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Aging in multilingual Netherlands

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CHAPTER 4

Second language abilities of older Turkish adults

Abstract | Research towards aging of migrant populations has so far mostly focused on (bio)medical and psychological aspects. This short chapter explores to what extent second language ability is a factor influencing the healthy aging process of older Turkish migrants in the Netherlands. To gain a first understanding of the linguistic situation of older migrants within this setting, this chapter reports interviews with ten healthcare consultants, who are appointed to provide information on elderly care and assistance in their local environments. Ten such consultants, with insight into their local Turkish community, are interviewed regarding the language and healthcare practices of their Turkish clientèle. The consultants' information forms the basis of a needs-analysis of the linguistic and health situation of Turkish older adults.¹

¹This chapter has been slightly adapted for this dissertation and is published as a paper in: Pot. A., Keijzer, M.C.J. and de Bot, K. (2018). Do low L2 abilities impede healthy aging for migrant older adults in the Netherlands? *Dutch Journal of Applied Linguistics* 7(1), 109-120.

4.1 Introduction

Today, migrant elderly make up 11% of all older adults (65+) in the Netherlands, a number that is said to increase to 26% by 2060 (van Duin and Stoeldraijer, 2014). So far, research on migration and aging in the Netherlands reports an overall worse health condition (with physical and psychosomatic illnesses and (mild) cognitive impairments being prevalent) for especially ‘first-generation’ older adults of Turkish and Moroccan descent, compared to their autochthonous peers (van der Wurff et al., 2004; Parlevliet et al., 2016). Crucially, it is not the case that ‘being a migrant’ by definition equals a poorer health status. Kotwal (2010) in Germany and Verhagen et al. (2013) in the Netherlands report no difference in health status between different social groups when looking solely at ethnicity (native-born versus immigrants from different social groups) as a factor. However, the migrant ‘experience’ is often associated with factors that impact health status, such as a lower socio-economic status (Verhagen et al., 2013), poorer health literacy levels (Kristiansen et al., 2016), and loneliness (Kotwal, 2010). These factors are prevalent across migrant groups, through which, indirectly, migrants may be at a greater risk of developing poor health outcomes (Uysal-Bozkir, 2016). Indeed, previous studies have noted a higher prevalence of cardiovascular diseases and psychological mood disorders, including depression, for older migrants of especially Turkish and Moroccan descent (van der Wurff et al., 2004; Solé-Auró and Crimmins, 2008).

One factor unique to being a migrant, as opposed to their native-born age-peers, is the fact that aging takes place in a second language (L2) environment. Even though older migrants may mostly venture in social environments where the use of the L1 is high and the L2 is hardly spoken (in local communities), they are more confined to particular (and fewer) social contexts (in which this L1 maintenance is high) than their peers in their country of origin. Access to healthcare may be more challenging in an L2 environment. This poses extra cultural, social and health-related challenges when mastery of the L2 is low. Statistics show that 50% of the older Turkish population in the Netherlands have a poor proficiency in Dutch (Dagevos and Gijsberts, 2007). Importantly, for other regions, a relation has been found between better health and second language (L2) proficiency. Being able to speak the target language was found to positively impact migrants’

(perception of) health (Wengler, 2011) in Germany. Moreover, a recent investigation into bilingualism in an immigrant context revealed that, among the Turkish population in the Netherlands, language shift (from socioemotional maintenance of the heritage language (Turkish) to the practical importance of the target language (Dutch)) induces intergenerational language tensions (Sevinç and Dewaele, 2016). For older (first-generation) Turkish migrants, the inability to use Dutch may induce linguistic anxiety, defined as an effect of language tensions within and outside the family and pressure to adopt the majority language, which may result in a decline of confidence in linguistic competence (Sevinç and Dewaele, 2016; Sevinç and Backus, 2017).

In a recent study, Sevinç and Backus (2017) note that limited L2 practices induce language anxiety, which may heavily impact daily communicative situations for the Turkish immigrant community. They draw on Wei (1994)'s observation of a vicious circle in immigrant communities: interacting with the mainstream (British) community promotes the development of English proficiency for Chinese immigrants, and their subsequently higher L2 proficiency strengthens the formation of L2 social network ties.

Similarly, Sevinç and Backus (2017) argue that linguistic and sociocultural obstacles prevent Turkish migrants from establishing social connections with the Dutch mainstream community. This is indicated to be especially true for the first-generation, who are now aging, and for females who, under their husband's authority, may be isolated at home and have little opportunities to practise Dutch (Sevinç and Dewaele, 2016). Low (self-perceived) proficiency induces anxiety and avoidance of L2 situations. This means fewer opportunities to interact and practise the language, through which L2 proficiency remains low and anxiety is triggered (2017, p.4). We know that anxiety in old age in general is detrimental to wellbeing, regardless of whether it is clinically diagnosed as a disorder or a symptom. Anxious individuals over-utilise healthcare services, yet only few receive adequate care or treatment (De Beurs et al., 1999).

In addition, from research conducted specifically in the Dutch context, we know that limited (L1) health literacy, which typically is also low for (especially female) migrants (Verhagen et al., 2013), proves detrimental for wellbeing (Jagt et al., 2015). In turn, limited L2 proficiency and literacy may affect wellbeing. Not being able to communicate effectively in the target language does not only put up

barriers in accessing (health)care, it also detrimentally affects the type and degree of interaction. Decreased or lower quality interaction can fuel withdrawal from communicative situations. This decreases the number of opportunities to practise the language and increases susceptibility to loneliness and depressive symptoms (De Bot and Van der Hoeven, 2011).

Here we therefore argue that language ability is an important modulating factor on older Turkish migrants' social wellbeing as well as cognitive, and perhaps even physical health. We base this argument first and foremost on the observation of the need for special 'healthcare consultants' for older migrants in the Netherlands. These healthcare consultants form a bridge between the individual who seeks help or assistance, and the relevant governmental institutions (such as tax services). In areas with large numbers of immigrant elderly, healthcare consultants with a migrant background often speak the language of the community and provide tailored services, mainly involving translating and navigating the tax system (Rijksoverheid 'Ouderenadviseur', 2016). Two recent investigations into the healthcare utilisation by older migrants revealed that many older migrants experience difficulties with voicing their healthcare needs, both because of low health-literacy as well as a low command of Dutch (Suurmond et al., 2016; van Wieringen, 2014).

This study aimed to explore the linguistic situation of older Turkish adults in the Netherlands with regard to accessing and communicating about health and care, a so-called 'needs-analysis'. To do so, information was gathered from ten healthcare consultants across the Netherlands, who have a good understanding of their local older Turkish clientèle. The question to be answered was how the (lack of) proficiency in the L2 may influence negative aspects of the aging process of older Turkish immigrants in the Netherlands.

4.2 Method

Ten consultants (2 males) shared their observations and insights regarding the health and wellbeing situation of their clients, for this study focusing solely on Turkish older adults.

Through semi-guided interviews, consisting of 30 questions and taking approximately 90 minutes, the main underlying question targeted was whether (and

to what extent) the mastery of Dutch plays a role in the older adults' aging process and particularly their health and wellbeing. The interviews were recorded and holistically transcribed using oTranscribe (Bentley, 2013), and subsequently coded with ATLAS.ti (Version 1.0.16; 2016). The coding procedure followed the steps for conducting a thematic analysis (Braun and Clarke, 2006), with the aim of arriving at a 'needs-analysis' of the Turkish group of migrants as observed by the consultants. First, interesting features across the dataset were assigned codes. Next, codes were collated into potential themes and checked against the coded extract (reviewing themes). The themes that emerged from this procedure can be found in Table 4.1, where they are illustrated with exemplar quotes from consultants (in brackets).

Table 4.1: *Extrapolated themes from the interviews with 10 consultants, with exemplar quotes to illustrate each theme.*

Theme	Data excerpt
Limited L2 use/abilities	<ul style="list-style-type: none"> ● ‘Many Turks are illiterate, through which they are oblivious to a lot of health and financially important information’ (HG, also in other 9 interviews). ● ‘Limited language abilities reduce mobility. Asking for directions is problematic, as is calling a taxi. Use of public transport requires navigating a complex ticketing system, which can be off-putting’ (HM; also SB, SA). ● ‘The older migrants rely heavily on their children. On the one hand this originates from cultural values, but on the other hand is borne out of necessity: children assist when communication in Dutch is needed. This may lead to increased pressure on the children and family tensions’ (SK; all others note this, too).
Extensive L2 needs	<ul style="list-style-type: none"> ● ‘Much information about health issues and healthcare provisions, such as information evenings, does not reach the older migrants. Immigrant elderly are not aware of the provisions and care rights because of a lack of knowledge of Dutch’ (SA; also HM, ND, HG, BT). ● ‘It is expected that people organise their care independently. Without the necessary language skills, older migrants are at a loss of not knowing where they can ask for help or assistance. They require, already in a very early stage, assistance from their family and friends, which induces an early and heavy dependence on others’ (LA).

Table 4.1: *Extrapolated themes (cont.)*

Theme	Data excerpt
Cultural-sensitive care, values and traditions	<ul style="list-style-type: none"> ● 'Out of tradition, older Turkish migrants want to organise care within their family and decline assistance from outside. This is no longer a realistic situation; generational tensions and changing lifestyles prevent their children to care for them. On the other hand, outside home care cannot always provide tailored and culturally sensitive care' (HG, corroborated by all consultants). ● 'If it is available, older migrants make use of household care provided by someone from their own ethnic background. Others, however, decline such assistance, afraid that they may know the carer from 'their community' and he or she will start gossiping' (SK, HI).
Physical and mental status of older migrants and language-related stress	<ul style="list-style-type: none"> ● 'A large number of migrants have physical and mental complaints through which they lack the concentration to participate in language classes. They already need to monitor their health status and take care of their finances, so learning Dutch in addition to this often fails' (SB). ● 'Inability to speak the target language leads to loneliness and stress. In addition, a large number of older adults show symptoms of depression. People live in-between two cultures; they feel they do not quite belong in the Netherlands, but can also no longer root in Turkey.' (ND; also HI, BT, HM, SK, SA).

Table 4.1: *Extrapolated themes (cont.)*

Theme	Data excerpt
Role of the consultant	<ul style="list-style-type: none"> <li data-bbox="666 473 1659 577">● ‘Sometimes people just need someone to listen to them, and then I am there. They cannot address certain issues among their family or friends for fear of losing face’ (BT also SA, SK, BT). <li data-bbox="666 589 1659 658">● ‘Most people need help with administrative issues. They receive for example a tax letter and panic, because they don’t understand what is required of them’ (LA, MS).

Note: these themes are broadly defined and the data excerpts can, for reasons of space, only give a limited insight into the data.

The ten consultants were contacted through some of the major care facilities in the Netherlands and referrals from their colleagues elsewhere in the Netherlands. They represent the larger cities of Den Haag (West), Leiden (W), Arnhem (S), Nijmegen (S) and Zwolle (N), and the smaller towns of Leerdam (W), Goor (E), Hengelo (E), Almelo (E), and Hoogezand (N). Although self-selection may have been an issue, the fact that the informants represent different parts of the Netherlands allows for a holistic insight into the linguistic situation of older Turkish migrants in various parts of the country.

4.3 Results and discussion

The central theme emerging from the interviews is the clear discrepancy between the overall minimal L2 use of the Turkish adults on the one hand, and their extensive and increasing L2 needs on the other hand, which the consultants claim becomes even greater as they age (see Table 4.1).

4.3.1 Limited L2 proficiency

The Turkish migrants seem to have had a ‘false start’ linguistically, as from the outset of their stay in the Netherlands, the intention was to return to Turkey. This idea of temporality, combined with the physically intense factory work and grouped housing facilities created a situation in which the need and opportunity to learn Dutch was low (Schellingerhout, 2004). When much later the Dutch government intensified the language requirements, subsidised language courses failed to reach the desired effect, as work proved difficult to combine with language learning. Together with the close-knit ethnic communities within which there was no need and few opportunities to interact in Dutch, L2 proficiency for the first-generation adults remained low (Yerden, 2000).

The continued notion of temporality fuelled the use of Turkish in the home. However, the question of return was continually postponed. When a large majority of the second-generation started family life in the Netherlands, the emotional losses when returning to Turkey increased even further for the first generation. Nonetheless, many still struggle with the issue of return (Percival, 2013). Rather

than purely belonging (feeling most at home) in Turkey or in the Netherlands, the first generation belongs ‘transnationally’ (Klok et al., 2017).

Because of this initially Turkish and later transnational perspective, the first generation is, as indicated by the consultants, at a disadvantage linguistically. Figure 1 below is an illustration of the observations of the consultants on the dependencies stemming from a low L2 proficiency for this group (cf. Table 4.1).

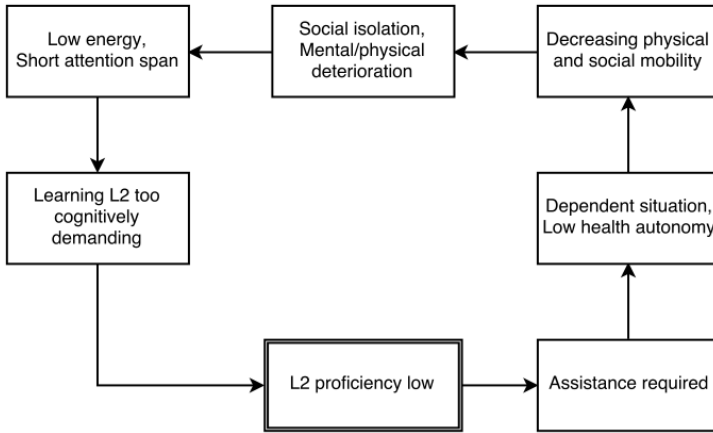


Figure 4.1: Schematic illustration of the observed effects of a limited L2 proficiency on health and wellbeing

The limited opportunities to interact in Dutch combined with their transnational form of aging, means that the older migrants have difficulty navigating Dutch society and participating independently in the Dutch healthcare system (phase 2 and 3 of Figure 4.1). The consultants hint at language anxiety as playing a role in this process too, with their clients experiencing stress in situations where they have to speak Dutch (cf. Table 4.1). Considering Figure 4.1, low L2 proficiency appears to induce a situation in older age that is characterised by dependence. Dynamic models on frailty and resilience in old age associate dependence with increased frailty (cf. Rockwood et al., 1994, 2005). Small changes to an older adult’s status (a new drug, surgery) may have a disproportionate impact on an individual’s health status, such as from independent to dependent; so-called

'dependency oscillations' (Clegg et al., 2013). The consultants thus suggest that the L2 environment may also contribute to dependency oscillations: largely through this physical and linguistic dependence, a vast number of older Turkish adults are at risk of becoming isolated or depressed (phase 5). The consultants attribute these detrimental effects to the migrants' increasing L2 needs.

4.3.2 Extensive L2 needs

The healthcare policy in the Netherlands requires citizens to take a proactive stance toward obtaining healthcare assistance. Individuals need to voice their care needs in the immediate environment and call upon their own social network to provide assistance where possible. All consultants noted that this proactive policy can be detrimental for older adults with a limited social network, and can be further impeded by a lack of language skills and the relevant knowledge of the healthcare system. Additionally, through recent societal budget cuts special facilities, such as an interpreter telephone, disappeared, making people more reliant upon their own personal networks, primarily their children, who assist and interpret. This may invoke family tensions (cf. Yerden, 2000). For low-proficient migrants, day-to-day tasks, such as taking the bus to maintain mobility, prove difficult (the consultants indicated this to be especially true for older Turkish females). More urgently, these simple tasks are a locus for more pressing problems, such as loneliness and depression (see Table 4.1 and phase 4 and 5 of Figure 4.1).

In line with Uysal-Bozkir (2016)'s dissertation on the health status of older migrants, the consultants echoed that psychosomatic illnesses widely exist within the Turkish community, but are often not recognized accordingly or acted upon. The elderly who frequent the consultants' offices often report psychosomatic complaints. Lack of knowledge on psychosomatic illnesses, however, block an adequate diagnosis and desired treatment. Stress only appears to intensify these feelings, as observed by the consultants (cf. Table 4.1).

The perceived stress is closely linked to limited L2 proficiency and low literacy levels in general. Stress may ensue from the inability to independently manage finance and living issues due to low levels of literacy among this group (cf. Table 4.1). Low literacy skills in general have been found to contribute to social exclusion in older adults, which increases their vulnerability (de Greef et al., 2014). For

the older migrants, not being able to sort important mail from 'junk mail', or the inability to manage finances because of limited literacy abilities, enhances stress levels and induces L2 anxiety, the consultants anecdotally observe.

4.4 Limitations and implications

The observations above reveal the importance of mastering the language of the environment in the aging process of individuals, and, indirectly, the niche that these consultants fill in forming a bridge between the elderly immigrant and health-care information. Of course, these notes are merely a snapshot and information is one-sided, reflecting only the views of a selection of healthcare consultants, and generalising over this particular migrant group. The notes do not cover individual cases either. Nonetheless, it is striking that, across the different consultants in different areas, similar issues surface.

Despite the limited generalizability of the observations to other migrant communities, the conclusions reached in these notes open up a theoretical opportunity to study L2 proficiency in relation to health and wellbeing also in other countries and situations, with other migrant groups and language communities. Migration, and factors resulting from it, is highly variable across contexts: different immigrant communities in different contexts may experience different migration trajectories, and it would be interesting to explore to what extent similar or different patterns may be observed regarding language usage, well-being, health and migration.

The point that we have aimed to make is that research into aging and migration features a strong linguistic component that, so far, has not been investigated systematically. The dependencies stemming from a limited L2 proficiency indirectly impacts an individual's health and wellbeing. This ties in, to some extent, with the interplay between (mental) health and acculturative stress. Acculturation, or the degree to which an individual has adapted to the dominant culture, relates to better mental health (Escobar and Vega, 2000). It is suggested that low levels of acculturation induce more acculturative stress, which negatively impacts psychological wellbeing (also see phase 6 and 7 of Figure 4.1).

Acculturative stress may arise as a result of language barriers (task-oriented stress) and/or feelings of alienation (emotion-oriented stress) (Jang and Chiri-

boga, 2010). Taking into account the dependencies stemming from a limited L2 proficiency, future research might explore to what extent a low L2 proficiency fuels acculturative stress, and how this in turn impacts on wellbeing. Notably, the consultants can already alleviate some of the acculturative task-oriented stress, by providing linguistic assistance in communicating with healthcare or financial institutions.

This needs-analysis provides a rough understanding of the complex interplay between L2 proficiency and health behaviour. To strengthen the conclusions reached, future research may double-check the statements against first-party data. These outcomes allow us to establish a more systematic insight into the health issues that older Turkish females encounter in relation to their limited Dutch proficiency by interviewing these older adults. Even though there may not be a direct link between language proficiency and health, the needs-analysis suggests that language is a strong mediating factor in gaining access to healthcare and maintain a degree of wellbeing.

