BICULTURALISM: A FOOT IN BOTH CAMPS.

Dr Linda Robertson and Dr Beatrice Hale

INTRODUCTION

Immigrants must come to terms with the cultural norms of the dominant group as well as work out ways of preserving their own cultural heritage. Moving between cultures is difficult and when people from different cultural backgrounds begin to engage with each other a process of acculturation begins, impacting on both parties. In this research report we identify integration strategies that included strong identifications with two cultures (Chinese and New Zealand) and the actions taken to maintain interactions with both cultures

Background

From the detailed Dunedin City Council Report 'Settling In' (Health Research Council, 2012), we learn that the 1871 census recorded 2,641 Chinese immigrants as being the largest number of migrants from any non-British colony. The Chinese experienced considerable discrimination in New Zealand, encapsulated in, for example, the 1881 Chinese Immigration Act which introduced the notorious poll tax at ten pounds a head (subsequently increased to 100 pounds in 1896); and legislation barring Chinese from seeking naturalisation in 1908. Despite these measures, a small, largely male Chinese community remained in New Zealand after the gold ran out, running market gardens and laundries, until the Japanese invasion of Kwangtung prompted the first labour government to allow the families of Chinese in New Zealand to join them as war refugees. The advent of world war two delayed repatriation, and in 1947, they were finally granted permanent residency, facilitating the beginnings of the New Zealand Chinese community in its present form.

There was very little other Asian immigration to New Zealand until changes in New Zealand's immigration policy in 1986, which generated an influx of people of Chinese ethnicity from China, Hong Kong, Malaysia and Taiwan swamping the older New Zealand Chinese population numerically.

One of the major issues highlighted in 'Settling In' (Health Research Council, 2012) was the number of older migrants who came to support their children while they were studying here, and who now find themselves alone because their children have moved elsewhere for better employment, among other reasons. The older people who do not speak good English have relied on their extended family for communication and socialisation so struggle when the younger family members leave Dunedin. Many faced issues of separation, both emotional and practical, and have been supported by the senior Chinese association in Dunedin.

Problems associated with a new country are two-fold. Migrants experience internal familial stresses caused by family disruption, with different members of the family migrating or remaining behind in the home country. Among these may be a lack of emotional resources to cope with difficult changes including the emotional distress when children are able to integrate and learn more quickly than their elders; this can lead to a distancing from the home culture by the children (Wong, 2001; Moon & Pearl, 1991). Further issues amongst the migrants consist of problems of establishing familiarity and a sense of belonging that could lead to a sense of identity (Li, 2011, Ip, 2006). These first generation Chinese immigrants have been socialized into their home culture before moving to New Zealand. Becoming familiar with new cultural practices of the host country and learning to use English effectively and appropriately is necessary to be accepted as a member of the mainstream society and to gain a sense of place. (Liu, 2015). Thus an awareness of language issues as well as a lack of knowledge of major systems and services contributes to negotiating a sense of belonging.

One of the most significant services for migrants is that of health. Much of the research on migration has found ignorance of health care systems to be a major barrier to accessing healthcare (DeSouza, 2006; Ngai & Chu, 2006; Mortensen & Young, 2004; Ho, Au, Bedford, & Cooper, 2003; Hobbs, Moor, Wansbrough, & Calder, 2002; North, 1995). These studies report that the main barriers include being unclear about what services can be accessed, a lack of awareness of available services and costs as well as a lack of English language competency.

While the above might seem to be self-evident, cultural issues explored in an American study found that a number of issues related to knowledge about and use of local health services were not immediately apparent (Chen, Kendall, & Shyu, 2010). For instance, issues such as privacy, unwillingness to share the health problem and a passive mentality contribute to the difficulties in successful usage of the health services. Chen et al., (2010) write of the "Ah Q mentality… [if] you do not find a problem, then there is no problem with the implication that if the problem is not shared, and there is no discovery of the problem, then there is no problem" (p. 344). Added to this is the difficulty when there is limited information given to the health care providers, then the provider will be unable to provide the best sources of help. This can ultimately lead to a lack of trust in the health care provider.

As Chen et al., (2010) found, privacy was valued to the extent that being passive was thought to be more polite than talking about private affairs with strangers such as the doctor. Harmony within personal relationships was important and because the American Health Practitioners were not trusted the Chinese seniors found it hard to follow their advice. Both of these points would lead to limited health information. Additionally it was believed that "western medicine only treated symptoms and did not cure the cause of the illness" and that it "lacked the holistic view that focused on the whole body" (Chen et al; 2013, p. 345). This was supported by a commentary on the article where statistics were cited for a greater number visiting Chinese health providers compared to Western health providers (Norris, 2010).

Essentially the participants in Chen et al., (2010) study favoured health practitioners who had emigrated from their country of origin and spoke their language. Even when they did use local medical assistance, with the help of interpreters, their experience of such translators resulted in them being suspicious that their concerns were not accurately portrayed. The participants indicated they felt they were viewed as 'outsiders' which caused them to feel powerless despite having lived in America for a long time. There was a sense of feeling overwhelmed by a sense of helplessness in most of the health situations they encountered. Interestingly a study of Chinese seniors in Canada found that their utilization of services is not different to other seniors (Chappell & Lai, 1998). It was also noted that

this group had a strong preference for western medicine and western-trained practitioners, unlike those in Chen et al.,'s (2010) study, and that only about half of the Chinese seniors seek traditional Chinese care for both minor and serious illnesses. Such a difference in findings may be an attribute of the methodology or the country where the data were gathered.

In New Zealand terms, feelings of safety and security are linked with improved health, as well as the feelings of less stress. Poorer health is reportedly due to factors including concern about family overseas, developing a medical condition in New Zealand and the disruption of support networks. (Ho et al., 2003; Pernice & Brooks, 1996). However, judging from the information from America (Chen et al., 2010), there may well be cultural issues not made explicit in the health literature.

METHOD

Ethical approval was obtained from the Otago Polytechnic ethics committee in 2014. An action research approach was used so that the group could not only understand their own issues but also would be able to recognise their own resources and develop knowledge on how to overcome inequities that they felt were important (Dickson & Green, 2001). Within this framework, both knowledge attainment and empowerment are considered to be outcomes and learning is viewed as a two way process where researchers and community members not only develop knowledge but also learn new ways of interpreting it (Van der Velde, Williamson, & Ogilvie, 2009)

We approached the local Chinese senior association when looking for participants in the project. This began with an introductory meeting in a room in the Chinese gardens. Following this, the research meetings were held in the community house, a central facility used for community meetings and near to bus routes. The research group consisted of about twenty senior Chinese, Mandarin speakers, invited through the senior Chinese association in Dunedin with numbers varying between sessions. There was a preponderance of women, with an age range of between 60s and 80s. All were immigrants and had lived in New Zealand from 10 to 30 years.

Additionally four members formed a steering group which included representatives from health services, migrant social services as well as an interpreter/ liaison person. Their function was both administrative and to act as facilitators to assist the group to identify problems and provide solutions. Additional supportive people such as an experienced Mandarin speaking Chinese researcher and interested Chinese students/professionals joined in with this research on occasions.

The group met for one and a half hours every second week over a 16 week period. This was recorded and transcribed with reflective notes also taken by an observer to capture the major issues and concerns. Due to language differences, the steering group met weekly to summarise the main action points from the meeting and to refocus. An agenda was developed for this meeting and minutes were recorded. The format for the group meetings of the Chinese seniors was an open format with discussions on the topics which most interested the group. The health related topic identified at the beginning of the project developed into a question about how to access health information and use the health system. Many stories were told that identified issues such as using emergency systems, communicating with the General Practitioner (GP), obtaining services for home help, using interpreters and

responses to being Chinese. Following on from the questions raised in the group we invited speakers on particular topics of interest, such as a needs assessor of older people, and the patient affairs advisor in the local district health board. Another feature of the research were two community meetings where the public were invited to attend and information about the group and the findings were shared.

The process of action research begins with sharing views and ideas, thus building trust amongst the group members and with the researchers. A sense of participating in the group method and focus is necessary. The process of research continued through working together to ensuring participation. We were careful to work with our interpreters, checking their understanding, of the project and of our questions, and ensuring our questions were manageable in terms of size and language. This ensured for us as researchers a good sense of the meaning of the responses through the spoken contributions, observing the interactions in the group, and trying to interpret their body language. When such interactions are culturally influenced, and linguistically different, the sharing of information requires careful management (Van der Velde et al., 2009).

To ensure a cooperative process, we adopted an informal approach, meeting and greeting the participants, helping with seating, offered food and drink generally took time before the topic of the session was opened for discussion. To assist in the clarity of messages, ideas and intentions were shared on paper so that those with some language skills could interpret for those with no skills, and that group members could take the questions home and mull over them, with the potential of help from others, e.g. family members or friends. Whiteboards were also used. While this formalised the proceedings and might have detracted from the focus group interactions, we felt it necessary so that we could record key ideas. Use of the whiteboard emphasized the English language visually, to ensure that even if the sound of the words was unfamiliar or difficult, they could be seen and perhaps read, and shared amongst the group for further interpretation and understanding. The numbers of participants maintaining a good attendance at the group suggests that the topics and the atmosphere were sufficient to maintain group involvement.

FINDINGS

The explicit concerns of the group members were lack of knowledge of the local health service; misunderstanding about the role of general practitioners; concerns over translations and interpretations of their health issues. A practical output of this group were two resources, one that would assist Mandarin and Cantonese speakers to locate important contact details for health providers and a 'wallet card' with basic information that could be used in an emergency. The outputs were carefully crafted by the group members with great care taken that the interpretation into the three languages (Mandarin, Cantonese and English) were accurate. These were circulated to the group members, distributed throughout GP practices and at a consultation forum held in community house. They were popular resources and the group were proud of these products.

Developing from the consultation forum where the results of the project was shared, a group of younger bilingual Chinese women organised themselves as contacts with the senior group. The purpose of this 'care group' was to create a network amongst the younger and older, to get to know the senior group. Another objective was to gain a better understanding of the needs of this senior group related to accessing the health system and then to put in place strategies to assist. This has resulted in a monthly network meeting and a buddying system between older and younger where support is provided by accompanying an older person to attend appointment related to health care. It has included elements of both translating and advising.

In discussions within the research group, there were occasions when issues raised were referred to indirectly. This approach to communication is counter to the usual style in New Zealand where there is an expectation that people will communicate directly. This style of communication took the researchers time to realise it was occurring. One such concept that was finally noted was that of 'qi' or life force which is integral to health in Chinese medicine (Ma, 1999). 'Qi' relates to breath or air, and to material energy and the group related it to singing, to assist the individual's health. This reference to cultural differences in understanding health showed how comfortable the group were with each other that they could discuss their culture so fully. It also reminded the steering group just how 'foreign' aspects of a western system were to the group. There were many complex conversations which hinted at these ideas and may have been lost or minimised in translation if they had not been pointed out specifically by the interpreter/researcher.

A further topic that was quite explicit and warranted considerable discussion in the group was the desire for reciprocity e.g. to volunteer their time to a good cause and to gift their arts, crafts and music skills on a voluntary basis. This was an aspect of a larger theme on how to establish a sense of belonging and familiarity within the host culture. There were two components, being with others from their own culture to reinforce a sense of 'being-at-home' as well as having the opportunity to contribute to the local community and become a productive member of the society they had chosen to live in. However the experience of some of the group members in becoming volunteers demonstrated that they had not understood well enough what being a volunteer in the general population entailed and where the boundaries lay. Their well-meant intentions were interpreted as being 'pushy' and 'intrusive' as they had misread the ethical concerns that were tied to volunteerism in New Zealand.

DISCUSSION

Through the discussions, it became clear that members of the group felt there was a place in New Zealand society which Chinese people could specially occupy. One particular discussion ranged round the sharing of Chinese culture, with the ability to show Chinese arts and crafts and music, and with the possibility of volunteering to help others in some way. This sense of a space to be occupied, of a role to be created and made visible, extended the sense of an identity.

Such discussions led to a conceptualising of place and identity of the Chinese seniors as being 'on the threshold' in a liminal position, for them being neither Chinese at home, nor New Zealanders, but being Chinese in the host New Zealand society. This sense of being and remaining on the threshold (Van Gennep, 1960) emerged in the discussions about what the group members would like to do to create a greater sense of local identity and a sense of familiarity and belonging. Two key strategies were discussed, these were communication and what could be done to 'give back' to the host community. At present, we suggest, many of the senior Chinese are in a liminal space, neither fully Chinese because of living in New Zealand as a host country, nor fully New Zealand, because of their own strong cultural identity. There was a continuum here with language skills and the ability to use a more direct style of communication determining where people were in this liminal space.

While the intention was that an action research approach would be an empowering process we discovered that poor grasp of English resulted in many of the group members being dependent on the interpreter or the few who were fluent in English. This socially oriented approach would seem to be appropriate in a culture that prioritises social relationships as opposed to individualism. However, it is important that the "emphasis is on proper social relationships and their maintenance rather than any abstract concern for a general collective body" (Yum, 1988, p. 375)

To begin with the practical issues of the 'flier' with information about how to access health resources and the wallet card was a tangible way of assisting the group to feel connected to the systems of the host country. They provided a way of helping them to manage the process of accessing health care. The care group instigated by the younger group added to this understanding of health care systems by buddying up with the senior Chinese members and by providing timely responses to their questions. The underlying theme would seem to be that knowledge of such an important system as health assists the sense of being more fully involved in the New Zealand culture. We hypothesise that a good knowledge of the host country's system emphasizes a sense of familiarity with that country and thus a sense of belonging.

The second and conceptual issue we describe as acculturation emerged from group discussions on living in Dunedin. The wish to display Chinese culture by means of arts and crafts, and perhaps music and also to act as volunteers and give to the host culture suggests a particular form of acculturation. The concept of acculturation means generally that the minority ethnic group will conform to the strong and predominant host group. However there are other elements in acculturation, a fourfold model (Berry, 1997) offers the following:

- Assimilation: individuals adopt the cultural norms of a dominant host or culture,
- Separation: individuals reject this dominant host in order to preserve their own culture,
- Integration: individuals can adopt the dominant cultural norms while maintaining their own. This can be considered synonymous with biculturalism
- Marginalization: individuals reject both culture of origin and host culture.

Our understanding from group discussions is that the term biculturalism is the most appropriate to describe the wishes of this group, adopting dominant cultural norms while not only maintaining, but also demonstrating their own ethnic identity. The literature indicates that much of the sense of belonging is created within the public sphere, with 'close' and 'loose' ties being formed through familiarity with the locality (Granovetter, 1973). Taking a role in the public arena was suggested by group members who offered both volunteering and demonstrating their own culture to the host culture by means of arts and crafts displays. We would argue that such a wish emphasizes a sense of biculturalism by creating not only a sense of belonging to the host culture but also by asking the hosts to become familiar with the Chinese culture. Anticipating that there would be an acceptance of some of the elements in the Chinese culture implies that there is a need for a reciprocal arrangement for biculturalism as an ideal to be a reality.

Volunteering, in particular, is a major part of this biculturalism for the group. Acting as a volunteer gives someone a particular role, and in the sense of biculturalism, demonstrates willingness to adopt significant requests and needs in the host country. In a New Zealand study (Dulin, Gavala, Stephens, Kostick, & Mcdonald, 2014, p. 617) it was noted that "volunteering is related to increased happiness, irrespective of ethnicity" and that an opportunity to provide helpful services to members of the community assisted older people to develop a sense of wellbeing. Therefore adopting the volunteer role is both good for health and wellbeing while also declaring 'I am a New Zealander too'.

CONCLUSION

We suggest that both the better understanding and use of the health care system as well as volunteering will assist in moving the individual(s) from a liminal position and having a restricted sense of belonging, to a stronger participation in the host culture. It will provide the individuals with the 'loose connections' of a microsocial system of what Blokland and Nast (2014) discuss in terms of small processes of neighbourhoods and locality living. However, the journey between cultural positions is difficult and requires a close consideration of the process of acculturation for example, taking an initial step of working out what the differences are between what is usually done in the home culture and the norm of the new culture. In summary, it is pertinent to note Lui's (2015) findings regarding Chinese identity negotiation. She suggests that although national identity tended to be derived from citizenship and residence, "a strong sense of place or belonging seemed to be formed based on descent, physical appearances, and values – something that was difficult to change, if not impossible" (p. 34).

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Linda Robertson is an Associate Professor in the School of occupational therapy where she teaches on the post graduate programme. Her areas of research interest lie in the wellbeing of older people and in clinical reasoning. Current interests have included the experiences of older immigrants and their views of integration into the local culture.

Beatrice Hale PhD after her retirement from social work, she focused on researching and writing in the areas of ageing and of informal caregiving. As a migrant herself (from Scotland), she is interested in not only ageing in place, but the experiences of other migrants ageing in a different country from 'home', and likewise, their experiences of caregiving, whether there is a cultural clash between the home country and the adopted country or whether the mores of the adopted country predominate.

Correspondence to Linda Robertson, School of Occupational Therapy, Otago Polytechnic, Private Bag 1910, Dunedin, New Zealand. Email: linda.robertson@op.ac.nz

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