration experiences, adherence to traditional Chinese culture, level of acculturation into Dutch society, and many other factors. Based on national census data and research on the Chinese ethnic group, four subgroups can be distinguished: Chinese who migrated before 2000 ('Pre-2000 Chinese'), Chinese who migrated after 2000 ('New Chinese'), Chinese from former Dutch colonies, and the second generation.

- Pre-2000 Chinese in general have a low educational level and limited Dutch language proficiency. Despite their high labour-market participation, many of them are socially isolated. Members of this group usually adhere closely to traditional Chinese cultural norms, values and customs.

- By contrast, the New Chinese have a much higher education level, although their Dutch proficiency may be very low (many of them do not intend to settle). Compared to older migrants, the New Chinese are more likely to accept Western values alongside traditional Chinese culture.
- Chinese from former Dutch colonies are well integrated in mainstream society, partly because of their early exposure to Dutch culture.
- The second generation generally show high levels of education and participation in the labour market. Although they grew up in families with traditional Chinese culture, many of them have to a certain extent let go of Chinese norms and values. In many respects, they are closer to native Dutch people.

Chapter 3 Approaches to health service delivery for migrants and ethnic minorities

Attention to diversity and health first arose mainly in the context of the Civil Rights Movement in the USA (ca. 1955-1968). In the beginning, the concept of 'culture' gained most attention from those trying to improve health services for minorities. Best practice in health service delivery was defined as 'culturally sensitive' or 'culturally competent' care. Gaining knowledge of 'other' cultures was regarded as the appropriate professional response to the challenges presented by an ethnically diverse population.

During the past three decades, however, the nature and importance of 'cultural competence' has been called in question. There have been three main (though overlapping) shifts in this notion.

- In the first shift, the knowledge-oriented concept of 'competence' was expanded to also take attitudes and skills into account (e.g. respect, discovering one's own prejudices, skills for intercultural communication).
- In the second, the understanding of culture was challenged: 'cultures' were seen as not static, but dynamic. Instead of focusing on the presumed characteristics of different cultures, health providers should continually engage in openness, self-reflection, respect towards the other, and self-critique (Harrison & Turner, 2010). 'Cultural humility' was seen as a more fitting goal than 'cultural competence'.
- In the third and most recent shift, the emphasis on the culture of migrants and ethnic minorities is coming to be seen as too narrow. Other types of diversity are also related to inequalities in health care and should be considered. In the USA, the concept of 'culture' has been redefined in response to this shift as covering any kind of diversity, whereas in Europe, the shift is seen as downplaying the importance of 'culture'. Instead, 'diversity sensitivity' has been proposed as a more comprehensive aim for health services than 'cultural competence'.

Chapter 4 Investigating health service delivery to migrants and ethnic minorities

Access to health services and quality of service delivery are the two basic elements which determine the adequacy of health services for migrants and minorities. Access is concerned with the opportunity to obtain health care when it is wanted or needed. The main factors determining it are entitlement to use health services and their accessibility for the user. Underutilisation of health services is often taken to indicate poor access, but other factors may complicate this relationship. Indicators of the quality of service delivery include its effectiveness in terms of outcomes, the satisfaction of both users and health care workers, and the extent to which the treatment process is properly carried out, avoiding therapy noncompliance and dropout.

After examining the basic concepts used to analyse issues concerning access and quality, this chapter reviews the literature on health services to migrants and ethnic minorities in order to identify the factors that have been frequently identified as problematic. This section focuses particularly on overseas Chinese and mental health care. Findings suggest that although many factors may undermine the mental health of overseas Chinese, they are less likely to utilise mental health services. Frequently mentioned barriers to seeking help among Chinese migrants include low socioeconomic status, education, gender, lack of entitlement, level of acculturation, linguistic discordance and communication barriers, self-medication and use of traditional treatment, health-related beliefs, cultural competency of health systems, stigma, and discrimination in the health care setting. Traditionally, researchers have emphasised 'cultural' factors such as mental health beliefs and stigma. In the past decade, however, the focus has shifted more to socioeconomic or 'practical' factors.

Finally, this chapter examines what is known about health service utilisation by Chinese in the Netherlands. Research on this group has been eclipsed by the attention paid to the four main ethnic groups, so that little is known about the health status and health service utilisation of the Chinese majority. Nevertheless, there are indications of unmet needs for mental health care, such as the finding that those who seek help present more serious symptoms in the first consultation. There is an urgent need for more research into the relationship between the Chinese minority and mental health services.

8.2.2 Findings of empirical research

Chapter 5 Barriers to health care for Chinese in the Netherlands

This study examined utilisation of the Dutch health care system by Chinese in the Netherlands as well as their attitudes to the system, paying special attention to mental health. Information was gathered by semi-structured interviews (n=102). The main issues investigated were help-seeking behaviour, access, and quality of care.

In Chapter 2 we showed that the Chinese minority in the Netherlands can be divided into four subgroups. Although the sample size in this study was too small to provide a

sufficiently powerful test of differences between these subgroups, all were represented among the respondents and clear differences between certain subgroups emerged in terms of their relationship to the health system.

Most respondents used Dutch health care as their primary method of managing health problems. Inadequate knowledge about the system and lack of Dutch language proficiency were found to impede access to care, in particular registration with a General Practitioner (GP). Users also complained that the care given differed from what they expected.

Nevertheless, results showed that Chinese in the Netherlands regard Dutch health care as their primary method of managing health problems in general. There was no evidence of differences in this respect as a function of age, sex, educational level or length of residence in the Netherlands. Western methods of treating mental illness appeared to be widely accepted by Chinese. At the same time, traditional Chinese medicine (TCM) or other methods were also regarded as appropriate for dealing with mental health problems. The researchers did not get the impression that mental health problems were heavily stigmatised by the respondents. Most of them seemed to feel comfortable talking about mental health and said they were willing to talk about it with relatives and friends.

The ease of using Dutch health care was affected by entitlement, age, gender, education, length of residency in the Netherlands, Dutch proficiency and knowledge of the health care system. Barriers mentioned in the open questions included language barriers, long waiting times and procedures, divergent ideas about health and discrimination.

Most problems were to be found in the group coming from Chinese-speaking regions, regardless of the time they had spent in the Netherlands. Their Dutch proficiency was often very low. This group contained all of those with no health insurance, as well as most of those who had received no information about Dutch health care, were not registered with a GP, and did not use the Dutch health system. Migrants from former Dutch colonies, as well the second and the third generation, were mostly well acculturated and had better Dutch language proficiency. They reported fewer problems in using health care.

This study concluded that the provision of relevant information in Chinese appears to be very important for improving access. Better interpretation and translation services are also required, especially for first-generation migrants from Chinese-speaking regions.

Chapter 6 Beliefs about mental illness among Chinese in the West

A reluctance to seek help among ethnic Chinese in the West is often attributed to different beliefs about mental health problems. However, this explanation has seldom been investigated empirically. This study set out to investigate beliefs about mental health problems among Chinese in the Netherlands, using a qualitative approach.

In-depth interviews were held with 23 Chinese respondents, who gave a total of 30 accounts of a Chinese person they knew who had experienced mental health problems. Data analysis focused on the way the respondents and the acquaintances they talked about

described and explained mental health problems, and the kinds of help they believed to be appropriate.

Conceptualisations of mental health problems did not differ greatly from those commonly found in Western countries, nor did the type of explanations given. There was little evidence of rejection of Western mental health care as an appropriate form of treatment, though other approaches were also mentioned as relevant. This supported the findings of the study reported in Chapter 5.

Problems were described by respondents as a question of 'mental health' if the everyday functioning of the sufferers, or the lives of people in the their immediate environment, were seriously affected because of their inability to act rationally or cope with their own emotions, and to control their behaviour in a way regarded by others as normal. Explanations for mental health problems were sought in external factors (e.g. life events) and/or endogenous ones (e.g. biological factors or personality dispositions). These factors could also interact with each other. Levels of social support and personal resilience could moderate the development of mental health problems. Such ideas seem perfectly compatible with current Western notions about mental health. Barriers to using Western mental health care services may exist, but in this group the reasons for underutilisation of services do not seem to have much to do with cultural differences in health beliefs.

Chapter 7 Barriers to mental health care utilisation for Chinese in Netherlands

Qualitative methods of analysis were applied to interview data in order to explore ways of finding help, barriers to accessing mainstream mental health care, experiences in care, factors jeopardizing the quality of care, and views on the services. The same corpus of data was used as in Chapter 6: rather than recruiting Chinese with mental health problems, an indirect method was used in which ethnic Chinese were invited to tell us about one or more Chinese persons in their social environment whom they regarded as having (had) mental health problems.

Although most Chinese regarded mainstream Dutch care as the appropriate resource for dealing with mental health problems, many barriers to access were reported. The most serious of these concerned practical issues. Most of the issues identified in our literature review regarding overseas Chinese in the West (see Chapter 4) were also found in this Dutch sample: communication problems (including language barriers), lack of knowledge about the health care system, concerns about the costs of care, service constraints and discrimination. Negative opinions about the quality of Dutch health care, whether or not based on personal experience, also deterred some people from using the system.

While positive outcomes were described in many accounts, difficulties in using mental health services were mentioned at the same time. Dropout was also frequently reported. Factors which impaired the quality of care included poor communication, discrimination, and practical matters such as time restriction.

Chinese reported that their problems in mastering the Dutch language made it harder for them to obtain knowledge about health and health care, and to communicate successfully with professionals. The inability of professionals to appreciate their cultural background and social context was felt to make communication difficult if not impossible.

The results suggested that the Dutch mental health care system is still far from optimal for Chinese migrants. Better interpretation services, the employment of more Chinese health workers and cultural mediators, and more possibilities for accessing help directly from educational institutions or workplaces were recommended in order to improve services for Chinese migrants.

8.3 Methodological considerations

8.3.1 Strengths

In this study a mixed-method approach was applied to investigate the reasons underlying the underutilisation of mental health care services by Chinese living in the Netherlands. An initial quantitative study looking at health-seeking tendencies and attitudes to mainstream health services showed that these services were the preferred option of the Chinese interviewed. At the same time, however, many complaints and criticisms were made about the services.

Following this, qualitative data were collected from in-depth interviews in order to explore in more detail the problems that Chinese have with using mainstream mental health services. This provided the basis for two studies, the first looking at the influence of health beliefs and the second examining the nature of factors undermining the accessibility and quality of care. The value of this qualitative approach is that it not only explores health behaviours and attitudes, but also shows in concrete detail what respondents mean when they talk about mental health problems and barriers to good care.

8.3.2 Limitations

This research was exploratory in character, which limits the possibility of generalising its results. It was not possible to compare Chinese with any other ethnic groups. Nor was any information collected on the nature or prevalence of mental health problems among the Chinese minority. Furthermore, the characteristics of this minority in the Netherlands might be different from Chinese minorities in other countries. Generalisation to other countries would need to make allowance for the specific features of the Chinese population in those countries.

Moreover, the method of recruitment and interviewing could have introduced biases. The method of recruiting respondents for the street interviews reported in Chapter 5 may have deprived us of the opportunity to gather data from certain groups of people, such as those who work during the daytime or do not visit Chinatowns. In the qualitative study

(Chapters 6 and 7), most information about the experiences of people undergoing treatment was obtained at second hand. Information about these people was therefore limited and it was often not possible to relate the problems experienced to their context. Thus, the results should not be assumed to apply in general to all Chinese in the Netherlands.

Because lay beliefs and understandings of mental health rather than medical diagnosis were the primary focus of this research, we used the term 'mental health problems' (精神問題) rather than 'mental illness' in our questioning of respondents. The interpretation of the concept 'mental health problem' was left up to the respondents: no precise criteria were given. It could be argued that respondents might have adapted their accounts so as to make them fit better with Western notions about mental illness. However, the terms used in all the languages employed in these studies (Chinese, Dutch and English) did not have specifically Western connotations.

In addition, the sample size of the quantitative study was not large enough to make multivariate analysis possible, include tests of variations of effects between subgroups. The composition of the sample used for the in-depth interviews contained many of the same kinds of diversity as the wider Chinese population in the Netherlands (in terms of country of origin, date of migration, age etc.), but no attempt was made to make the sample representative by matching the proportions. Here too, biases cannot be entirely ruled out.

8.4 Theoretical reflection

Chinese in the Netherlands show their needs for mental health care

As described in Chapter 4, it is widely reported in the literature that Chinese in the West underuse regular (mainstream) health care services, especially mental health care. Our research confirms that this phenomenon is also found in the Netherlands. The results of our quantitative study further showed that more than half of the respondents had relatives or friends with mental health problems or had themselves experienced issues related to mental health problems in the Netherlands. This backs up suggestions in the literature that the mental health care needs of the Chinese minority are unlikely to be lower than those of the rest of the population.

Cultural barriers exist but do not seem to be the main determinant of mental health care underutilisation among Chinese migrants

Although researchers have claimed that the health beliefs of ethnic Chinese in the West are incompatible with Western ideas about mental illness and that this leads them to underutilise mental health care, the results of our research do not support this view. In our studies, barriers to accessing care had more to do with other factors rather than divergent 'explanatory models'. The following findings are salient in this respect:

1. *Chinese migrants show positive attitudes toward Western mental health care.*

   While Chinese in the Netherlands show a lower uptake of mental health care, the majority of respondents in both our quantitative and qualitative studies regarded Western mental health care as an appropriate and indeed preferred method of dealing with mental health problems. This finding is at loggerheads with the traditional 'cultural' explanation that overseas Chinese hold divergent health beliefs and perceive Western health care as not appropriate. Something else besides cultural beliefs seemed to be standing in the way of using mainstream Dutch services.

2. *Mental health beliefs of Chinese migrants are more similar to Western ones than is usually supposed.*

   We found little evidence, either in the literature reviews or the empirical studies, to back up the widespread assumption that overseas Chinese do not recognise the existence of mental illness. The descriptions of the nature of 'mental health problems', the explanations believed in, and the attitudes to these problems do not differ much from those of Westerners. As Luk (1992) has pointed out, modern Chinese actually have a similar understanding of mental health as people in the West and regard environmental/hereditary and social/personal factors as the main causes of mental illness. Many studies seem to overlook the evolving nature of Chinese culture. Wong and Tsang (2004, p. 458) argued in their Canadian study on Asian migrants and mental health: "The selective attention to classic cultural systems is a symptom of an ethnocentric perspective based on European American norms, which position non-Western people as 'the other', defining them as 'different'. The characterization of cultural differences often represents projections of opposites of what is culturally valued in the West."

3. *Chinese migrants present a tendency to 'health pluralism'.*

   While Chinese in the Netherlands regard Western mental health care as the primary method of dealing with mental illness, they consider Traditional Chinese Medicine (TCM) or other alternative therapies as appropriate methods as well. This tendency to health pluralism is also observed in Chinese communities in the USA and the UK (Hsiao et al., 2006; Green et al., 2006). It seems that inheriting traditional Chinese health beliefs does not preclude Chinese migrants from using regular mental health care services. A study on Vietnamese Americans put forward a similar argument (Jenkins et al., 1996). Indeed, we have already remarked that traditional Chinese beliefs are not necessarily incompatible with Western ones. TCM's holistic approach of considering simultaneously body, mind and environment is largely compatible with the 'bio-psycho-social' model.

Practical factors, especially language and communication problems, form the main barriers to health care utilisation among Chinese migrants

Although in our research cultural differences have been observed which can create barriers to mutual understanding, they are not such as to prevent Chinese from accepting and benefiting from Dutch health care. Health insurance in the Netherlands is compulsory but affordable, so that Chinese in the Netherlands are generally entitled to health care – by contrast with their compatriots in the USA, many of whom cannot afford health insurance (Clough et al., 2013). However, the expectation of high costs for mental health care can affect Chinese migrants' readiness to use such services.

In line with previous findings that the utilisation of health care by Chinese migrants is closely linked to their proficiency in the local language (see Chapter 4), we found that the main barriers have to do with low Dutch proficiency, lack of knowledge of the health system, lack of cultural sensitivity among professionals, and the failure of the health system to take steps to overcome these. Because Dutch mental health services are incorporated in both primary and secondary care, the barriers to mental and general health care utilisation often overlap.

Individuals in the Chinese minority may need different kinds of help to facilitate their utilisation of health services

Being aware of the fact that 'the Chinese community' comprises several subgroups with different demographic and cultural characteristics, it is worth noting that language and communication barriers particularly concern those who have migrated from Chinese-speaking regions during the last two decades. Compared to Chinese from former Dutch colonies and the second generation, this group shows the greatest problems in accessing and using mental health care. Results showed that Chinese with a higher level of acculturation – in particular, better Dutch language proficiency – have easier access to Dutch health care and can profit more from it. This supports Kung's (2004) suggestion that acculturation level is significantly related to the practical barriers affecting health care utilisation and quality.

Although it is important for all migrants to acquire a certain level of proficiency in the language of the host country, it is an undeniable fact that developing language proficiency takes time. Thus, professional interpretation services, health information in Chinese language and having more health care professionals of Chinese descent are crucial for some people to receiving adequate care. Unfortunately the Dutch Health Ministry has withdrawn support both for interpreter services and the programme "Health information in migrants' own languages and cultures", which had been run by the Dutch government since 1986 (Singels et al., 2008). The problem of language barriers for Chinese and other ethnic groups is likely to have become even more serious due to these regressive and inequitable measures (Mikado, 2012; Priebe et al., 2011; Meeuwesen et al., 2012).

Again, however, Chinese in the Netherlands form a heterogeneous group. While language and communication problems are often reported, other barriers can remain even if there are no such problems. For instance, effective dissemination of information about entitlements to health care is urgently needed for irregular migrants; and all migrants need information about how the health system works and how to make use of it.

8.5 Conclusion and recommendations

8.5.1 From 'cultural competence' to 'diversity sensitivity'

As we saw in Chapter 3, the increasing diversity of ethnic minorities has presented a challenge to the original model of 'cultural competence'. In response to this, a split has developed between American and European approaches to health service delivery to migrants and ethnic minorities. In the USA the concept of 'culture' has been redefined so as to cover all types of variation in human characteristics, resulting in the development of two streams: a broader definition of 'cultural competence' in the USA, versus a switch to the term 'diversity sensitivity' in Europe.

Regardless of the terms used, the findings of our research support this shift. First, Chinese in the West are very diverse in terms of their culture, migration history, socioeconomic status and acculturation level. Different individuals have different needs. Second, the health beliefs held by Chinese migrants are not static. Their understanding of health and illness evolves in response to the ideas and developments they encounter. Third, however important health beliefs may be, practical barriers - such as communication problems, restrictions of time and money, and negative experiences in health care – seem to be more serious barriers to utilisation among overseas Chinese.

In short, simply knowing that a person is of Chinese origin is likely to tell us little about their beliefs concerning mental health and what they need from a service provider. As far as these matters are concerned, traditional Chinese beliefs are in any case not necessarily incompatible with Western ones. Service providers should pay more attention to issues such as communication barriers, entitlement to care, knowledge of the health care system, attitudes of professionals and discrimination.

8.5.2 Recommendations

Policies for Chinese in the Netherlands need to be adapted to improve the adequacy of both general and mental health care. The present research implies that special measures to overcome language barriers should be implemented for the benefit of certain migrants: for example, those from Chinese-speaking regions who arrive later in life, those who seldom have contact with native Dutch, and students or business people not intending to stay permanently. For migrants with a low level of Dutch proficiency, better interpretation and translation services are urgently required. To counter the lack of knowledge about the health system, activities to improve health literacy are clearly necessary. Information

about the health system in migrants' own languages is urgently needed and should be incorporated in integration programs.

It is also clear from these results that health workers' skills in intercultural communication need to be enhanced. This has implications for the training of medical staff and the formulation of quality standards. With the proper knowledge, attitudes and skills, health care professionals can identify patients' specific needs and develop the necessary skills. The employment of more Chinese-speaking health workers would help to improve both access and the quality of care. The use of 'cultural mediators' is another strategy that can be employed to bridge the gaps in language, knowledge, and culture between care users and professionals.

In the Netherlands, very few research studies or interventions in health care or health promotion have focused on the Chinese minority in comparison with the four largest non-Western ethnic groups. Given the growing size of this group, their increasing level of participation in mainstream society, and the barriers to access and threats to health care quality that have been demonstrated by this research and earlier studies, it is high time that more attention is paid to their health needs.

References

Abbott, M. W., Abbott, M. W., Wong, S., Giles, L. C., Wong, S., Young, W., & Au, M. (2003). Depression in older Chinese migrants to Auckland. *Australian and New Zealand Journal of Psychiatry*, *37*(4), 445–451.

Abbott, M. W., Wong, S., Williams, M., Au, M., & Young, W. (1999). Chinese migrants' mental health and adjustment to life in New Zealand. *The Australian and New Zealand Journal of Psychiatry*, *33*(1), 13–21.

Abe-Kim, J., Takeuchi, D. T., Hong, S., Zane, N., Sue, S., Spencer, M. S., … Alegría, M. (2007). Use of mental health–related services among immigrant and US-born Asian Americans: Results from the National Latino and Asian American Study. *American Journal of Public Health*, *97*(1), 91–98.

Adams, D. L. (Ed.). (1995). *Health issues for women of color: A cultural diversity perspective*. Thousand Oaks: Sage.

Aday, L. A., & Andersen, R. (1974). A framework for the study of access to medical care. *Health Services Research*, *9*(3), 208.

Agudelo-Suárez, A. A., Benavides, F. G., Felt, E., Ronda-Pérez, E., Vives-Cases, C., & García, A. M. (2010). Sickness presenteeism in Spanish-born and immigrant workers in Spain. *BMC Public Health*, *10*(1), 791.

Albayrak, A. (2013, April 30). Turkey works to transform overseas Turks into diaspora. *Today's Zaman*.

Algra, W. (2001, October 18). Er zijn er maar weinig die willen praten [There are few who want to tell]. *Trouw.*

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, *36*(1), 1–10.

Andersen, R. M. (2008). National health surveys and the behavioral model of health services use. *Medical Care*, *46*(7), 647–653.

Aragona, M., Tarsitani, L., Colosimo, F., Martinelli, B., Raad, H., Maisano, B., & Geraci, S. (2005). Somatization in primary care: A comparative survey of immigrants from various ethnic groups in Rome, Italy. *International Journal of Psychiatry in Medicine*, *35*(3), 241–248.

Attané, I. (2002). China's family planning policy: An overview of its past and future. *Studies in Family Planning*, *33*(1), 103–113.

Baskerville, R. F. (2003). Hofstede never studied culture. *Accounting, Organizations and Society*, *28*(1), 1–14.

Beach, M. C., Inui, T. (2006). Relationship-centered care. *Journal of General Internal Medicine*, *21*(S1), S3–S8.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, *118*(4), 293–302.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs*, *24*(2), 499–505.

Bischoff, A., Bovier, P. A., Rrustemi, I., Gariazzo, F., Eytan, A., & Loutan, L. (2003). Language barriers between nurses and asylum seekers: Their impact on symptom reporting and referral. *Social Science & Medicine*, *57*(3), 503–512.

Blaak, M., & Huijbregts, V. (2004). *De smaak van noedelsoep: Begeleiding van Chinese AMA's in opvang en onderwijs*. *[The taste of noodle soup: the guidance of Chinese unaccompanied minor asylum seekers in care and education]*. Utrecht: Pharos.

Blanchard, J. C. (2006). *Discrimination and health care utilization*. Santa Monica: RAND.

Blignault, I., Ponzio, V., Rong, Y., & Eisenbruch, M. (2008). A qualitative study of barriers to mental health services utilisation among migrants from mainland China in south-east Sydney. *International Journal of Social Psychiatry*, *54*(2), 180–190.

Bodeker, G., & Ong, C.-K. (2005). *WHO global atlas of traditional, complementary and alternative medicine.* Kobe: WHO.

Boeije, H. R. (2010). *Analysis in qualitative research*. London: Sage.

Bond, M. H. (1996). Introduction. In M. H. Bond (Ed.), *The handbook of Chinese psychology* (pp. xviii–xx). Hong Kong: Oxford University Press.

Bovenkerk, F., & Brunt, L. (Eds.) (1977). *De rafelrand van Amsterdam: Vier sociografische schetsen. [The 'rafelrand' in Amsterdam: Four sociographic sketches]*. Meppel: Boom.

Brown, E. R., Ojeda, V. D., Wyn, R., & Levan, R. (2000). *Racial and ethnic disparities in access to health insurance and health care.* CA: UCLA Center for Health Policy Research.

Cattacin, S., Chiarenza, A., & Domenig, D. (2013). Equity standards for healthcare organisations: a theoretical framework. *Diversity and Equality in Health and Care*, *10*(4), 249–258.

CBS. (2009). *Jaarrapport integratie 2008 [Annual report intergration 2008]*. Den Haag: Centraal Bureau voor de Statistiek.

CBS (2011, February 4). Werkloosheid niet-westerse allochtonen in 2010 verder opgelopen. [Unemployment among non-western immigrants in 2010 further increased]. *CBS Persbericht PB11-05*.

CBS (2013, February 8). Werkloosheid niet-westerse allochtonen in 2012 verder opgelopen. [Unemployment among non-western immigrants in 2012 further increased]. *Centraal Bureau voor de Statistiek*. Retrieved June 4, 2013, from http://nos.nl/l/471776

CBS. (2014). Buitenlandse migratie naar geboorteland [Emigration to the country of birth]. *Statistisch Bulletin 2014*, *70*(8), 9.

COA (2008). *Feiten en cijfers tot 1 oktober 2008 [Facts and numbers until 1 October 2008]*. Centraal Orgaan opvang asielzoekers. Retrieved November 17, 2008, from www.coa.nl/NED/website/page.asp?menuid=101

Chan, Y. F., & Quine, S. (1997). Utilisation of Australian health care services by ethnic Chinese. *Australian Health Review: A Publication of the Australian Hospital Association*, *20*(1), 64–77.

Chauvin, P., Parizot, I., & Simonnot, N. (2009). *Access to healthcare for undocumented migrants in 11 European countries: 2008 survey report*. Paris: Médecins du monde.

Chen, A. W., & Kazanjian, A. (2005). Rate of mental health service utilization by Chinese immigrants in British Columbia. *Canadian Journal of Public Health/ Revue Canadienne de Santé Publique*, *96*(1), 49–51.

Chen, A. W., Kazanjian, A., & Wong, H. (2008). Determinants of mental health consultations among recent Chinese immigrants in British Columbia, Canada: Implications for mental health risk and access to services. *Journal of Immigrant and Minority Health*, *10*(6), 529–540.

Chen, A. W., Kazanjian, A., & Wong, H. (2009). Why do Chinese Canadians not consult mental health services: Health status, language or culture? *Transcultural Psychiatry*, *46*(4), 623–641.

Chen, G.-M. (2001). Chapter 3: Toward transcultural understanding: A harmony theory of Chinese communication. In V. H. Milhouse, M. K. Asante, & P. Nwosu, (Eds.), *Transcultural realities: Interdisciplinary perspectives on cross-cultural relations* (pp. 55–70). Thousand Oaks: Sage.

Chen, G.-M. (2013). The two faces of Chinese communication. *Human Communication: A Journal of the Pacific and Asian Communication Association*, *7*(1): 25–36.

Chen, S., Sullivan, N. Y., Lu, Y. E., & Shibusawa, T. (2003). Asian Americans and mental health services. *Journal of Ethnic and Cultural Diversity in Social Work*, *12*(2), 19–42.

Chen, S. X., & Mak, W. W. S. (2008). Seeking professional help: Etiology beliefs about mental illness across cultures. *Journal of Counseling Psychology*, *55*(4), 442–450.

Cheung, F. M., Lau, B. W. K., & Waldmann, E. (1980). Somatization among Chinese depressives in general practice. *The International Journal of Psychiatry in Medicine*, *10*(4), 361–374.

Cheung, P., & Spears, G. (1992). Psychiatric morbidity among Dunedin Chinese women. *Australian and New Zealand Journal of Psychiatry*, *26*(2), 183–190.

Cheung, Y., & Lam, P. (2006). *Vallende bladeren op nieuwe wortels [Falling leaves on new roots]*. Rotterdam: Stichting Welzijnsbehartiging Chinezen Wah Fook Wui.

Chiarenza, A. (2012). Development in the concept of "cultural competence." In D. Ingleby, A. Chiarenza, W. Devillé, & I. Kotsioni (Eds.), *Inequalities in health care for migrants and ethnic minorities* (pp. 66–81). Antwerp-Apeldoorn: Garant.

Chin, K.-L. (2011). The social organization of Chinese human smuggling. In D. Kyle, & R. Koslowski, (Eds.), *Global human smuggling: Comparative perspectives (pp* 216–235). Baltimore: The John Hopkins University Press.

Choe, M. K., & Han, S.-H. (1984). *Family size ideal and reproductive behaviour in South Korea.* Paper presented at the USSP Workshop on Abortion, Infanticide and Neglect. Kyoto, Japan.

Chow, Y. F., Zwier, S., & Zoonen, L. van (2008). Bananen, modelminderheid en integratie: Mediagebruik en identificaties onder jonge chinezen in Nederland (Bananas, model minority and integration: Media utilisation and identifications among young Chinese in the Netherlands). *Migrantenstudies*, *24*(1), 72–85.

Chu, J. P., & Sue, S. (2011). Asian American mental health: What we know and what we don't know. *Online Readings in Psychology and Culture*, *3*(1), 1–18.

Chung, I. (2010). Changes in the sociocultural reality of Chinese immigrants: Challenges and opportunities in help-seeking behaviour. *The International Journal of Social Psychiatry*, *56*(4), 436–447.

Clough, J., Lee, S., & Chae, D. H. (2013). Barriers to health care among Asian immigrants in the United States: A traditional review. *Journal of Health Care for the Poor and Underserved*, *24*(1), 384–403.

Corbin, J. M., & Strauss, A. L. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Los Angeles: Sage.

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: CASSP Technical Assistance Center and Georgetown University Child Development Center.

Cuadra, C. B. (2012). Right of access to health care for undocumented migrants in EU: A comparative study of national policies. *The European Journal of Public Health*, *22*(2), 267–271.

Culley, L. (2006). Transcending transculturalism? Race, ethnicity and health-care. *Nursing Inquiry*, *13*(2), 144–153.

Dayib, F. (2005). The experiences and perceptions of Somalis in Finnish primary health care services. In Clarke K. (Ed.), *The problematics of well-being: Experiences and expectations of migrants and New Finns in the Finnish welfare state* (pp. 21–75). Tampere: University of Tampere.

Dere, J., Sun, J., Zhao, Y., Persson, T. J., Zhu, X., Yao, S., … Ryder, A. G. (2013). Beyond "somatization" and "psychologization": Symptom-level variation in depressed Han Chinese and Euro-Canadian outpatients. *Frontiers in Psychology*, *4*, 377.

Derose, K. P., Bahney, B. W., Lurie, N., & Escarce, J. J. (2009). Review: Immigrants and health care access, quality, and cost. *Medical Care Research and Review*, *66*(4), 355–408.

Derose, K. P., Escarce, J. J., & Lurie, N. (2007). Immigrants and health care: Sources of vulnerability. *Health Affairs*, *26*(5), 1258–1268.

Engebretson, J., Mahoney, J., & Carlson, E. D. (2008). Cultural competence in the era of evidence-based practice. *Journal of Professional Nursing*, *24*(3), 172–178.

Engelhard, D. (2007). No place like home? Return and circular migration among elderly Chinese in the Netherlands. *IIAS Newsletter*, 45, 20–21.

Fang, L., & Schinke, S. P. (2007). Complementary alternative medicine use among Chinese Americans: Findings from a community mental health service population. *Psychiatric Services*, *58*(3), 402–404.

Field, K. S., & Briggs, D. J. (2001). Socio-economic and locational determinants of accessibility and utilization of primary health-care. *Health and Social Care in the Community*, *9*(5), 294–308.

Flores, G. (2006). Language barriers to health care in the United States. *New England Journal of Medicine*, *355*(3), 229–231.

Fortier, J. P., & Bishop, D. (2003). *Setting the agenda for research on cultural competence in health care: Final report*. Edited by C. Brach. Rockville: U.S. Department of Health and Human Services Office of Minority Health and Agency for Healthcare Research and Quality. Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/agendarptAll.pdf

FRA: European Union Agency for Fundamental Rights. (2011). *EU-MIDIS: European Union Minorities and Discrimination Survey.* Luxembourg: EUR-OP. European Union Agency for Fundamental Rights.

Fung, K., & Wong, Y.-L. R. (2007). Factors influencing attitudes towards seeking professional help among East and Southeast Asian immigrant and refugee women. *International Journal of Social Psychiatry*, *53*(3), 216–231.

Furnham, A., & Li, Y. H. (1993). The psychological adjustment of the Chinese community in Britain. A study of two generations. *The British Journal of Psychiatry*, *162*(1), 109–113.

Garssen, J., & van Duin, C. (2007, January 8). *In 2050 ruim 1,6 miljoen meer allochtonen [In 2005, about 1,6 million more migrants]*. *Statistics Netherlands*. Retrieved October 18, 2013, from http://www.cbs.nl/NR/rdonlyres/

Garssen, J., & van Duin, C. (2011). Bevolkingstrends: Statistisch kwartaalblad over de demografie van Nederland [Population trends: Quarterly statistics on the demographics of the Netherlands]. *Statistics Netherlands*. Retrieved from http://www.cbs.nl/NR/rdonlyres/

Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing*, *26*(10), 979–999.

Geense, P. (2003). Chinese migranten in Nederland [Chinese migrants in the Netherlands]. In J. Tenwolde, J. E. Neef, & K. Mouthaan (Eds.), *Handboek interculturele zorg* (Vol. 25, pp. 83–110). Maarssen: Elsevier/De Tijdstroom.

Geertz, C. (1973). *The interpretation of cultures: Selected essays*. New York: Basic Books.

Gelfand, M. J., & Realo, A. (1999). Individualism-collectivism and accountability in intergroup negotiations. *Journal of Applied Psychology*, *84*(5), 721–736.

Gijsberts, M. (2011a). Taalbeheersing [Language proficiency]. In M. Gijsberts, W. Huijnk, & R. Vogels (Eds.), *Chinese Nederlanders: Van horeca naar hogeschool [Chinese Dutch: From catering to college]* (pp. 62–77). Den Haag: Sociaal en Cultureel Planbureau.

Gijsberts, M. (2011b). The Chinese in the Netherlands. In M. Gijsberts, W. Huijnk, & R. Vogels (Eds.), *Chinese Nederlanders: Van horeca naar hogeschool [Chinese Dutch: From catering to college]*(pp. 182–191). Den Haag: Sociaal en Cultureel Planbureau.

Gijsberts, M., Huijnk, W., & Vogels, R. (Eds.). (2011). *Chinese Nederlanders: Van horeca naar hogeschool [Chinese Dutch: From catering to college]*. Den Haag: Sociaal en Cultureel Planbureau.

Gill, P. S., Kai, J., Bhopal, R., & Wild, S. (2007). Black and minority ethnic groups. In J. Raftery (Ed.), *Health care needs assessment: Black and minority ethnic groups. The epidemiogically based needs assessment reviews.* (pp. 227–400). Abingdon: Radcliffe Medical Press.

Green, A. R., Ngo-Metzger, Q., Legedza, A. T. R., Massagli, M. P., Phillips, R. S., & Iezzoni, L. I. (2005). Interpreter services, language concordance, and health care quality: Experiences of Asian Americans with limited English proficiency. *Journal of General Internal Medicine*, *20*(11), 1050–1056.

Green, G., Bradby, H., Chan, A., & Lee, M. (2006). "We are not completely westernised": Dual medical systems and pathways to health care among Chinese migrant women in England. *Social Science & Medicine*, *62*(6), 1498–1509.

Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does "access to health care" mean? *Journal of Health Services Research & Policy*, *7*(3), 186–188.

Gunaratnam, Y. (1997). Culture is not enough. In D. Field, J. L. Hockey, & N. Small (Eds.), *Death, gender, and ethnicity* (pp. 166–186). London/New York: Routledge.

Gushulak, B., Pace, P., & Weekers, J. (2010). Migration and health of migrants. In T. Koller (Ed.), *Poverty and social exclusion in the WHO European Region: Health systems respond.* (pp. 257–81). Copenhagen: WHO Regional Office for Europe.

Gupta, D. M., Zhenghua, J., Bohua, L., Zhenming, X., Chung, W., & Hwa-Ok, B. (2003). *Why is son preference so persistent in East and South Asia? A cross-country study of China, India, and the Republic of Korea*. World Bank Publications. Retrieved from http://www.worldbank.icebox.ingenta.com/content/wb/

Harmsen, C. (1998, July 13). *Chinezen in Nederland [Chinese in the Netherlands]. Statistics Netherlands.* Centraal Bureau voor de Statistiek. Retrieved October 18, 2013, from http://www.cbs.nl/nl-NL/menu/themas/bevolking/

Harmsen, C. (2011, April 28). *Ruim 51 duizend Chinezen van de eerste generatie in Nederland [About 51 thousand first generation Chinese in the Netherlands]. Statistics Netherlands*. Centraal Bureau voor de Statistiek. Retrieved October 18, 2013, from http://www.cbs.nl/nl-NL/menu/themas/bevolking/

Harmsen, J. A. M. , Bernsen, R. M. D., Bruijnzeels, M. A., & Meeuwesen, L. (2008). Patients' evaluation of quality of care in general practice: What are the cultural and linguistic barriers? *Patient Education and Counseling*, *72*(1), 155–162.

Harris, M. F., Furler, J. S., Mercer, S. W., & Willems, S. J. (2011). Equity of access to quality of care in family medicine. *International Journal of Family Medicine*, *2011*, 1–2.

Harrison, G., & Turner, R. (2010). Being a "culturally competent" social worker: Making sense of a murky concept in practice. *British Journal of Social Work*, *41*(2), 333–350.

Hernández-Quevedo, C., & Jiménez-Rubio, D. (2009). A comparison of the health status and health care utilization patterns between foreigners and the national population in Spain: New evidence from the Spanish National Health Survey. *Social Science & Medicine*, *69*(3), 370–378.

HHS. (2011). *HHS action plan to reduce racial and ethnic health disparities: A nation free of disparities in health and health care*. Washington, DC: US Department of Health and Human Services [HHS].

HHS. (2013a). National CLAS Standards: Fact Sheet. U.S. Department of health and human services. Retrieved from https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf

HHS. (2013b). *About Health Literacy*. *Health Resources and Services Administration*. U.S. Department of health and human services. Retrieved from http://www.hrsa.gov/publichealth/healthliteracy/healthlitabout.html

Ho, D. Y. F. (1996). Filial piety and its psychological consequences. In M. H. Bond (Ed.), *The handbook of Chinese psychology* (pp. 155–165). Hong Kong/New York: Oxford University Press.

Hofstede, G. (1984). *Culture's consequences: International differences in work-related values*. Beverly Hill: Sage.

Hofstede, G. H., Hofstede, G. J., & Minkov, M. (2010). *Cultures and organizations software of the mind: Intercultural cooperation and its importance for survival*. New York: McGraw-Hill.

Hsiao, F.-H., Klimidis, S., Minas, H., & Tan, E.-S. (2006). Cultural attribution of mental health suffering in Chinese societies: The views of Chinese patients with mental illness and their caregivers. *Journal of Clinical Nursing*, *15*(8), 998–1006.

Huijnk, W. (2011). Sociaal-culturele positie [Social cultural position]. In M. Gijsberts, W. Huijnk, & R. Vogels (Eds.), *Chinese Nederlanders: Van horeca naar hogeschool [Chinese Dutch: From catering to college]* (pp. 130–150). Den Haag: Sociaal en Cultureel Planbureau.

Huiskamp, N., Vis, H., Swart, W., & Voorham, T. (2001). *Gezondheidskaart allochtonen [Health review of migrants]*. Rotterdam: GGD Rotterdam en omstreken. Retrieved from http://www.mighealth.net/nl/images/6/6e/Gz1.pdf

Ingelby, D. (2011). Good practice in health service provision for migrants. In B. Rechel, P. Mladovsky, W. Deville, B. Rijks, R. Petrova-Benedict, & M. McKee (Eds.), *Migration and health in the European Union* (pp. 215–232). Maidenhead, Berkshire: Open University Press. Retrieved from http://www.euro.who.int/__data/assets/

Ingleby, D. (2009). *European Research on Migration and Health*. Brussels: International Organization for Migration (IOM). Retrieved from http://www.emeraldinsight.com/

Ingleby, D. (2012). Acquiring health literacy as a moral task. *International Journal of Migration, Health and Social Care*, *8*(1), 22–31.

Inspraakorgaan Chinezen. (2010). *Achtergrond van de Chinezen in Nederland [Background of Chinese in the Netherlands]*. *Inspraakorgaan Chinezen*. Retrieved from http://www.ioc-ch.nl/

Institute of Medicine (US) [IOM], & Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm a new health system for the 21st century*. Washington, D.C.: National Academy Press. Retrieved from http://search.ebscohost.com/

Jacob, K. S., Bhugra, D., Lloyd, K. R., & Mann, A. H. (1998). Common mental disorders, explanatory models and consultation behaviour among Indian women living in the UK. *Journal of the Royal Society of Medicine*, *91*(2), 66–71.

James, C., Thomas, M., Lillie-Blanton, M., & Garfield, R. (2007). *Key facts: Race, ethnicity and medical care* (No. #6069-02). Menlo Park, Calif.: Kaiser Family Foundation. Retrieved from http://kff.org/disparities-policy/report/

James, W. (1902). *The varieties of religious experience: A study in human nature.* New York: Longmans, Green and Co.

Jenkins, C. N. H., Le, T., McPhee, S. J., Stewart, S., & Ha, N. T. (1996). Health care access and preventive care among Vietnamese immigrants: Do traditional beliefs and practices pose barriers? *Social Science & Medicine*, *43*(7), 1049–1056.

Jennissen, R. P. ., & Oudhof, J. (2007). *Ontwikkelingen in de maatschappelijke participatie van allochtonen: een theoretische verdieping en een thematische verbreding van de Integratiekaart 2006*. Den Haag: Boom Juridische uitgevers; Wetenschappelijk Onderzoek- en Documentatiecentrum.

Johnson, Y. M., & Munch, S. (2009). Fundamental contradictions in cultural competence. *Social Work*, *54*(3), 220–231.

Kim, G., Jang, Y., Chiriboga, D. A., Ma, G. X., & Schonfeld, L. (2010). Factors associated with mental health service use in Latino and Asian immigrant elders. *Aging & Mental Health*, *14*(5), 535–542.

Kim-Godwin, Y. S., Clarke, P. N., & Barton, L. (2001). A model for the delivery of culturally competent community care. *Journal of Advanced Nursing*, *35*(6), 918–925.

Kirmayer, L. J., & Young, A. (1998). Culture and somatization: clinical, epidemiological, and ethnographic perspectives. *Psychosomatic Medicine*, *60*(4), 420–430.

Kleinen, J., & Custers, M. (1987). De Hoa's: Chinese vluchtelingen uit Vietnam [The Hoa's: Chinese refugees from Vietnam]. In G. Benton & H. Vermeulen (Eds.), *De Chinezen: Migranten in de Nederlandse samenleving* (pp. 170–180). Muiderberg: Coutinho.

Kleinman, A. (1977). Depression, somatization and the "new cross-cultural psychiatry." *Social Science & Medicine*, *11*(1), 3–9.

Kleinman, A. (1978). Concepts and a model for the comparison of medical systems as cultural systems. *Social Science & Medicine. Part B: Medical Anthropology*, *12*, 85–93.

Kleinman, A. (1982). Neurasthenia and depression: A study of somatization and culture in China. *Culture, Medicine and Psychiatry*, *6*(2), 117–190.

Kleinman, A. (1991). *Rethinking psychiatry: From cultural category to personal experience*. New York/London: Free Press, Collier Macmillan.

Kleinman, A., Anderson, J. M., Finkler, K., Frankenberg, R. J., & Young, A. (1986). Social origins of distress and disease: Depression, neurasthenia, and pain in modern China. *Current Anthropology*, *24*(5), 499–509.

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLoS Medicine*, *3*(10), e294.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of International Medicine*, *88*(2), 251–8.

Kleinman, A., & Kleinman, J. (1985). Somatization: The interconnections in Chinese society among culture, depressive experiences, and the meanings of pain. In A. Kleinman & B. Good (Eds.), *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder* (pp. 429–490). Berkeley: University of California Press.

Kleinman, A., & Lin, T. (1981). *Normal and abnormal behavior in Chinese culture*. Dordrecht/Boston: Kluwer Boston.

Kleinman, A., & Sung, L. H. (1979). Why do indigenous practitioners successfully heal? *Social Science & Medicine. Part B: Medical Anthropology*, *13*(1), 7–26.

Kohn-Wood, L. P., & Hooper, L. M. (2014). Cultural competency, culturally tailored care, and the primary care setting: Possible solutions to reduce racial/ethnic disparities in mental health care. *Journal of Mental Health Counseling*, *36*(2), 173–88.

Kramer, E. J., Kwong, K., Lee, E., & Chung, H. (2002). Cultural factors influencing the mental health of Asian Americans. *The Western Journal of Medicine*, *176*(4), 227–231.

Ku, L., & Matani, S. (2001). Left out: Immigrants' access to health care and insurance. *Health Affairs*, *20*(1), 247–256.

Kullberg, J. (2011). De woonsituatie [The living situation]. In M. Gijsberts, W. Huijnk, & R. Vogels (Eds.), *Chinese Nederlanders: Van horeca naar hogeschool [Chinese Dutch: From catering to college]* (pp. 102–116). Den Haag: Sociaal en Cultureel Planbureau.

Kumar, S., Tse, S., Fernando, A., & Wong, S. (2006). Epidemiological studies on mental health needs of Asian population in New Zealand. *The International Journal of Social Psychiatry*, *52*(5), 408–412.

Kung, W. W. (2003). Chinese Americans' help seeking for emotional distress. *Social Service Review*, *77*(1), 110–134.

Kung, W. W. (2004). Cultural and practical barriers to seeking mental health treatment for Chinese Americans. *Journal of Community Psychology*, *32*(1), 27–43.

Kuo, W. (1976). Theories of migration and mental health: An empirical testing on Chinese-Americans. *Social Science & Medicine (1967)*, *10*(6), 297–306.

Kwok, C. F.-Y. (2009). My journey to wellness. *Psychiatric Rehabilitation Journal*, *32*(3), 235–236.

Laczko, F. (2003). Introduction: Understanding migration between China and Europe. *International Migration*, *41*(3), 5–19.

Lai, D., & Chappell, N. (2007). Use of traditional Chinese medicine by older Chinese immigrants in Canada. *Family Practice*, *24*(1), 56–64.

Lai, D. W. L., & Chau, S. B. Y. (2007). Predictors of health service barriers for older Chinese immigrants in Canada. *Health & Social Work*, *32*(1), 57–65.

Lasser, K. E., Himmelstein, D. U., & Woolhandler, S. (2006). Access to care, health status, and health disparities in the United States and Canada: Results of a cross-national population-based Survey. *American Journal of Public Health*, *96*(7), 1300–1307.

Lauderdale, D. S., Wen, M., Jacobs, E. A., & Kandula, N. R. (2006). Immigrant perceptions of discrimination in health care: The California Health Interview Survey 2003. *Medical Care*, *44*(10), 914–920.

Lee, C., Ayers, S. L., & Kronenfeld, J. J. (2009). The association between perceived provider discrimination, healthcare utilization and health status in racial and ethnic minorities. *Ethnicity & Disease*, *19*(3), 330–337.

Leong, F. T., & Lau, A. S. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research*, *3*(4), 201–214.

Leung, A. (1989). *Onderzoek naar de werkgelegenheid en het ondernemingsbeleid van de Chinees-Indische Horecasector [Research on the employment and enterprise in the Chinese-Indonesian catering section]*. Sittard: Hoger Economisch Administratief Onderwijs.

Leung, P. W. L., & Lee, P. W. H. (1996). Psychotherapy with the Chinese. In M. H. Bond (Ed.), *The handbook of Chinese psychology* (pp. 441–456). Hong Kong/New York: Oxford University Press.

Lewis, M. P., Simons, G. F., & Fennig, C. D. (Eds.) (2013). Chinese. In *Ethnologue: languages of the world* (17th ed.). Dallas: SIL International. Retrieved from http://www.ethnologue.com/family/17-837

Li, M. (1999). *We need two worlds: Chinese immigrant associations in a western society*. Amsterdam: Amsterdam University Press.

Li, M. (2002). A group in transition: Chinese students and scholars in the Netherlands. In P. Nyíri & I. R. Savel′ev (Eds.), *Globalizing Chinese migration: Trends in Europe and Asia* (pp. 167–184). Aldershot/Hampshire/Burlington: Ashgate.

Li, M. H. (2011). Honderd jaar Chinezen in Nederland [Hundred years Chinese in the Netherlands]. In M. H. Li & M. van der Linden (Eds.), *100 jaar Chinezen in Nederland*. Utrecht: Stichting 100 jaar Chinezen in Nederland; China Publishing House.

Li, P.-L., Logan, S., Yee, L., & Ng, S. (1999). Barriers to meeting the mental health needs of the Chinese community. *Journal of Public Health*, *21*(1), 74–80.

Like, R. C., & Goode, T. D. (2012). Promoting cultural and linguistic competence in the American health system: Levers of change. In D. Ingleby, A. Chiarenza, W. Devillé, & I. Kotsioni (Eds.), *Inequalities in health care for migrants and ethnic minorities* (pp. 29–46). Antwerp-Apeldoorn, Belgium: Garant Publishers.

Lin, E. H., Carter, W. B., & Kleinman, A. M. (1985). An exploration of somatization among Asian refugees and immigrants in primary care. *American Journal of Public Health*, *75*(9), 1080–1084.

Lin, K.-M. (1981). Traditional Chinese Medical beliefs and their relevance for mental illness and psychiatry. In *Normal and abnormal behavior in Chinese culture* (pp. 99–144). Boston /Hingham: Kluwer Boston.

Lin, T.-Y., & Lin, M.-C. (1978). Service delivery issues in Asian-North American communities. *The American Journal of Psychiatry*, *135*(4), 454–456.

Linder, F., van Oostrom, L., van der Linden, F., & Harmsen, C. (2011). Chinezen in Nederland in het eerste decennium van de 21ste eeuw [Chinese in the Netherlands in the first decade of the 21st century]. In *Bevolkingstrends, 4e kwartaal 2011* (pp. 28–45). Den Haag: Centraal Bureau voor de Statistiek. Retrieved from http://www.cbs.nl/NR/rdonlyres/

Lindert, J., Schouler-Ocak, M., Heinz, A., & Priebe, S. (2008). Mental health, health care utilisation of migrants in Europe. *European Psychiatry*, *23*, 14–20.

Lipowski, Z. J. (1988). Somatization: The concept and its clinical application. *The American Journal of Psychiatry*, *145*(11), 1358–1368.

Liu, C.-H., Ingleby, D., & Meeuwesen, L. (2011). Barriers to health care for Chinese in the Netherlands. *International Journal of Family Medicine*, *2011*, 1–10.

Liu, C.-H., Meeuwesen, L., van Wesel, F., & Ingleby, D. (2013). Beliefs about mental illness among Chinese in the West. *International Journal of Migration, Health and Social Care*, *9*(3), 108 – 121.

Liu, C.-H., Sbiti, A., Huijbregts, V., & Tonk, F. (2008). *Stil verdriet: Chinese migranten en gezondheid [Silent suffering]*. Rotterdam: Mikado.

Luk, C., & Bond, M. H. (1992). Chinese lay beliefs about the causes and cures of psychological problems. *Journal of Social and Clinical Psychology*, *11*(2), 140–157.

Ma, G. X. (1999). Between two worlds: The use of traditional and Western health services by Chinese immigrants. *Journal of Community Health*, *24*(6), 421–437.

Mak, W. W. S., & Chen, S. X. (2006). Face concern: Its role on stress–distress relationships among Chinese Americans. *Personality and Individual Differences*, *41*(1), 143–153.

Mak, W. W. S., Poon, C. Y. M., Pun, L. Y. K., & Cheung, S. F. (2007). Meta-analysis of stigma and mental health. *Social Science & Medicine*, *65*(2), 245–261.

Mak, W. W. S., & Zane, N. W. S. (2004). The phenomenon of somatization among community Chinese Americans. *Social Psychiatry and Psychiatric Epidemiology*, *39*(12), 967–974.

Manfellotto, D. (2003). From misinformation and ignorance to recognition and care: Immigrants and homeless in Rome, Italy. In E. Ziglio, R. Barbosa, Y. Charpak, & S. Turner (Eds.), *Health systems confront poverty* (pp. 69–78). Copenhagen: World Health Organisation.

Martin, M., & Vaughn, B. (2007). Cultural competence: The nuts and bolts of diversity and inclusion. *Strategic Diversity & Inclusion Management*, *1*(1), 31–8.

Meeuwesen, L. (2012). Language barriers in migrant health care: A blind spot. *Patient Education and Counseling*, *86*(2), 135–136.

Meeuwesen, L., Ani, E., Cesaroni, F., Eversly, J., & Ross, J. (2012). Interpreting in health and social care: Policies and interventions in five European countries. In D. Ingleby, A. Chiarenza, W. Devillé, & I. Kotsioni (Eds.), *Inequalities in health care for migrants and ethnic minorities* (pp. 158–70). Antwerp-Apeldoorn: Garant.

Meeuwesen, L., Twilt, S., ten Thije, J. D., & Harmsen, H. (2010). “Ne diyor?” (What does she say?): Informal interpreting in general practice. *Patient Education and Counseling*, *81*(2), 198–203.

Meeuwsen, L. (2000). Chinezen in Nederland: Pleidooi voor erkenning als minderheid [Chinese in the Netherlands: Advocacy for recognition as a minority]. *Psychologie en Maatschappij [Psychology and Society]*, *24*(4), 373–385.

Mikado kenniscentrum interculturele zorg. (2012). *Wij zijn sprakeloos [We are speechless]*. Retrieved from http://www.wijzijnsprakeloos.nl/

Ministerie van VWS. (1999, May 17). *Resultaten onderzoek goksverslaving onder chinezen [Research results gambling addiction among Chinese people]*. *Nieuwsbank.nl*. Retrieved May 10, 2014, from http://www.nieuwsbank.nl/inp/

Ministry of Health and Welfare. (2013, October 2). *Department of Chinese Medicine and Pharmacy Brief Introduction*. *Ministry of Health and Welfare Taiwan*. 公告. Retrieved May 24, 2014, from http://www.mohw.gov.tw/EN/Ministry/

Ministry of Health, Welfare and Sport. (2009). *Brochure Dutch Healthcare*. Den Haag: Ministry of Health, Welfare and Sport. Retrieved from http://www.rotterdam.nl/OBR/Document/

Nadeau, R. L. (2012). Introduction. In R. L. Nadeau (Ed.), *The Wiley-Blackwell companion to Chinese religions* (pp. 1–24). Chichester/West Sussex/Malden: Wiley-Blackwell.

NAMI Multicultural Action Center. (2011). *Chinese American mental health facts*. Arlington: NAMI Multicultural Action Center. Retrieved from http://www.nami.org/

Nazroo, J. (1997). *Ethnicity and mental health: Findings from a National Community Survey*. London: P.S.I.

Netherlands organisation for international cooperation in higher education [Nuffic]. (2013). *Mapping Mobility 2012: International mobility in Dutch higher education*. Den Haag: Nuffic.

Netto, G., Bhopal, R., Lederle, N., Khatoon, J., & Jackson, A. (2010). How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions. *Health Promotion International*, *25*(2), 248–257.

Ngo-Metzger, Q., Massagli, M. P., Clarridge, B. R., Manocchia, M., Davis, R. B., Iezzoni, L. I., & Phillips, R. S. (2003). Linguistic and cultural barriers to care: Perspectives of Chinese and Vietnamese immigrants. *Journal of General Internal Medicine*, *18*(1), 44–52.

Nørredam, M., & Krasnik, A. (2011). Migrants' access to health services. In B. Rechel, P. Mladovsky, W. Deville, B. Rijks, R. Petrova-Benedict, & M. McKee (Eds.), *Migration and health in the European Union* (pp. 67–80). Maidenhead, Berkshire: Open University Press.

O'Donnell, C., Burns, N., Dowrick, C., Lionis, C., & MacFarlane, A. (2013). Health-care access for migrants in Europe. *The Lancet*, *382* (9890), 393.

OCAC: Overseas Chinese Affairs Council, R.O.C. (Taiwan). (2013). Overseas Chinese population count.. Retrieved from http://www.ocac.gov.tw/OCAC/

OCAC: Overseas Chinese Affairs Council, R.O.C. (Taiwan). (2014). *Overseas Chinese population count by country*. Retrieved May 28, 2014, from http://www.ocac.gov.tw/OCAC/

OMH. (2001). *National standards for culturally and linguistically appropriate services in health care*. Office of Minority Health (OMH). Retrieved from http://minorityhealth.hhs.gov/assets/

OMH. (2011). *National standards on culturally and linguistically appropriate services (CLAS)*. *Office of Minority Health*. Retrieved May 2, 2014, from http://minorityhealth.hhs.gov/templates/

OECD. (2004). *Trends in international migration 2003*. Washington: Organization for Economic Cooperation & Development (OECD).

Overseas Chinese Affairs Office of The State Council. (2013). *Main functions*: *Overseas Chinese Affairs Office of The State Council*. Retrieved from http://www.gqb.gov.cn/

Pachter, L. M., Auinger, P., Palmer, R., & Weitzman, M. (2006). Do parenting and the home environment, maternal depression, neighborhood, and chronic poverty affect child behavioral problems differently in different racial-ethnic groups? *Pediatrics*, *117*(4), 1329–1338.

Pan, L. (1999). Emigration from China. In L. Pan (Ed.), *The encyclopedia of the Chinese overseas* (pp. 48–56). Cambridge, Mass: Harvard University Press.

Parker, G. (2001). Depression in the planet's largest ethnic group: The Chinese. *American Journal of Psychiatry*, *158*(6), 857–864.

People's Republic of China. Article 50, § II. The Fundamental Rights And Duties Of Citizens (2013).

Perreira, K. M., Crosnoe, R., Fortuny, K., Pedroza, J., Ulvestad, K., Weiland, C., & Yoshikawa, H. (2012). Barriers to immigrants' access to health and human services programs. *ASPE Issue Brief*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation.

Phalet, K., Van Lotringen, C., & Entzinger, H. (2000). *Islam in de multiculturele samenleving: Opvattingen van jongeren in Rotterdam [Islam in the multicultural society: parenting of youth in Rotterdam]*. Utrecht: Universiteit Utrecht, European Research Centre on Migration and Ethnic Relations.

Pieke, F. N. (1988). *De positie van de Chinezen in Nederland*. Leiden: Documentatiecentrum voor het Huidige China, Sinologisch Instituut, Rijksuniversiteit Leiden.

Pieke, F. N. (1999). The Netherlands. In L. Pan (Ed.), *The encyclopedia of the Chinese overseas* (pp. 322–327). Richmond, Surrey: Curzon.

Pieke, F. N., & Benton, G. (1995). *Chinese in the Netherlands*. Leeds: University of Leeds.

Population Reference Bureau (PRB). (2013). *Total fertility rate*. *Population reference bureau*. Retrieved September 24, 2013, from http://bit.ly/1o9ALnY

Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M., … Tugwell, P. (2011). Evidence-based clinical guidelines for immigrants and refugees. *Canadian Medical Association Journal*, *183*(12), E824–E925.

Priebe, S., Sandhu, S., Dias, S., Gaddini, A., Greacen, T., Ioannidis, E., … Bogic, M. (2011). Good practice in health care for migrants: Views and experiences of care professionals in 16 European countries. *BMC Public Health*, *11*(1), 187.

QSR International. (2010). *NVivo 9 tutorials*: *QSR International*. Retrieved from http://www.qsrinternational.com/

Quan, H., Fong, A., De Coster, C., Wang, J., Musto, R., Noseworthy, T. W., & Ghali, W. A. (2006). Variation in health services utilization among ethnic populations *Canadian Medical Association Journal/ Journal de l'Association Medicale Canadienne*, *174*(6), 787–791.

Renschler, I., & Cattacin, S. (2007). Comprehensive "difference sensitivity" in health systems. In *Migration and health: Difference sensitivity from an organisational perspective* (pp. 37–41). Malmo: Malmo University Press.

Republic of China (Taiwan). Article 141, § XIII. Fundamental National Policies (2013).

Richters, E., Roodenburg, S., & Kolster, R. (2012). *Mapping Mobility 2012: International Mobility in Dutch Higher Education*. Den Haag: Nuffic.

Richters, E., Roodenburg, S., & Kolster, R. (2013). *Mapping mobility 2012: Study in Holland*. The Hague: Nuffic.

Rijkschroeff, B. R. (1998). *Etnisch ondernemerschap: De Chinese horecasector in Nederland en in de Verenigde Staten [Ethnic entrepreneurship: The Chinese catering section in the Netherlands and in the USA]*. Capelle a/d IJssel: Labyrint.

Rijkschroeff, B. R., Gwan Tjaij, P. T., & Verlaan, A. (2010). *Indonesische Chinezen in Nederland [Indonesian Chinese in the Netherlands]*. Amsterdam: SWP.

Russell, J. A., & Yik, M. S. M. (1996). Emotion among the Chinese. In M. H. Bond (Ed.), *The handbook of Chinese psychology* (pp. 166–188). Hong Kong; New York: Oxford University Press.

Saha, S., Arbelaez, J. J., & Cooper, L. A. (2003). Patient–physician relationships and racial disparities in the quality of health care. *American Journal of Public Health*, *93*(10), 1713.

Sandhu, S., Bjerre, N. V., Dauvrin, M., Dias, S., Gaddini, A., Greacen, T., … Priebe, S. (2012). Experiences with treating immigrants: A qualitative study in mental health services across 16 European countries. *Social Psychiatry and Psychiatric Epidemiology*, *48*(1), 105–116.

Sareen, J., Jagdeo, A., Cox, B. J., Clara, I., ten Have, M., Belik, S.-L., … Stein, M. B. (2007). Perceived barriers to mental health service utilization in the United States, Ontario, and the Netherlands. *Psychiatric Services (Washington, D.C.)*, *58*(3), 357–364.

Schäfer, W., Kroneman, M., Boerma, W., van den Berg, M., Westert, G., Devillé, W., & van Ginneken, E. (2010). The Netherlands: Health system review. *Health Systems in Transition*, *12*(1), 1–229.

Scheineson, A. (2009, May 14). *China's internal migrants*. Council on Foreign Relations. Retrieved May 29, 2014, from http://www.cfr.org/china/chinas-internal-migrants/p12943

Schellingerhout, R. (2011). Gezondheid en zorggebruik [Health and care utilisation]. In M. Gijsberts, W. Huijnk, & R. Vogels (Eds.), *Chinese Nederlanders: Van horeca naar hogeschool [Chinese Dutch: From catering* to college] (pp. 117–129). Den Haag: Sociaal en Cultureel Planbureau.

Scheppers, E., van Dongen, E., Dekker, J., Geertzen, J., & Dekker, J. (2006). Potential barriers to the use of health services among ethnic minorities: A review. *Family Practice*, *23*(3), 325–348.

Scragg, R., & Northern DHB Support Agency. (2010). *Asian health in Aotearoa in 2006-2007 trends since 2002-2003*. Auckland: Northern DHB Support Agency.

Selten, J.-P. (2001). Incidence of psychotic disorders in immigrant groups to The Netherlands. *The British Journal of Psychiatry*, *178*(4), 367–372.

Simich, L., Maiter, S., Moorlag, E., & Ochocka, J. (2009). Taking culture seriously: Ethnolinguistic community perspectives on mental health. *Psychiatric Rehabilitation Journal*, *32*(3), 208–214.

Singels, L., Drewes, M., & van der Most van Spijk, M. (2008). *De effecten van voorlichting in de eigen taal en cultuur in beeld [The effect of information in one's own language and culture]*. Woerden: Nationaal Instituut Gezondheidsbevordering en Ziektepreventie (NIGZ).

Smits, C. H. ., Seeleman, M. C., Van Buren, L. P., & Yuen, C. (2006). Psychische gezondheid bij oudere Chinese migranten: Een onderzoeksverkenning [Mental health of Chinese elderly: An exploratory research]. *Tijdschrift voor Gezondheidswetenschappen*, *84*, 67–75.

Snowden, L. R., & Yamada, A.-M. (2005). Cultural differences in access to care. *Annual Review of Clinical Psychology*, *1*(1), 143–166.

Sodowsky, G. R., & Lai, E. W. M. (1997). Asian immigrant variables and structural models of cross-cultural distress. In A. Booth, A. C. Crouter, & N. S. Landale (Eds.), *Immigration and the family: Research and policy on U.S. immigrants.* (Vol. viii, pp. 211–234). Hillsdale: Lawrence Erlbaum.

Spencer, M. S., & Chen, J. (2004). Effect of discrimination on mental health service utilization among Chinese Americans. *American Journal of Public Health*, *94*(5), 809–814.

Spencer, M. S., Chen, J., Gee, G. C., Fabian, C. G., & Takeuchi, D. T. (2010). Discrimination and mental health–related service use in a national study of Asian Americans. *American Journal of Public Health*, *100*(12), 2410–2417.

Stichting Chinees onderwijs in Nederland. (2013). *關於協會 [About]*. *Stichting Chinees onderwijs in Nederland*. Retrieved May 4, 2013 from http://www.chineesonderwijs.nl/content/guan-yu-xie-hui

Stronks, K. (2001). Immigrants in the Netherlands: Equal access for equal needs? *Journal of Epidemiology & Community Health*, *55*(10), 701–707.

Sue, D. W. (1994). Asian-American mental health and help-seeking behavior: Comment on Solberg et al. (1994), Tata and Leong (1994), and Lin (1994). *Journal of Counseling Psychology*, *41*(3), 292–295.

Sue, D. W., & Sue, D. (1977). Barriers to effective cross-cultural counseling. *Journal of Counseling Psychology*, *24*(5), 420–429.

Sue, S., & Chu, J. Y. (2003). The mental health of ethnic minority groups: Challenges posed by the supplement to the surgeon general's report on mental health. *Culture, Medicine and Psychiatry*, *27*(4), 447–465.

Sue, S., & Sue, D. W. (1971). Chinese-American personality and mental health. *Amerasia Journal*, *1*(2), 36–49.

Sue, S., Wagner, N., Ja, D., Margullis, C., & Lew, L. (1976). Conceptions of mental illness among Asian and Caucasian-American students. *Psychological Reports*, *38*(3), 703–708.

Sun, A. (2013). Chinese Americans and health: The impact of culture on disease prevention and management. In G. J. Yoo, M.-N. Le, & A. Y. Oda (Eds.), *Handbook of Asian American Health* (pp. 23–46). New York: Springer.

Sun, T. H. (1987). Promotion of a family planning program: The Taiwan model. *Southern African Journal of Demography/ Suidelike Afrikaanse Tydskrif Vir Demografie*, *1*(1), 32–42.

Sundquist, J. (2001). Migration, equality and access to health care services. *Journal of Epidemiology & Community Health*, *55*(10), 691–692.

Tabora, B. L., & Flaskerud, J. H. (1997). Mental health beliefs, practices, and knowledge of Chinese American immigrant women. *Issues in Mental Health Nursing*, *18*(3), 173–189.

Takeuchi, D. T., Zane, N., Hong, S., Chae, D. H., Gong, F., Gee, G. C., … Alegria, M. (2007). Immigration-related factors and mental disorders among Asian Americans. *American Journal of Public Health*, *97*(1), 84–90.

Tang, T. N., & Oatley, K. (2009). Belief in common fate and psychological well-being among Chinese immigrant women. *Asian Journal of Social Psychology*, *12*(4), 274–284.

Tang, Y. L., & Tjon, C. (2006). *2x 9 levens: Chinese ouderen in Nederland [2x 9 lives:Chinese elderly in the Netherlands]*. Amsterdam: De Verbeelding.

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117–125.

Thunø, M. (2003). Channels of entry and preferred destinations: The circumvention of Denmark by Chinese Immigrants. *International Migration*, *41*(3), 99–133.

Tiwari, S. K., & Wang, J. (2008). Ethnic differences in mental health service use among White, Chinese, South Asian and South East Asian populations living in Canada. *Social Psychiatry and Psychiatric Epidemiology*, *43*(11), 866–871.

Tseng, W.-S. (1975). The nature of somatic complaints among psychiatric patients: The Chinese case. *Comprehensive Psychiatry*, *16*(3), 237–245.

Tseng, W.-S. (1986). Chinese psychiatry: Development and characteristic. In J. L. Cox (Ed.), *Transcultural psychiatry* (pp. 274–290). London: Croom Helm.

United Nations. (1948). *The Universal Declaration of Human Rights*. Retrieved May 29, 2014, from http://www.un.org/en/documents/udhr/

United Nations. (1966). *International Covenant on Economic, Social and Cultural Rights*. *Office of the United Nations High Commissioner for Human Rights (OHCHR)*. Retrieved May 29, 2014, from http://www.ohchr.org/

United Nations General Assembly. (1968). The Universal Declaration of Human Rights. *Journal of Health, Physical Education, Recreation*, *39*(3), 37–38.

US Office of the Surgeon General (US). (2001). Mental health care for Asian Americans and Pacific Islanders. In *Mental health: Culture, race, and ethnicity: A supplement to mental health: A peport of the surgeon general.* (pp. 107–126). Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK44245/

Van Agtmaal-Wobma, E., & Nicolaas, H. (2009). Demografie [Demography]. In M. Gijsberts & J. Dagevos (Eds.), *Jaarrapport integratie 2009 [Yearly report of integration 2009]* (pp. 39–67). Den Haag: SCP.

Van der Sijde, R. R. (1983). *Chinees-Indische restaurants ["ChineseIndonesian restaurants]*. 's-Gravenhage: Bedrijfschap Horeca.

Van Dijk, R. (1998). Culture as excuse: The failure of health care to migrants in the Netherlands. In A. Rienks & S. van der Geest (Eds.), *The art of medical anthropology: Readings* (pp. 243–250). Amsterdam: Het Spinhuis.

Van Dijk, R., & Van Dongen, E. (2000). Migrants and health care in the Netherlands. Health for all, all in health. *European Experiences on Health Care for Migrants*, 47–68.

Van Dongen, E. (2005). Repetition and Repertoires: The Creation of Cultural Differences in Dutch Mental Health Care. *Anthropology & Medicine*, *12*(2), 179–197.

Van Dongen, E. (2003). Walking stories: Narratives of mental patients as magic a. *Anthropology & Medicine*, *10*(2), 207–222.

Van Duin, C., & Wobma, E. (2010). Schatting van de toekomstige omvang van de tweede generatie [Estimate of the future size of the second generation]. In *Bevolkingstrends [Trends of population], 4e kwartaal 2010* (pp. 39–49). Den Haag: Centraal Bureau voor de Statistiek. Retrieved from http://www.cbs.nl/

Van Galen, K. (1987). Dorp zonder naam: De Chinezen uit Indonesië [Village without a name: The Chinese from Indonesia]. In G. Benton & H. Vermeulen (Eds.), *De Chinezen [Chinese]* (pp. 144–145). Muiderberg: Dick Coutinho.

Van Heek, F. (1936). *Chineesche immigranten in Nederland [Chinese immigrants in the Netherladnds]*. Amsterdam: Universiteit van Amsterdam.

Verkuyten, M., & Kwa, G. A. (1996). Ethnic self-identification, ethnie involvement, and group differentiation among Chinese youth in the Netherlands. *The Journal of Social Psychology*, *136*(1), 35–48.

Vertovec, S. (2000). *The Hindu diaspora: Comparative patterns*. London and NewYork: Psychology Press.

Vertovec, S. (2007). Super-diversity and its implications. *Ethnic and Racial Studies*, *30*(6), 1024–1054.

Vogels, R. (1999). Sociale relaties en sociale contacten. In R. Vogels, P. Geense, & E. Martens, (Eds) *De maatschappelijke positie van Chinezen in Nederland* (pp. 141–80). Assen: Van Gorcum.

Vogels, R. (2011). Onderwijspositie [Education]. In M. Gijsberts, W. Huijnk, & R. Vogels (Eds.), *Chinese Nederlanders: Van horeca naar hogeschool [Chinese Dutch: From catering to college]* (pp. 46–61). Den Haag: Sociaal en Cultureel Planbureau.

Vogels, R., Geense, P., & Martens, E. (1999). *De maatschappelijke positie van Chinezen in Nederland [The social position of Chinese in the Netherlands]*. Assen: Van Gorcum.

Vogels, R., Gijsberts, M., & Liu, C. (2011). Honderd jaar Chinezen in Nederland [Hundred years Chinese in the Netherlands]. In M. Gijsberts, W. Huijnk, & R. Vogels (Eds.), *Chinese Nederlanders: Van horeca naar hogeschool [Chinese Dutch: From catering to college]* (pp. 21–28). Den Haag: Sociaal en Cultureel Planbureau.

Voronov, M., & Singer, J. A. (2002). The myth of individualism-collectivism: A critical review. *The Journal of Social Psychology*, *142*(4), 461–480.

Wachtler, C. (2005). Meeting and treating cultural difference in primary care: A qualitative interview study. *Family Practice*, *23*(1), 111–115.

Wang, M.-Q., Li, W.-H., Qiao, M.-Q., Du, W.-D., Zhang, X.-J., Dong, X.-Y., … Wang, W.-D. (2010). Traditional Chinese medicine psychology: Foundation, development and prospect. *Research in Applied Psychology Journal*, *46*, 21–49.

Wang, Y. (2004). 2004 "Human smuggling, illegal Chinese immigrants and crimes: An examination of the American experience. *Tamkang Journal of International Affairs (Taiwan)*, *8*(1), 45–66.

Watters, C. (2002). Migration and mental health care in Europe: Report of a preliminary mapping exercise. *Journal of Ethnic and Migration Studies*, *28*(1), 153–172.

Weech-Maldonado, R., Morales, L. S., Elliott, M., Spritzer, K., Marshall, G., & Hays, R. D. (2003). Race/ethnicity, language, and patients' assessments of care in Medicaid managed care. *Health Services Research*, *38*(3), 789–808.

Weissman, J. S. (1991). Delayed access to health care: Risk factors, reasons, and consequences. *Annals of Internal Medicine*, *114*(4), 325.

White, J. (1970). Towards a Black Psychology. *Ebony*, 25, 45–52.

Whitehead, M. (1992). The concepts and principles of equity and health. *International Journal of Health Services: Planning, Administration, Evaluation*, *22*(3), 429–445.

Wilson, E., Chen, A. H. M., Grumbach, K., Wang, F., & Fernandez, A. (2005). Effects of limited English proficiency and physician language on health care comprehension. *Journal of General Internal Medicine*, *20*(9), 800–806.

Witte, L. (2009). *"Ik voel me een banaan: geel van buiten, wit van binnen" ["I feel myself a banana: Yellow outside, white inside"]*. Amsterdam:Vrije Universiteit Amsterdam.

Woloshin, S., Schwartz, L. M., Katz, S. J., & Welch, H. G. (1997). Is language a barrier to the use of preventive services? *Journal of General Internal Medicine*, *12*(8), 472–477.

Wong, R. Y.-L., & Tsang, A. K. T. (2004). When Asian immigrant women speak: From mental health to strategies of being. *American Journal of Orthopsychiatry*, *74*(4), 456–466.

Wu, Z., Penning, M. J., & Schimmele, C. M. (2005). Immigrant status and unmet health care needs. *Canadian Journal of Public Health/ Revue Canadienne de Santé Publique*, *96*(5), 369–373.

Wubben, H. J. J. (1986). *Chineezen en ander Aziatisch ongedierte: Lotgevallen van Chinese immigranten in Nederland 1911-1940 [Chinese and other Asian: compatriots of Chinese immigrants in the Netherlands 1911-1940]*. Zutphen: Walburg Pers.

Wynaden, D., Chapman, R., Orb, A., McGowan, S., Zeeman, Z., & Yeak, S. (2005). Factors that influence Asian communities' access to mental health care. *International Journal of Mental Health Nursing*, *14*(2), 88–95.

Yang, G. (2006). Indigenous personality research: The Chinese case. In U. Kim, G. Yang, & G. Huang (Eds.), *Indigenous and cultural psychology: Understanding people in context* (pp. 285–314). New York: Springer.

Yang, K.-S. (1995). Chinese social orientation: An integrative analysis. In *Chinese societies and mental health* (pp. 19–39). Oxford/ New York: Oxford University Press.

Yang, L. H., Corsini-Munt, S., Link, B. G., & Phelan, J. C. (2009). Beliefs in traditional Chinese medicine efficacy among Chinese Americans: Implications for mental health service utilization. *The Journal of Nervous and Mental Disease*, *197*(3), 207–210.

Ye, J., Mack, D., Fry-Johnson, Y., & Parker, K. (2011). Health care access and utilization among US-born and foreign-born Asian Americans. *Journal of Immigrant and Minority Health*, *14*(5), 731–737.

Yeh, C. J. (2003). Age, acculturation, cultural adjustment, and mental health symptoms of Chinese, Korean, and Japanese immigrant youths. *Cultural Diversity & Ethnic Minority Psychology*, *9*(1), 34–48.

Yeo, S. (2004). Language barriers and access to care. *Annual Review of Nursing Research*, *22*, 59–73.

Yeung, A., & Kam, R. (2006). Recognizing and treating depression in Asian Americans. *Psychiatric Times*, *23*(14), 50–59.

Ying, Y. W., & Miller, L. S. (1992). Help-seeking behavior and attitude of Chinese Americans regarding psychological problems. *American Journal of Community Psychology*, *20*(4), 549–556.

Yip, K.-S. (2004). Taoism and its impact on mental health of the Chinese communities. *International Journal of Social Psychiatry*, *50*(1), 25–42.

Zendedel, R., & Meeuwesen, L. (2013). Ervaringen van informele tolken in een medische setting [Experiences of informal interpreters in a medical setting]. In S. Willems & J. Mertens (Eds.), *Professioneel omgaan met diversiteit [Professional competences in diversity]* (pp. 143–57). Mechelen: Kluwer.

Zhang, N., & Dixon, D. N. (2003). Acculturation and attitudes of Asian international students toward seeking psychological help. *Journal of Multicultural Counseling and Development*, *31*(3), 205–222.

Zhuang, G. (2011). Historical changes in numbers and distribution of overseas Chinese in the world. *World History*, *5*. Retrieved from http://qwgzyj.gqb.gov.cn/yjytt/155/1830.shtml

Zuckerman, P. (2007). Atheism: Contemporary rates and patterns. In M. Martin (Ed.), *The Cambridge companion to atheism* (pp. 47–68) New York: Cambridge University Press.

Samenvatting

Summary in Dutch

Lijden in stilte?

De adequaatheid van de Nederlandse geestelijke gezondheidszorg voor etnische Chinezen in Nederland

In vergelijking met de vier grootste etnische minderheidsgroepen in Nederland (Turken, Marokkanen, Surinamers en Antillianen), maken Chinezen minder gebruik van de geestelijke gezondheidszorg, hoewel hun symptomen doorgaans ernstiger zijn bij het eerste bezoek. De achterliggende reden voor deze verschillen is onbekend. Er is zeer weinig onderzoek naar verricht. Dit promotieonderzoek dient om deze kennisleemte te dichten en om meer zicht te krijgen op het gebruik van de geestelijke gezondheidszorg onder deze groep. In het onderzoek wordt tevens aandacht besteed aan de mate waarin de Nederlandse geestelijke gezondheidszorg aansluit bij de behoeften van de groep Chinezen.

Het onderzoek is opgezet vanuit een aantal disciplines binnen de medische en sociale wetenschappen, zoals de psychiatrie, de klinische- en gezondheidspsychologie, de medische antropologie, de sociale geschiedenis en de sociologie. Om de onderstaande onderzoeksvragen te beantwoorden, zijn zowel literatuurstudies als empirische studies uitgevoerd:

1. Wie zijn de groep Chinezen in Nederland? (hoofdstuk 2)
2. Hoe is de aandacht voor specifieke voorzieningen van gezondheidszorg voor migranten en etnische minderheden ontstaan en welke ontwikkelingen hebben zich voltrokken ten aanzien van de belangrijkste benaderingen daarvan? (hoofdstuk 3)
3. Welke basisconcepten worden gebruikt voor het analyseren van zorgverlening aan migranten en etnische minderheden? Wat is er bekend over a) de problemen met geestelijke zorgverlening aan deze groepen in Westerse landen en b) over problemen ten aanzien van Chinezen in Nederland? (hoofdstuk 4)
4. Welke patronen zijn te onderscheiden in het hulpgedrag van Chinezen in Nederland? Hoe toegankelijk is de gezondheidszorg voor hen? Welke opvattingen hebben zij over geestelijke gezondheidsproblemen en de Nederlandse systeem van (geestelijke) gezondheidszorg? (hoofdstuk 5)
5. Welke rol spelen aannames over geestelijk gezondheid in het daadwerkelijke gebruik van zorg? Welke soorten problemen worden gezien als geestelijke gezondheidsproblemen? Welke aspecten worden gezien als veroorzakers en welke soorten hulp worden geschikt geacht? (hoofdstuk 6)

6. Wat zijn de ervaringen van Chinezen in Nederland met het gebruik van geestelijke gezondheidszorg? Kunnen deze ervaringen ons iets leren over hun geringe gebruik van geestelijke gezondheidszorg? (hoofdstuk 7)

Methoden

Literatuuronderzoek vormt de basis van hoofdstukken 2, 3 en 4. De bestudeerde artikelen en boeken bieden informatie over Chinezen in Nederland, onderwerpen m.b.t. de gezondheidszorg voor migranten, levering en gebruik van gezondheidszorg, alsmede onderzoeken naar deze onderwerpen specifiek gericht op Chinezen in Westerse landen en in Nederland in het bijzonder.

Er zijn empirische studies uitgevoerd naar het gebruik van geestelijke gezondheidszorg door Chinezen in Nederland (hoofdstukken 5, 6 en 7). Voor de verzameling en analyse van de data is gebruik gemaakt van een zogenaamde *mixed-methods* benadering. In fase I zijn kwantitatieve gegevens verzameld door op straat 102 gestructureerde interviews af te nemen bij Chinezen in de Randstad (Amsterdam, Den Haag, Rotterdam en Utrecht). In fase II zijn kwalitatieve data verzameld middels 23 semigestructureerde diepte-interviews met Chinezen die bereid waren om te vertellen over één of meerdere personen in hun sociale omgeving, die verondersteld werden geestelijke gezondheidsproblemen te hebben (gehad). Deze interviews leverden 30 vertellingen op.

Hoofdstuk 2. Etnische Chinezen in Nederland

De migratie van Chinezen naar Nederland is te onderscheiden in vier golven. In het begin van de 20e eeuw arriveerden jonge Chinese zeelui, gerekruteerd als goedkope arbeidskrachten, in de Nederlandse havens. Na de Tweede Wereldoorlog migreerden Chinezen naar Nederland vanuit haar voormalige koloniën als Indonesië en Suriname. Tussen de jaren ’70 en 2000 arriveerden arbeidsmigranten uit Hong Kong en China, gevolgd door hun families. In die tijd kwamen ook vluchtelingen uit Vietnam en andere landen in Zuidoost Azië. Sinds 2001 is een toenemend aantal mensen gekomen voor zaken of het volgen van een studie.

Door de verschillende herkomstlanden en migratiepatronen vormen etnische Chinezen in Nederland een heterogene groep. We kunnen vier subgroepen onderscheiden: Chinezen die vóór 2000 migreerden (‘Pre-2000 Chinezen), Chinezen die migreerden na het jaar 2000 (‘Nieuwe Chinezen’), Chinezen afkomstig uit voormalige Nederlandse koloniën en tot slot de tweede generatie.

Hoofdstuk 3. Benaderingen van voorzieningen van gezondheidszorg voor migranten en etnische minderheden

Aandacht voor diversiteit en gezondheid is aanvankelijk ontstaan in de context van de mensenrechtenbeweging van de Verenigde Staten (circa 1955-1968). In het begin werden *best practices* in de zorgverlening gedefinieerd als 'cultureel-sensitief' of 'cultureel competent'. Meer begrip vergaren over 'andere' culturen werd beschouwd als de juiste professionele reactie op een etnisch diverse populatie. Ten aanzien van de aard en het belang van het begrip 'cultureel competent' hebben er drie belangrijke (hoewel deels overlappende) verschuivingen plaatsgevonden.

Ten eerste is het op kennis gerichte concept 'cultureel competent' ook attitudes en vaardigheden gaan omvatten (zoals respect en vaardigheden t.a.v. interculturele communicatie). Ten tweede is men 'culturen' gaan beschouwen als iets dynamisch in plaats van een statisch fenomeen. 'Culturele nederigheid' werd gezien als een meer geschikte benadering dan 'cultureel competent': zorgverleners dienen voortdurend open te staan voor andere culturen, te beschikken over zelfreflectie, respect te tonen naar anderen en kritisch naar het eigen handelen te kijken. Met de derde en meest recente verschuiving zijn andere vormen van diversiteit, naast culturele diversiteit, ook van belang geworden met betrekking tot gelijkheid in gezondheidszorg. In de VS is het concept 'cultuur' op dusdanige wijze geherdefinieerd dat het alle vormen van diversiteit dekt, terwijl in Europa het begrip 'culturele diversiteit' wordt voorgesteld als een veelomvattender benadering voor de gezondheidszorg dan 'culturele competentie'.

Hoofdstuk 4. Onderzoek naar de gezondheidszorgvoorzieningen voor migranten en etnische minderheden.

Toegankelijkheid en kwaliteit zijn de twee basiselementen die bepalen in welke mate de gezondheidszorg voor migranten en minderheden adequaat is. Toegankelijkheid heeft betrekking op de mogelijkheden om zorg te ontvangen wanneer deze gewenst of noodzakelijk is. Kwaliteit van gezondheidzorg heeft betrekking op de effectiviteit, de tevredenheid van zowel gebruikers als zorgverleners en de mate waarin een behandeling correct is uitgevoerd.

Hoewel in de literatuur vele factoren vermeld worden die de mentale gezondheid van in het buitenland wonende Chinezen kunnen ondermijnen, maken Chinezen minder gebruik van de geestelijke gezondheidszorg in vergelijking met andere minderheidsgroepen. Veelgenoemde drempels bij het zoeken naar hulp door Chinese migranten zijn: sociaal-economische status, opleidingsniveau, geslacht, gebrek aan kennis over rechten, het niveau van integratie, taalverschillen en andere drempels in communicatie, zelfmedicatie en het gebruik van traditionele behandelingen, aan gezondheid gerelateerde opvattingen, culturele competentie van gezondheidszorgsystemen, stigmatisering en discriminatie in een gezondheidszorgsetting. Onderzoekers benadrukten traditioneel 'culturele' factoren, in het bijzonder opvattingen over geestelijke gezondheidszorg en stigmatisering.

Onderzoek onder Chinezen in Nederland is schaars. Desalniettemin zijn er duidelijke aanwijzingen dat er onvoldoende tegemoet wordt gekomen aan de behoefte aan geestelijke gezondheidszorg en dat degenen die hulp zoeken serieuzere symptomen vertonen tijdens het eerste consult.

Hoofdstuk 5. Drempels in de gezondheidszorg voor Chinezen in Nederland

De meeste respondenten uit de interviews op straat zien de Nederlandse gezondheidszorg als het voornaamste middel om gezondheidsproblematiek het hoofd te bieden. Onvoldoende kennis over het systeem en een gebrekkige beheersing van het Nederlands belemmeren echter de toegang tot deze zorg; in het bijzonder het aanmelden bij een huisarts. Gebruikers klaagden over het feit dat geleverde zorg niet overeenkwam met hun verwachtingen. De grootste problemen kwamen voor in de groep afkomstig uit de Chinees-sprekende regio. Westerse concepten van geestelijke gezondheid leken algemeen aanvaard door Chinezen in Nederland. Desondanks gaf bijna de helft van de respondenten aan te geloven dat traditionele Chinese medicijnen of andere methoden ook kunnen helpen bij geestelijke gezondheidsproblematiek. Het verschaffen van relevante informatie in de Chinese taal lijkt belangrijk voor het verbeteren van de toegankelijkheid. Betere vertalingen van patiëntinformatie zijn noodzakelijk voor met name eerste-generatie migranten uit Chinees sprekende regio's.

Hoofdstuk 6. Opvattingen over geestelijke stoornissen onder Chinezen in Nederland

Opvattingen over geestelijke stoornissen die geuit werden in de diepte-interviews leken niet erg af te wijken van gangbare Westerse opvattingen, althans niet in de mate dat een discrepantie een grote barrière vormt in het zoeken naar hulp van belangrijke gezondheidszorgdiensten. Problemen werden door de respondenten beschreven als een kwestie van 'geestelijke gezondheid of ziekte' wanneer het dagelijks functioneren van de lijders, dan wel de levens van mensen in hun directe omgeving, ernstig beïnvloed werden. Deze beïnvloeding werd daarbij direct gerelateerd aan hun onvermogen om rationeel te handelen, om te gaan met hun eigen emoties en hun gedrag te beheersen op een manier die volgens anderen normaal werd geacht. Verklaringen voor geestelijke gezondheidsproblematiek werden gezocht in externe factoren (zoals levensgebeurtenissen) en/of endogene factoren (zoals biologische factoren of persoonlijkheidstrekken). De factoren zouden elkaar ook kunnen versterken. De mate van sociale steun en individuele veerkracht zouden de ontwikkeling van geestelijke problemen kunnen modereren. Dergelijke ideeën lijken perfect in lijn met Westerse opvattingen over geestelijke gezondheid.

Hoofdstuk 7. Drempels voor het gebruik van de geestelijke gezondheidszorg onder Chinezen in Nederland

Hoewel de meeste respondenten in de studie reguliere Nederlandse zorg beschouwden als de juiste hulpbron voor het omgaan met geestelijke problemen, werden er ook drempels gerapporteerd met betrekking tot de toegang tot zorg en bedreigingen voor de kwaliteit van zorg. In tegenstelling tot de alom geaccepteerde zienswijze dat culturele verschillen in opvatting over gezondheid en ziekte ten grondslag liggen aan het lage gebruik van gezondheidszorgvoorzieningen door Chinezen in het Westen, zijn de belangrijkste obstakels, die in deze studie geïdentificeerd werden, praktische zaken zoals problemen in de communicatie of een gebrek aan kennis over het gezondheidszorgsysteem. Respondenten droegen ook zorgen aan over het recht op zorg en (verwachte of ervaren) discriminatie. Door de respondenten aangedragen maatregelen omvatten: meer gebruik van vertalers en culturele mediators, migranten aanmoedigen om hun taalvaardigheid te verbeteren en betere informatievoorziening over het gezondheidszorgsysteem.

Hoofdstuk 8. Discussie en conclusie

Het is algemeen bekend uit de literatuur dat Chinezen in het Westen minder gebruik maken van reguliere (‘mainstream’) gezondheidszorg, in het bijzonder van geestelijke gezondheidszorg. Ons onderzoek bevestigt dit fenomeen met betrekking tot Nederland. De resultaten van onze kwantitatieve studie laten tevens zien dat meer dan de helft van de respondenten familieleden of vrienden in Nederland hadden met geestelijke gezondheidsproblematiek, dan wel deze persoonlijk hebben ervaren. Dit toont aan dat geestelijke hulpverlening noodzakelijk is voor deze etnische groep.

Onderzoekers hebben geclaimd dat de opvattingen over gezondheid van Chinezen in het Westen onverenigbaar zijn met Westerse opvattingen over geestelijke stoornissen en dat deze discrepantie lijdt tot minder gebruik van de geestelijke gezondheidszorg. De resultaten van ons onderzoek ondersteunen deze zienswijze niet. De volgende bevindingen zijn daarbij van belang. Ten eerste hebben Chinezen positieve attitudes ten aanzien van Westerse geestelijke gezondheidszorg. Deze wordt gezien als geschikt en is de eerste keuze bij geestelijke gezondheidsproblematiek. Ten tweede komen de opvattingen over geestelijke gezondheid van Chinezen meer overeen met Westerse opvattingen dan doorgaans wordt verondersteld. De beschrijvingen en verklaringen van geestelijke gezondheidsproblematiek, alsmede de attitudes ten aanzien van deze problemen, wijken niet erg af van de opvattingen van Westerse mensen. Ten derde vertonen etnisch Chinezen een neiging tot ‘gezondheidspluralisme’. Het hebben van traditionele Chinese opvattingen over gezondheid sluit het gebruik van reguliere geestelijke gezondheidszorg niet uit.

Ons onderzoek vond culturele verschillen die wederzijds begrip kunnen belemmeren. De verschillen zijn echter niet zo groot, dat ze ervoor zorgen dat Chinezen de Nederlandse gezondheidszorg niet accepteren, of daarvan kunnen profiteren. Daar staat tegenover dat het in Nederland verplicht en betaalbaar is om een zorgverzekering af te sluiten. De bereidbaarheid van Chinese migranten om gebruik te maken van gezondheidszorg wordt soms beïnvloed door verwachtingen over hoge kosten. De resultaten van dit onderzoek lijken erop te wijzen dat de belangrijkste drempels te maken hebben met praktische zaken, zoals beperkte Nederlandse taalvaardigheden, gebrekkige kennis over het gezondheidszorgsysteem en taal- en communicatieproblemen. Andere barrières worden gevormd door een gebrek aan culturele sensitiviteit onder professionele zorgverleners en het falen van de gezondheidszorg om stappen te zetten om deze problemen het hoofd te bieden. Gezien het feit dat geestelijke gezondheidszorg in Nederland zowel primaire als secundaire zorg omvat, is er vaak sprake van een overlap in gebruik van geestelijke gezondheidszorgvoorzieningen.

Nogmaals, Chinezen in Nederland vormen een heterogene groep. Terwijl taal- en communicatieproblemen vaak genoemd worden (vooral onder eerste-generatie migranten afkomstig uit Chineessprekende gebieden), kunnen ook andere drempels blijven bestaan . Bijvoorbeeld: er is grote nood aan informatievoorziening over recht op zorg onder niet-reguliere migranten en alle migranten hebben informatie nodig over hoe het gezondheidssysteem werkt en hoe er gebruik van te maken.

Ten slotte, maar daarom niet minder onbelangrijk, ondersteunen de resultaten van dit onderzoek de recente verschuivingen in benadering van gezondheidszorg voor migranten en etnische minderheden. Ten eerste zijn Chinezen in Nederland erg divers in termen van hun cultuur, migratiegeschiedenis, sociaal-economische status en mate van integratie. Verschillende individuen hebben verschillende behoeften. Ten tweede zijn de opvatting van Chinese migranten t.a.v. gezondheid niet statisch. De manier waarop zij gezondheid en ziekte begrijpen evolueert in reactie op de ideeën en ontwikkelingen die ze tegenkomen. Ten derde, ongeacht hoe belangrijk opvattingen over gezondheid ook mogen zijn, praktische drempels (zoals communicatieproblemen, beperkingen in tijd of geld en negatieve ervaringen met de gezondheidszorg) blijken de hardnekkigste obstakels te zijn voor Chinezen in emigratielanden. Zorgverleners zouden meer aandacht moeten besteden aan zaken als communicatiebarrières, kennis over recht op zorg, kennis over het gezondheidssysteem, discriminatie en de attitudes van professionals.

摘要

Summary in Chinese

有苦難言？

荷蘭精神健康系統在提供荷蘭華人服務方面的充足性研究

壹、研究目的

相較於荷蘭其他民族群，華人較少使用精神健康服務；初診時所呈現的症狀表徵也相對嚴重。由於相關研究缺乏，目前對於導致這個現象的原因仍所知不多。本研究之目的即在填補此知識上的空缺、闡明此族群的精神健康照護使用行為，並進一步地檢驗荷蘭精神健康照護系統在提供此族群服務方面的充足性。

貳、研究方法

此研究橫跨精神醫學、臨床與健康心理學、醫療人類學、社會歷史學與社會學等的醫學與社會科學領域。採用之研究法包括文獻探討與實證研究。

一、文獻探討

文獻探討為第二、三、四章的基礎。其中所檢視的文章與書籍主題包括了荷蘭華人的背景，有關移民健康照護、健康照護服務與健康照護利用率的議題，及在這些議題上針對旅居西方國家的華人與荷蘭華人方面之相關研究。

二、實證研究

實證研究階段，本研究採用混合研究法（mixed methods）的概念，在兩階段中分別以結構式訪談與深度訪談進行量性及質性資料蒐集與分析，以探討荷蘭華人的健康服務使用情形。

1. 結構式訪談：研究者以結構式問卷方式進行隨機性的街頭訪問，蒐集關於荷蘭華人在健康服務的態度及使用情形之量性資料。
2. 深度訪談：研究者邀請荷蘭華人談論在其社交環境中（曾）有精神問題的華人個案，以收集此族群使用精神健康服務的經驗。

參、研究結果

一、文獻探討結果

1. 荷蘭華人族群：

由於移民的模式與來源地不同，荷蘭華人並不是一個具同質性的族群。可略分為四種族群：來自華語地區於西元 2000 年前移居荷蘭的華人、來自華語地區於西元 2000 年後移居荷蘭的華人、來自前荷蘭殖民地的華人及第二代華人移民。

2. 提供移民與少數族裔健康服務的發展與評估：

在對不同族群與健康照護議題的初期發展階段，使健康服務具有「文化能力（cultural competence）」被認為是最佳因應方案。過去數十年間，「文化能力」所代表的意義與重要性經過三次（具重疊性）的轉變：一、以知識為主導的「能力」被擴充到包含態度與技能；二、「文化」逐漸被視為動態而非靜態的；三、除了文化議題，其他影響健康服務公平的差異點也應列入考慮。

3. 評估移民與少數族裔健康服務之提供：

評估對移民與少數族群之健康服務提供是否合宜的基本要素有二：健康服務的可得性（accessibility）與服務品質（quality of services）。文獻中通常以健康服務使用率作為可得性的參考指標。相對於其他族群，西方華人的精神健康服務使用率偏低。歷來針對這個現象的研究，多以精神健康信念與屈辱感等文化因素來解釋這個族群的低服務使用率。

二、實證研究結果

1. 荷蘭華人的健康服務使用情形：受訪者視荷蘭健康服務系統為管理一般健康問題時的首要選擇，亦是應對精神疾病的適當資源。但半數受訪者認為傳統中醫或其他療法也是合宜的精神照護。研究顯示，因個人背景不同，族群內對荷蘭健康服務的態度及使用上有所差異。不同人可能會有不同健康服務需求，如：來自華語地區的第一代移民尤其需要翻譯或口譯服務。

2. 荷蘭華人的健康信念：研究中受訪華人所表達的精神疾病觀，並不會與西方認知有太大的差異。例如：精神健康問題的解釋包括外在因素（如重大生活事件）或內在因素（如生物因素或人格性格）；這些因素會相互影響。而社會支持與個人抗逆能力也可以減緩精神疾病的發展。這些想法都與西方的當代精神健康概念相容。

3. 使用健康服務的障礙：華人的精神健康信念似乎不致於在尋求主流醫療照護服務時造成重大的屏障。主要的障礙是例如荷蘭語能力低落、健康照護系統知識的缺乏、溝通困難、擔心醫療費用等等的實際問題。其他障礙還包括了醫療照護人員缺乏文化敏感度及健康服務系統無法克服以上所指出問題。由於荷蘭精神健康服務被歸納在基層健康照護與二級健康照護系統中，精神健康服務與一般健康服務的使用障礙也有所交疊。受訪者認為提供健康服務的中文信息、口譯服務、文化健康協調顧問及學校或工作單位方面的就醫協助，能幫助他們使用荷蘭健康服務。

肆、結論與建議

雖然有許多文獻認為：西方華人族群的健康信念與西方精神疾病概念不合，是造成此族群精神健康服務使用率低的主要原因；但本研究結果並不支持這個論述。第一，根據研究結果，華人族群對西方精神健康服務持正面態度，認為是適當且首要的精神問題應對方法。第二，華人族群對精神健康信念比一般所認為的更貼近西方精神疾病觀－此族群對「精神疾病」的定義與解釋，以及對疾病的態度與西方人士差異並不大。第三，華人族群顯示出「多元健康照護（health pluralism）」的傾向，此族群並不會因為繼承了傳統的健康信念，而將自己排除在常規的精神健康服務之外。

本研究的結果亦支持目前移民、少數族群與健康服務的理論發展－除了文化因素，健康服務提供者應將其他關於健康照護公平性的差異點也列入考量。第一、荷蘭華人彼此之間的文化、移民歷史、社經地位及文化融合程度有很大差異。對健康服務的需求會因人而異。第二、海外華人的健康信念並非不會改變的，他們對於健康與疾病的理解會隨著所接觸的知識與理論發展而衍變。第三，無論健康信念在健康服務的使用上有多重要，對海外華人來說如不良溝通、時間與金錢限制、健康服務的負面經驗等實際障礙，更需要認真對待。

荷蘭健康服務系統在使華人取得優質服務（quality service）上似乎仍有不足。服務提供者在面對不同族群使用者時，除了考量健康信念之文化差異，應該同時專注於解決溝通、健康服務使用權、健康照護系統知識、專家態度與歧視等等妨礙健康服務使用及影響服務品質的問題。

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Cha-Hsuan Liu

Utrecht, August 2014

Curriculum vitae and publications

Curriculum vitae

Cha-Hsuan Liu (劉家瑄) was born on June 19, 1972 in Taipei, Taiwan. In 1994, she obtained a Bachelor degree in Medical technology at Kaohsiung Medical University, Taiwan. Afterwards she was awarded the degrees of Master in Management of Health Administration (MHA) at National YangMing University (Taiwan) in 1998 and Master of Science in Health Psychology at Leiden University (The Netherlands) in 2002. In 2007, she applied for the Mosaic programme of the Netherlands Organisation for Scientific Research (NWO) with her original PhD research plan 'The adequacy of Dutch mental health care for ethnic Chinese in the Netherlands'. This research project was later recommended to Utrecht University and was awarded a research grant from Utrecht University Fund. Her PhD project on Cultures and Minorities was taken place in the Department of Interdisciplinary Social Science at Utrecht University in 2008 and was accomplished in 2014. Her published works focus on health equity, disparities in care service delivery, health behaviour, health services, migration and health, and health care utilisation among minority populations with a special focus in mental health. She is currently a research member of the European Research Centre on Migration and Ethnic Relations (ERCOMER) and Interuniversitary Research School for Resource Studies for Development (CERES). She also works as a health educator in Dutch health care system, mental health and breast cancer for minority groups in the Netherlands.

Publications

Liu, C.-H., Meeuwesen, L., van Wesel, F., & Ingleby, D. (in press). Why do ethnic Chinese in the Netherlands underutilize mental health care services? Evidence from a qualitative study. *Transcultural Psychiatry*.

Liu, C.-H., Meeuwesen, L., van Wesel, F., & Ingleby, D. (2013). Beliefs about mental illness among Chinese in the West. *International Journal of Migration, Health and Social Care*, 9 (3), 108 – 121.

Liu, C. (2012). Adequacy of Dutch mental health care for Chinese immigrants. *Art of the state, state of the art: Asiel, immigratie, integratieonderzoek [Asylum, immigration, integration research]*. Promovendimiddag. Den Haag: Ministerie van Binnenlandse Zaken en Koninkrijksrelaties [Ministry of the Interior and Kingdom Relations].

Liu, C.-H., Ingleby, D., & Meeuwesen, L. (2012). The experience of mental health service use of Chinese Dutch, *Psychology & Health: EHPS 2012 Abstracts*, 27(S1), 264.

Liu, C., Ingleby, D. & Meeuwesen, L. (2011). Barriers to health care for Chinese in the Netherlands, *International Journal of Family Medicine*, vol. 2011, Article ID 635853.

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Vogels R., Gijsberts, M. & Liu, C-H. (2011). Honderd jaar Chinezen in Nederland [Hundred years Chinese in the Netherlands]. In Gijsberts M., Huijnk, W. & Vogels, R. (red.). *Chinese Nederlanders. Van horeca naar hogeschool [Chinese Dutch. From restaurant to higher education]*. 21-28. Den Haag: SCP.

Liu, C.-H. & Lin, K.-M. (2011). The higher education system of the Netherlands and an analysis of its features. *Bulletin of the National Institute of Education Resources and Research (Taiwan)*. 52, 113-134. Taipei: The National Institute of Educational Resources and Research.

Liu, C.-H. & Lin, K.-M. (2011). The secondary education system of the Netherlands. *Bulletin of The National Institute of Education Resources and Research (Taiwan)*. 50, 173-197. Taipei: The National Institute of Educational Resources and Research.

Liu, C.-H. & Lin, K.-M. (2011).The primary education system of the Netherlands. *Bulletin of The National Institute of Education Resources and Research (Taiwan)*. 49, 225-252. Taipei: The National Institute of Educational Resources and Research.

Liu, C., Sbiti, A. & Huijbregts, V. (2008). *Stil verdriet: Chinese migranten en gezondheid [Silent Sadness: Chinese migrants and health]*. Rotterdam: MIKADO.

Liu, C. (2008). Verslag: Cross-culturele gezondheidszorg [Report: Transcultural health care]. *Cultuur Migratie Gezondheid [Culture Migration Healthcare]*. 5(3), pp.184-187.

Sbiti, A. & Liu, C. (2007). *Geestelijke Gezondheid, Voorlichtingsbrochure voor Nederlandse Chinezen [Mental health: Guidelines for Dutch Chinese]*. Rotterdam: MIKADO.

Sbiti, A. & Liu, C. (2007). *The Mental Health Care for the Chinese in the Netherlands*, Commissioned by: Inspraakorgaan Chinezen, Utrecht.

Liu, C. (2006). Verslag: Ceres summerschool [Report: Ceres summerschool]. *Cultuur Migratie Gezondheid [Culture Migration Healthcare]*. 3(3), pp.181-182.

Liu, C. & Liu, H. C. (2006). *Chinese migration in the Netherlands: A comparison with the migration in Taiwan.* Paper presented at the Conference of South Taiwan Social Development 2006, Pingtung, Taiwan.

Liu, C. (2004). *Health Insurance System in the Netherlands*, Commissioned by: Bureau of National Health Insurance, Taiwan.