Chinese Culture and Disability:

Information for U.S. Service Providers

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Preface

As every school child knows, China is the most populous nation on our planet. Historically, Chinese immigration to the United States was limited, compared to immigration from Europe, due to strict immigration quotas. In recent decades, however, that has been reversed. Currently, China, including Hong Kong and Taiwan, is one of the principal countries of origin of immigrants to the U.S.

In spite of the large numbers of Chinese in the U.S., most Americans have a very limited knowledge of Chinese language and culture. Culture has a very strong impact upon our understanding of disability and of the goals and processes of rehabilitation. Therefore, persons born in China may, like other recent immigrants, have difficulty using rehabilitation services in this country. The goal of this monograph is to provide an introduction to Chinese culture, focusing on information that may help rehabilitation service providers to better serve this population.

The author is very well qualified to write on this subject. A first generation immigrant from the People's Republic of China, Gloria Liu holds a master's degree in special education with a major in Rehabilitation Science from Clarion University of Pennsylvania. Since 1993 she has been working with people with disabilities in the capacity of counselor and bilingual case manager. She started working with people with traumatic brain injury (TBI) in 1995 and has served as coordinator of different traumatic brain injury projects for the Association for the Help of Retarded Children-New York City Chapter and currently as a regional resource development Specialist for the New York State Department of Health TBI Waiver Program. Part of her responsibilities in these roles has been to develop and translate culturally competent education and outreach materials on TBI for use by rehabilitation professionals, consumers and family. She has also worked to establish support networks for consumers and their families from ethnically and culturally diverse communities. These activities have given Ms. Liu a keen insight into the difficulties in bridging the cultural gap between the rehabilitation service provider and persons from China, as well as strategies for overcoming these difficulties. Most of the case examples presented in this monograph are derived from the author's own experience.

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This monograph is part of a series developed by CIRRIE - the Center for International Rehabilitation Research Information and Exchange at the University at Buffalo. The mission of CIRRIE is to assist rehabilitation researchers and practitioners in the U.S. to access international expertise. CIRRIE is supported by a grant from the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education. In addition to the monograph series, CIRRIE conducts workshops on providing rehabilitation services to foreign-born persons. We hope that this monograph will be useful to you in your work with persons born in China. We welcome your comments that will enable us to deepen our understanding of ways to increase the effectiveness of rehabilitation services for persons born in other countries.

John H. Stone, Ph.D., Series Editor and Director,
Center for International Rehabilitation Research Information and Exchange (CIRRIE)

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PART I: INTRODUCTION

The 2000 census shows the Chinese to be the largest single group of Asians in America and that Asians and Pacific Islanders represent four percent of the U.S. population (U.S. Bureau of Census, 2000). The Asian American Health Forum (1990) revealed that more than 63 percent of Chinese Americans are foreign-born, 23 percent do not speak English well, 72.5 percent speak a language other than English at home and 53 percent live in the Western United States.

The Chinese in America are a heterogeneous group. They include people from mainland China, Taiwan, Hong Kong and other Southeast Asian countries, and are characterized by significant linguistic, social, economic and political differences (Chan, 1998).

This author has uses the word "China" there to refer to mainland China, Hong Kong and Taiwan. The purpose of this monograph is to present the unique cultural backgrounds, sub-cultures, religions, socio-cultural milieu and rehabilitation systems in mainland China, Taiwan and Hong Kong and compare the practice and delivery of rehabilitation services in China and the United States.

There are differences in acculturation among Chinese immigrants from different parts of the world, between foreign-born versus American-born Chinese Americans and between different generations of Chinese Americans, but the focus here will be on the common elements in their cultural backgrounds. This author believes that cross-cultural analysis of this kind will help American rehabilitation providers appreciate and understand the Chinese culture and rehabilitation system. Only with genuine understanding of the Chinese culture and subcultural differences can American rehabilitation professionals effectively serve individuals with special needs within the Chinese-American community.

Part II: China: An Overview

China has one of the four oldest civilizations in the world and a written history of 4,000 years. China's long history includes eras of primitive society, slave society, feudalism and semi-feudalism, semi-colonialism and the present socialist society ("China Today, 2000"). The Chinese are very proud of their society. They value their own culture and religion but are open and pragmatic towards the religions and cultures of others.

Chinese people in general are peaceful, hardworking and easily contented. They respect authority and elders and are patient with their fellows. They will, however, push and sacrifice for their children. The Chinese value modesty, reserved behavior and humility. They believe in harmony and tend to avoid confrontation.

China in the 21st century is stronger than ever. Since 1979, when its "Open Door Policy" was established, it has been engaged in an effort to reform its economy. Deng Xiao Ping and his supporters placed top priority on the opening of its economic market. When Jiang Zemin was re-elected president and Zhu Rongji selected as premier in 1998 after Deng's death, the "third generation leaders" firmly committed to economic reform and opened China to the outside world. The new Chinese leadership has identified reform of state industries as a government priority. Government strategies for achieving that goal include large-scale privatization of unprofitable state-owned enterprises as well as downsizing the government bureaucracy (Bureau of East Asian and Pacific Affairs U.S. Department of State, 2001). The reunification of China, and Hong Kong and Macao at the end of the 20th Century also strengthened China.

Profile: People's Republic of China

Population:	*1.26 billion*
Religions:	*Buddhism, Confucianism, Taoism, Islam, Catholicism, Moslem, Christianity, Judaism*
Language:	*Mandarin (the official and common speech), Cantonese (largely used in southern China) and various dialects*
Size:	*One-fifteenth of the world's land mass ("China Today", 2000)*

Profile: Hong Kong

Population:	*5.8 million*
Religions:	*Buddhism, Taoism, Christianity and small numbers of Moslems, Hindus, Jews and Sikhs*
Languages:	*English and Cantonese, although Mandarin is on the increase*
Size:	*Approximately the size of New York City (Engholm, 1994, p.26)*

Profile: Taiwan

Population:	*20.8 million*
Religions:	*Buddhism, Confucianism, Taoism, Christianity*
Languages:	*Mandarin (official), Taiwanese, Hakka*
Size:	*Approximately the size of the Netherlands (Engholm, 1994, p.28)*

Part III. Immigration History

Chinese migration to the U.S. has a history of more than 150 years. It is a complex, fascinating story of change, adaptation, and survival that reveals how the Chinese family system is affected by the immense power of political, legal, social and economic forces (Lee, 1996).

The First Wave: The Pioneer Family (1840-1919)

Although, there were Chinese in the United States prior to 1800, they began to arrive in large numbers in the 1840s in response to the demand for cheap labor provoked by the discovery of gold in California and the construction of railroads (Sue & Sue, 1999).

The Chinese Exclusion Act of 1882, which was not repealed until 1943 when China became an American ally at the beginning of World War II, barred Chinese laborers and their relatives (including wives) from entering the United States. The act was broadened to include all Chinese people.
Early Chinese immigrants lived in a virtually womanless world without family life (Lee, 1996).

While the Chinese immigrant population declined, those remaining survived in the face of anti-miscegenation laws, special taxes directed against them, institutional racism, persistent humiliation, racial violence, loss of property, loss of livelihood and sometimes loss of life (Chan, 1998). All this had a profound impact on the development of family life among the early Chinese in the U.S (Lee, 1996).

The Second Wave: The Small Business Family (1920-1940)

The discriminatory Immigration Act of 1924 allowed American citizens of Chinese ancestry to work in the United States but without their wives and families. The law changed in 1930 to allowed wives of Chinese merchants and Chinese women married to American citizens before 1924 to immigrate to the United States. As a result, sizable family units with second-generation, American-born Chinese people began to come together in "Chinatowns". Meanwhile, many first-wave laborers left the mines and railroads and used their savings to start small businesses (Lee, 1996).

The Third Wave: The Reunited Family (1943-1964)

In 1943 after years, even decades of separation changes in the immigration law meant that many wives were reunited with their husbands for the first time. Due to the reform in immigration policies, many Chinese men returned to their native land to find wives, who were usually 10-20 years younger than them. Consequently from 1943 to the repeal of the quota law in 1965, most Chinese immigrants were female (Lee, 1996).

The Fourth Wave: The Chinatown, Dual Worker Family and the Students (1965-1977)

The 1965 Immigration Act replaced a 21 year-old exclusionary system of immigration. If the earlier policy aimed to freeze the country's ethnic balance, the 1965 act assigned a flat annual quota of 20 thousand immigrant visas to every country outside the Western Hemisphere. Following the passage of this act, Chinese immigration reached its peak (Pan, 1990). Most of the Chinese immigrants who arrived under the Immigration Act of 1965 came as families. Many initially settled in or near Chinatowns in the major metropolitan areas. Approximately half were of the working- class. Most husbands and wives sought employment in labor-intense, low-capital services, such as garment sweatshops and restaurants. Economic survival was the primary goal for many Chinese families, especially the new immigrants. (Lee, 1996).

Before 1978, when the U.S. established diplomatic relations with mainland China and crossed its recognition of Taiwan in favor of that of the People's Republic, Taiwanese comprised most of the 20 thousand per year quota. Taiwanese students have been settling in the U.S. using the quota since the 1960's. Unlike the earlier immigrants of humble rural origin, many of the Taiwan

arrivals came from well-to-do and/or well-educated families and many were students who, upon graduation from American universities, stayed on to work in the United States (Pan, 1990).

The Fifth Wave: The Students/Scholars and Refugees (1978-Present)

Taiwan retained its right to a 20 thousand per-year U.S. immigration quota when the U.S. normalized its relations with mainland China in 1978, and the People's Republic was given its own quota of 20 thousand. There was an additional quota of 600 (increased to five thousand on October 1, 1987) immigrants from Hong Kong. That meant that a total of 40,600 Chinese could come to the US each year (Pan, 1990).

The reestablishment of diplomatic relations between the Unites States and the People's Republic of China in 1978 provided an opportunity for students and professionals from China to study and lecture in the United States, and many of them elected to stay (Lee, 1996). The U.S. government granted special permanent residency status to a large number of Chinese students and visiting scholars in the U.S. immediately following the 1989 Tiananmen protest demonstrations (Pan, 1990). Most of these students and scholars came from prestigious universities in China.

Another group of immigrants to the U.S. were refugees of Chinese decent from Vietnam, Laos, and Cambodia. A significant number of them were survivors of hunger, rape, incarceration, forced migration and torture. There are also "overseas Chinese" who emigrate from countries like Japan, Korea, Philippines, Singapore, Malaysia, Thailand, Mexico, Canada and many other countries in South America and Europe. (Lee, 1996).

In summary, as Lee (1996, p.252) points out, "the influx of immigrants and refugees from many different parts of Asia and from many different socioeconomic and political backgrounds has contributed to the complexity of existing Chinese American communities."

PART IV. CONCEPT OF DISABILITY

The traditional Chinese term for disability is "canfei", meaning "handicap" and "useless", or "canji," meaning "handicap" and "illness". This demonstrates how the Chinese used to view disability. The term "canji ren," meaning "handicapped" and "sick people," is also common. The term "gong neng zhang ai zhe," meaning "individuals with disabilities" is rarely used.

In many areas of China disability is viewed as a punishment for the disabled person's parental or past-life sins. When encountering health problems, many religious people, especially those from rural areas where medical resources are not readily available or sufficient will visit temples or Taoist priest houses to pray, worship or perform rituals in order to find out the cause of and/or the solutions to their diseases or disabilities.

Mental health is believed to be achieved through self-discipline, exercise of power and the avoidance of morbid thoughts. Emotional problems are understood to be associated with weak character. (Lee, 1996). In some cases, mental illness is blamed on evil spirits or punishment from god(s). Another belief is that unbalanced diet, eating food that should be avoided, or emotional disturbance during pregnancy will cause illness or disability of the newborn. For instance, grief or having temper tantrums during pregnancy is perceived to possibly cause the mother to lose her baby or to produce a baby with disabilities. Lam (1992 discussed an example of a mother who blamed her child's epilepsy on the lamb she ate during pregnancy. Epilepsy, "Yang Dian Feng," translates as "shaking of the lamb" in Chinese. The mother believed that the lamb she ate passed the "shaking of the lamb" to her child. In general, disability is viewed as something shameful - and a skeleton in the closet. One of the author's cousins was diagnosed with schizophrenia in his early twenties. No one in the family wanted to talk about it, certainly not to people outside of the family. So it simply remained a well-kept family secret for many years.

Lam (1992) described shame and guilt as a complicated mix in the family of the disabled. Shame towards the outside world is would be felt by the family (especially the head of the family) as well as by the disabled persons themselves. The stigma attached to disability may generate the family's fear of exposure to criticism and disgrace. Guilt might be felt by the individual with a disability towards his or her family or by the family towards the individual with disability, as well as towards ancestors. These feelings often create conflicts and barriers to for acceptance among family members (Lam, 1992). Although shame and guilt are often associated with disabilities in Chinese culture, as in American culture, Chung (1996) pointed out that the Eastern system focuses on the cause of illness, that is, why it happened, whereas in the West, the focus is usually on the solution to treatment for the disease. It is essential, therefore, to educate the Chinese consumer and family about the nature and/or cause of the disability as well as about treatment methods and available services.

Misunderstanding of or lack of knowledge about a specific disability or illness can cause a tremendous amount of fear, hostility, alienation and blame. This author was stunned by an article in the most popular Chinese newspaper World Journal. It tells a sad story of a nine-year old Chinese boy, Ning Li, who acquired AIDS from a blood transfusion, received for a broken arm in 1996.

Immediately after his diagnosis, Ning Li was terminated from his school and to date no school will accept him due to the nature of his illness. He has since lost all his friends, as have his parents. A neighbor even moved after learning the boy had AIDS. The neighbor's house is still empty because nobody will purchase it. Ning's father took him to see a doctor who told Ning, "don't touch my desk" when he learned the boy had AIDs. (Wu, 2000). This happened in a small town in 21st century mainland China.

Wang, Chan, Thomas, Lin & Larson (1997) summarized Chan and colleagues' 1984 and 1988 study findings that Chinese participants were more positive toward people with physical disabilities than toward people with developmental disabilities and mental disorders but that Chinese students were less positive in their attitudes toward people with physical or mental disabilities than their American counterparts. Chinese people are generally more accepting and sympathetic toward an acquired injury that causes physical limitations than toward a congenital physical or mental disorder. The same section of the previously mentioned World Journal for instance, there was an article about a 29-year-old lady, Lan Mao, who has been loved by numerous health care professionals and strangers despite her severe disabilities. Unlike Ning Li, Lan was born in Beijing, the capital city of mainland China, where she lives today. Lan was almost burned to death in a fire 27 years ago. She is reported to be the only survivor of such severe burns in Chinese medical history.

Lan's face remains severely maimed even after numerous reconstructive surgeries. She lost her hands, her hair, many facial features and will never be able to stand. Lan's parents left and never returned after seeing her on the hospital bed after the fire. So she has remained in the hospital for 27 years, cared for by team after team of physicians, nursing personnel and volunteers. The hospital received many donations that paid for all the expenses of her stay including her medical bills. In order to facilitate Lan's independent living in the community, her hospital assisted her in selecting a "new home." Recently, she transferred to an excellent independent living and vocational training residential facility (Dong, 2000).

PART V. DISABILITY AND REHABILITATION SYSTEMS

Due to the political, economic and social differences between mainland China, Hong Kong and Taiwan, provisions of rehabilitation and social services to people with disabilities vary considerably. For instance, mainland China, a communist country that went through ten years of cultural revolution and many other socialist movements, has adopted many aspects of the Western medical/rehabilitation system and it has aggressively developed its own system

over the past two decades. Hong Kong, a British Colony for 99 years and a Special Administrative Region of China today, has a very advanced rehabilitation system. Lam (1992) noted that one of its major rehabilitation services, vocational rehabilitation, is quite similar to that of the United States. Taiwan, a strategic partner of the U.S. during the cold war era, also is strongly influenced by the U.S. health care and rehabilitation systems.

Mainland China

China Disabled Persons Federation (CDPF, 2000), based on its 1987 national survey, claims that persons with disabilities comprise 5 percent of the Chinese population (63 million). For various social, and economic reasons, historically there has not been much emphasis on disability issues. The China Fund for the Disabled was not established until 1984. The China Disabled Persons Federation was established in 1988. Prior to that, little attention or assistance was given to those with disabilities (Ong, 1993).

Yamashiro & Matsuoka (1997) found that Asian Americans significantly underuse formal mental health services, a fact they attribute to a mismatch of cultural perspectives and language barriers. In the view of this author one of the major reasons that mainland Chinese immigrants underuse existing mental health services is that in China people with mental illness are commonly cared for by their families and/or depend on community support rather than institutional care.

Chen (1995) found that in mainland China, state-run inpatient services for the mentally ill have about 140,000 psychiatric beds available in 800 psychiatric institutions, or 1.17 beds for every 10,000 Chinese. This means more than 95 percent of the mentally ill are unable to be admitted to the hospital, which is why so most are taken care of by their families. Since China's implementation of the one child per couple policy, however, greater attention has been given to the mental health of the single child. The first Child Mental Health Research Center was established in Nanjing in 1984 (Bond, 1986). It is suggested increasing emphasis on hospital-based and community-based rehabilitation for the mentally ill in recent years. Programs involving psychological counseling, psychotherapy and behavior modification have been set up in many general hospitals, universities and schools (Chen, 1995). Such concepts, then are not new to recently immigrated Chinese consumers and families.

Another area of development is the field of special education. China's Education Law of 1986 made it obligatory to provide special education for individuals with mental retardation (Chen, 1995). The Chinese definition of mental retardation is similar to that of the American. It recognizes four degrees: first degree (IQ under 20 or 25), second degree (IQ between 20-35 or 25-40), third

degree (IQ between 35-50 or 40-55) and the fourth degree (IQ 50-70 or 55-75) (Shanghai Books Publisher, 1994). The China Disabled Person's Federation consequently set up the Rehabilitation Research Association for people with mental retardation and a number of other societies have been formed under the auspices of the Chinese Medical Association. These societies provide professional consultation to concerned ministries and play a significant role in the evolution of rehabilitation policy. All this has helped create favorable conditions for the continued development of mental rehabilitation in China. (Chen, 1995). In general, however only children with physical disabilities can receive mainstream education. Children with mental disabilities, hearing/language impairment and visual impairment receive special education in special schools, such as schools for the mentally retarded, schools for the mute and deaf, and schools for the blind.

Mainland China is at a stage at which it is pushing for the establishment of segregated special education schools, while Americans have embraced the mainstreaming and are working for inclusion. Therefore, recently immigrated Chinese parents of children with disabilities may be very skeptical about the inclusion concept. The parents may fear that their children cannot receive an appropriate education or get the attention they need in "regular" classroom/school settings. They may also fear that their children will be stigmatized and laughed at by "normal" American children. Due to language barriers, however, they may not be able to convey their concerns. Also, due to their accepting and non-confrontational nature, they may seem to be contented with an arrangement even if they are not.

This author worked as a case manager for a 25 year-old young woman, Sun, a Chinese American who was legally blind, non-verbal and diagnosed with moderate mental retardation. Sun was able to understand Cantonese, which was the only language that her parents spoke, and a few words in English. She responded to questions by nodding, shaking her head or making certain sounds. When the author started working with her she had been attending a traditional day treatment program for people with mental retardation for a few years. She seemed to be comfortable there, but on the occasion of a home visit to see her and her parents in their Chinatown apartment, it became apparent that Sun's parents really preferred that she attend a special school for the blind. They said that even though they had this wish for a long time, they were not able to make their needs known because of language barriers.

Sun's past case masnagers spoke only English. They would periodically check as to whether Sun's parents were satisfied with the day treatment program and the parents would always say "yes," unable to express their wish for a more appropriate setting for their daughter. This author worked with Sun's parents and located an excellent program for adults and children with visual impairment. Sun was transferred to this program and appeared to be happier as she was more

comfortable with the environment and was able to engage in activities designed for the blind. Sun has been attending the special program ever since.

Like the development of special education, the development of rehabilitation also started in China in the 80's. China Rehabilitation Research Center (CRRC), a state owned institution, was established in 1988. CRRC, affiliated with the China Disabled Persons Federation, provides comprehensive rehabilitation and social services to people with disabilities, carries out scientific research, offers professional training, conducts information exchange and serves as a technical resource to the Chinese rehabilitation network. Combining educational, social and vocational rehabilitation, CRRC established a comprehensive medical rehabilitation system that integrates western medicine and traditional Chinese medicine, emergency care, early recovery and long term care.

Subsequent to the establishment of CRRC, many rehabilitation centers were established in the country's large urban cities (CRRC, 2000). They are divided primarily into hospital- or community-based rehabilitation centers. Shanghai Cishu Chu Ban She (1994, p.108) defined rehabilitation as

> "comprehensively and appropriately utilizing medical, social, educational, vocational and other measures to train and re-train individuals with disabili ties in order to reduce the consequences caused by the factors of disabilities, to improve their functions and abilities, therefore, for them to integrate into the society with equal rights, value and dignity as human beings."

Even though this rehabilitation concept was adopted from western countries, the Chinese system includes traditional Chinese treatment methods. For instance, in mainland China, massage, Tai Chi, Chi Gong, magnetic treatment and acupuncture are part of physical therapy.

Mainland China has many programs, procedures, laws and policies that are mandated and enforced by the government. For example, in vocational rehabilitation, four steps are followed: 1) Vocational assessment, which assesses the consumer's vocational uniqueness and employment preference. 2) Vocational guidance which provides assistance in vocational selection and employment adjustment. It includes job placement, employment and settlement. 3) Vocational training which provides training to consumers according to their needs, background and ability. For instance, language training is provided to individuals with language impairment. Mobility/travel training is provided to individuals with visual impairment. Training programs are it is divided into pre-employment training, employment adjustment training and work placement. 4) Job placement helps individuals with disabilities find suitable employment.

While vocational assessment, vocational guidance and vocational training systems in China are similar to those in the American system, job placement works very differently.

The revised Chinese Constitution of 1982 and the Law on the Protection of the Disabled Persons (1992) emphasizes that families, work units and community organizations must share the responsibility for caring for the disabled. Under the work program for disabled persons, the government provides income tax relief to any enterprise in which 35 percent of the employees are disabled (Chen, 1995).

Shanghai, one of the largest and most developed cities in China, has issued in procedures that command state organs, public organizations, enterprises and institutions within the administrative area of the Shanghai municipality to allocate 1.6 percent of the average number on their payroll lists for the previous year as jobs for persons with disability.

The unit that does not fulfil the specified quota for the job placement of the handicapped must submit 1.6 percent of its gross salary account for the previous year to an employment guarantee fund for the handicapped.

It is important for American vocational counselors to keep different work incentives in mind when working with immigrants from mainland China. They are likely to experience from their Chinese consumers different expectations of and different requirements for job placement.

In addition to the development of laws, organizations and rehabilitation services for persons with disabilities, China has made a great effort to promote sports among people with disabilities. Almost two decades after the founding of the International Special Olympics Committee in 1968, the Chinese founded a sports association for the mentally retarded. Since then more then 500,000 individuals with mental retardation have participated in mainland China's Special Olympics (Wong, 2000)

Population of People with Disabilities

The first census of individuals with disabilities in mainland China was taken in 1987. There were 19 categories in the census, which sampled 369,448 households, a total of 1,579,316 individuals. The sampling indicated that 5 percent of the population or 63 million people had visual, hearing, physical, mental impairments and/or mental illness (see Table 1).

Wong (2000) reported that there are 11.82 million people with mental retardation alone in mainland China today

Table 1 1987 Census
(Sample was 1.5/1000 of the entire population.)

Categories	Number out of the Total Population Surveyed	Percentage of the Total Population Surveyed
Males with disabilities	176,888	11.20%
Households with members with disabilities	66,902	18.11%
Hearing & linguistically impaired	26,518	1.68%
Physically disabled	11,305	0.72%
Visually impaired	11,300	0.72%
Mentally retarded	15,235	0.97%
Mentally Ill	2,907	0.18%

Note: Table contents were translated and summarized from Shanghai Books Publisher (1994, pp.89-90).

Table 2
Published law and established organizations, foundations, and committees; Peoples Republic of China (PRC)

Name	Start Date	Nature
China Fund for the Disabled	3/15/1984	A national foundation that manages benefits of people with disabilities
Chinese Disabled Persons' Federation	8/11/1988	Represents the common needs of Chinese with disabilities; advocates for the human rights of people with disabilities; educates, serves, and collaborates with the government in the development and management of the disability field.
China Rehabilitation Research Center	10/28/1988	A state-owned institution that provides rehabilitation and social services to people with disabilities, carries out scientific research, offers training, conducts information exchange and serves as a technical resource.
The People's Republic of China Protection of the Disabled Persons' Law	12/28/1990	The first law in P.R.C. to protect and safeguard the rights of people with disabilities.
National Help the Disabled Day	5/19/1991	The first official "National Help the Disabled Day" was written into The People's Republic of China Disabled Protection Law to launch comprehensive activities that help people with disabilities.
The State Council's Disability Coordination Committee	4/19/1993	To enhance the leadership of the disability undertaking and further develop unique Chinese characteristics within the disability rehabilitation movement.

Note: Table contents were translated & summarized from Shanghai Books Publisher (1994, pp.90-100).

Hong Kong

Lam (1992) commended Hong Kong's long history of rehabilitation services, whose most significant developments have occurred since World War II. Chronologically, the 1940s were marked by the development of physiotherapy, occupational therapy and prosthetics. The 1950s saw the development of sheltered workshops, training centers, residential homes and recreational and social clubs for people with physical disabilities, blindness and mental retardation. In the 1960s, special education developed as a separate service within the education system. The first two medical rehabilitation centers in Hong Kong opened in 1962 and 1963. (Lam, 1992).

The former Hong Kong government and voluntary agencies worked closely on an integrated and coordinated approach to rehabilitation. They completed of a ten-year rehabilitation program plan in 1976 and in 1977 published a white paper titled "Integrating the Disabled into the Community: A United Effort." Subsequently a Rehabilitation Development Coordinating Committee (RDCC) was appointed by the governor to advise the overall development of rehabilitation services and policies. Under RDCC, three subcommittees focus on employment, education and personnel; accessibility and transportation, and public education (Lam, 1992).

The rehabilitation program plan developed by the RDCC presents a comprehensive picture of current rehabilitation services in Hong Kong and projects development needs a decade in advance. The program plan is reviewed annually by a joint committee of government departments and non-government organizations. Through this planning process, priorities and needs are identified and of resources are allocated (Lam, 1992).

With the exception of medical rehabilitation, about 70 percent of direct services for people with disabilities in Hong Kong are provided by voluntary organizations. The Joint Council for the Physically and Mentally Disabled, a division of the Hong Kong Council for Social Services, coordinates voluntary rehabilitation organizations and represents their interests in policy making with the Hong Kong government (Lam, 1992).

Vocational rehabilitation, which includes vocational guidance and assessment, vocational training and placement, is one of the major rehabilitation services available to Hong Kong residents with disabilities (Lam, 1992). Ting & Fitzgerald (1996) found some increases in awareness and knowledge of occupational health and rehabilitation matters by legislative councilors, District Board members, labor union members, and employees. They also pointed out that attitude changes towards occupational rehabilitation services had created opportunities to expand services in this area.

By and large, Hong Kong, which was under British rule for about 100 years, has medical and rehabilitation systems more similar to those in the U.S. than to those in mainland China. Since English is the official language in Hong Kong, it may be easier for Hong Kong immigrants to understand and maneuver through the American rehabilitation system than for newcomers from mainland China and/or Taiwan.

Population of People with Disabilities

A computerized central registry for rehabilitation was set up by the Hong Kong government in 1983 to systematically collect data on persons with disabilities in need of rehabilitation services. Through September 1989, there were 111,298 persons with disabilities registered with the central registry, or 1.9 percent of the total population of 5.8 million. Prevalence rates derived from the United States and other western countries, coupled with the reluctance of the Chinese to report such cases, suggests that the total population of people with disabilities is closer to 437,569 or 7.5 percent of the total population of Hong Kong (Lam, 1992).

Taiwan

Copper (1999) maintains that social welfare has had a deep impact on Taiwan's society and culture. Social welfare programs used to aim at groups considered vital to maintaining political stability. Therefore, the military, labor, and government employees were the biggest beneficiaries. They now address anyone who needs assistance. Copper points out that in the early 1980s the government passed three pieces of legislation to aid the disadvantaged population: the Aged Welfare Law the Handicapped Welfare Law, and the Social Assistance Law. Child care, child protection services, campaigns against drug abuse, services for the disabled and low-cost housing are just some of the services made available by these laws (Copper, 1999).

National Health Insurance (NHI) was inaugurated by the Taiwan government in 1995 to provide health care for the entire nation, lighten the public's financial burden, provide adequate health care and uphold the rights of the public to equal-access medical care (National Health Insurance Profile, 1999). The NHI program includes outpatient and inpatient services, Chinese medicine, dental care, childbirth, physical therapy, preventive health care, home care, rehabilitation for chronic mental illness, etc.

The scope of care includes diagnosis, examinations, tests, consulting, surgery, drugs, supplies/devices, treatment, nursing care, etc. It is noteworthy that NHI offers services to the disadvantaged and patients who need medical care most. More than 350,000 people hold major illness/injury certificates that exempt them

from co-payments. In addition, the Bureau of National Health Insurance (BNHI) offers attractive commissions to medical teams willing to serve in remote regions with scarce health resources (National Health Insurance Profile, 1999). Individuals with disabilities also can apply for a "handicapped ID" that entitles them to available social welfare and health services.

In order to discourage discriminatory practices imposed on people with disabilities, a law passed in 1990 calls for state-run enterprises to hire at least one individual with a disability for every fifty employees and for private companies to hire one for every one hundred employees. Organizations that fail to comply face a fine equal to the minimum monthly wage of $487 American dollars. The penalties collected by the respective local government are used to implement welfare programs such as vocational training and employment assistance and to reward companies that employ more people with disabilities than required by the legal quota. Since the law on mandatory employment began to be enforced, some 20,000 job opportunities annually have been extended to people with disabilities (Her, 1999).

Amendments to Taiwan's laws include the abolition of restrictions imposed upon people with disabilities who take the Joint University Entrance Exam. It was not until 1988 that the government finally abolished these restrictions and opened the door for people with disabilities to pursue advanced education. There also is a new requirement for the construction of accessible facilities for people with disabilities (Her, 1999).

Her (1999) estimates that the number of Taiwan's children with mental retardation is 158,000. Jacob Chen, chief executive officer of the Eden Social Welfare Foundation, points out that if children with mental retardation can receive early treatment before the age of three, the benefits to them will be ten times greater than with later treatment. Her said the period from birth to age six is critical and determines the extent of physical disability in of these children (Her, 1999). Her also reported that Chen expressed his sadness at the current conditions for Taiwan's children with mental retardation, since fewer than three percent are lucky enough to receive early treatment.

Eden, founded in 1982, was the first organization to provide the disabled in Taiwan with vocational training. Eden obtains funds from private fundraising activities, government subsidies or government commissioned projects and Eden's own business operations. Eden offers vocational training to people with disabilities in the moderate to severe range. Those who participate in these vocational training program not only receive intensive professional training free of charge, but can also apply for a monthly living subsidy of about US$400.

Her (1999, p. 36) noted that "the traditional view in Taiwan is that disabled people are the way they are because they did something bad in their previous lives, and that they therefore deserve their afflictions." Eden makes an effort to change public perception of people with disabilities through publications (including books, short promotional films, videotapes, TV and radio programs) and outreach activities. In addition to vocational training, Eden offers professional training, employment assistance, psychological counseling, legal representation, religious services, physical examinations and many other services to people with disabilities (Her, 1999).

Part VI. Communication Between Consumers and Service Providers

Sung (1985) found that the language barrier was the problem most commonly cited by the immigrant Chinese. Language is the conduit through which we interact with other people. It is the means by which we think, learn, and express ourselves. Although many immigrants have learned some English either formally or through their exposure to it via the media, most are fluent only in their native tongues (Hernandez & Isaacs, 1998). To complicate the situation, there are many different dialects in the Chinese language.

When the author began working as a case manager many years ago, she was asked to interpret for a Chinese family. Knowing Mandarin and a couple of other Chinese dialects, she went into the meeting with confidence. As soon as the conversation started, however she realized that she did not understand a word the Chinese family was saying. She even asked whether they were actually Chinese. Later she learned that the family only spoke Hakka, a Taiwanese dialect. This experience taught her a good lesson. Any health care professional seeking Chinese interpreter(s) should first , find out what dialect(s) the consumer and/or family speak. Many Chinese immigrants are multilingual-fluent in the official language, a local dialect and English as well.

Hernandez & Isaacs (1988) pointed out that members of an immigrant family settling into a new community will learn English at different rates, so there might be many levels of English fluency within a family. Hernandez & Isaacs (1998, p.255) commented that "it is often tempting to resort to the use of English in these situations, but doing so may undermine service providers' rapport with parents and may be interpreted by the parents as dismissal of their culture of origin."

It is always helpful for providers to take the time to learn as much as possible about the family's unique cultural and linguistic backgrounds. Though taking

the time up front maybe difficult for the provider(s) and may even cause conflict with some agencies' policies, the knowledge and understanding that follows will help the provider build a trusting and helping relationship with the individual or family and make more effective services provision possible.

Besides language barriers, Chinese and Americans differ in their styles of communication. Chinese in general communicate less directly and less explicitly and their communication often relies on body movements, facial expressions, eye messages and other non-verbal signals (Engholm, 1994). Interpreting nonverbal expressions can be quite difficult, however. Chinese may have completely different meanings for nonverbal expressions than Americans. For instance, to most Americans, smiling generally means agreement, a positive reaction and liking. The Chinese may smile when they feel embarrassed or shy, however. Engholm (1994) noted that direct eye contact may be taken as an intimidation tactic by the Chinese, while the American makes eye contact to indicate he is giving the Chinese his full attention. Americans are taught to look at others when speaking to them. Americans view eye contact as an indication of mutual understanding and trust. For the Chinese, looking a superior or an elderly person directly in the eye indicates disobedience and threat.

Sue & Sue (1999) discussed the concept of high-low context communication proposed by Hall (1976). A high-context (HC) communication emphasizes the physical or social context of the situation and relies heavily on nonverbal cues and identification or understanding shared by the communicators.

"In traditional Asian society, many interactions are understandable only in light of high-context cues and situations" (Sue & Sue, 1999, p. 82). For example, if you have dinner at a traditional Chinese home, the host will on numerous occasions offer you drinks and food to show hospitality and sincerity. The host will not accept no for an answer and will continue to offer the fine food/drinks until the end of the dinner. It is expected that the guest will turn down the offers to show his politeness.

Another example relates to the Chinese way of greeting. The author's friend, a third-generation Italian American, used to complain to her about a Chinese neighbor "Mei," who would always ask her "did you eat?" and "where are you going" every time she saw her. The friend would say to the author "why is Mei so nosey? Why does she have to know everywhere I go? Why does she ask me ten times a day whether I ate or not? I am Italian, alright, but that doesn't mean I eat ten times a day."

For many Chinese, asking "did you eat?" or "where are you heading?" is a way of greeting or starting a conversation, as when Americans say "how are you today?"

The United States is a low-context (LC) culture. LC cultures place emphasis on the verbal part of the communication (Hall, 1976, Sue & Sue, 1999). LC cultures are associated with opportunism, being more individual-than group-oriented and greater focused on rules of law and procedures (Smith, 1981, Sue & Sue, 1999). Sue & Sue (1999) believe that Asian Americans, African Americans, Hispanics, American Indians and some other minority groups in the United States emphasize High-Context (HC) cues. A misunderstanding of HC and LC orientations can lead to conflicts of interest since communicators from these two types of culture often do not understand each other.

When dealing with criticism, LC white Americans are more likely to be direct, upfront and get right to the point. Conversely, their Chinese counterparts (with HC orientation) may view such behavior as rude and blunt. Since the Chinese tend to go to extremes so as not to offend or embarrass others, they may seem ambiguous or "wishy-washy".

Chinese people are often shy, especially in an unfamiliar environment (Chin, 1996). Gentle and friendly tones of greetings are helpful. It is more appropriate to address older consumers and/or family members by "Mr. or Mrs." as it can be viewed as disrespectful to address older people by their first names. Be aware that married women from mainland China generally carry their maiden names. If a consumer's parents or other older relatives are participating in a conversation or meeting with a rehabilitation counselor, it is extremely important to give the older family members equal attention while discussing the care of the younger family member.

Sue & Sue (1999) compared communication style differences among Asian Americans, both white and black in Table 3. The description of the Asian-American way of communication can apply to that of the Chinese. It is important for us to consider the above-mentioned general Chinese communication styles since they may affect our perception and ability to work with Chinese consumers, but it is equally important to remember that these style differences are generalization(s) of traditional cultural/communication behaviors and will not apply to every individual of a specific background.

Table 3 Communication Style Differences
(Overt Activity Dimension-Nonverbal/Verbal)

Asian Americans	Whites	Blacks
1. Speak softly	1. Speak loud/fast to control listener	1. Speak with affect
2. Avoidance of eye contact when listening or speaking to older or high-status persons	2. Greater eye contact when listening or speaking	2. Direct eye contact (prolonged) when speaking, but less when listening
3. Interject less/seldom offer verbal or non-verbal cues to encourage communication	3. Head nods, nonverbal markers	3. Interrupt (turn-taking) when possible
4. Mild delay in response time	4. Quick response	4. Quicker response
5. Low-key, indirect communication	5. Objective, task oriented communication	5. Affective, emotional, interpersonal communications

Note: Edited from "Counseling the Culturally Different: Theory and Practice" (3rd ed., p.89) by D.W. Sue & D. Due, 1999.

PART VII. ROLE OF FAMILY

The roles of members of a Chinese family are highly interdependent (Ong, 1993). Traditionally the family has been the most fundamental and important unit of society among the Chinese and this is still true. The family is also an important economic unit. In today's China, it is still very common for three generations to live under one roof. Lam (1992) notes that Confucian philosophy advocates the virtue of sacrificing individual needs for the good of the group.

Parents are the highest authority in the family. To maintain family harmony, child rearing focuses on obedience, proper conduct, control of emotion and personal desire, moral training, impulse control, achievement and the acceptance of social obligations. Chinese are brought up to remain an integral part of their families throughout their lives, instead of being trained to function independently (Bond, 1986).

The Chinese are willing to sacrifice for family members. They tend to seek help from immediate and extended family first, before turning to neighbors, communities and professionals. Seeking help, such as social welfare and benefits from the government, can be very intimidating. Since respect for the elders and filial piety are so important, it would be wise for rehabilitation professionals to establish a working relationship with parents or significant extended family members. Their involvement will be vital to the success of the rehabilitation process (Ong, 1993).

There are contemporary Chinese-American families who are "Americanized" but still hold some traditional values. While it is important for American professionals to have knowledge of the Chinese traditional values and family structure, it is also important for us to recognize that economic and political changes in mainland China, Taiwan, and Hong Kong have had a dramatic impact on Chinese family system and values. As a result of the Communist takeover of mainland China in 1949, Confucian thought and religion were banned. A one-child per family policy has replaced the traditional extended family system (Lee, 1996) and the ten-year Cultural Revolution caused many families to suffer forced separation. Filial piety and respect for the elderly were seriously questioned by Red Guard youths. In recent years, the open-door policy and the economic boom in China have brought another wave of Western influence and urbanization (Lee, 1996) which have placed additional stress on traditional families.

Outside the mainland, Hong Kong and Taiwan underwent rapid growth in light industries and exports after World War II. The forces of industrialization westernization, urbanization, and economic affluence brought a change in their social and family structures. While older- and middle-generation Chinese still

maintain some traditional beliefs and practices, the younger generation has tended to reject conservatism and traditionalism (Lee, 1996).

Lee (1996) emphasizes that as a result of the social, political and economic changes described above, there is no one "typical" Chinese family. Although most families share many of the same beliefs and traditions but also have their differences and variations in values.

Case Study 1

Zhang (1994) used the following case study to argue that American counseling is deeply rooted in individualism often at the expenses of family and community. He questioned the suitability of American counseling strategies for other cultures.

> Carol, 29 years of age, blames herself for her family's tension and dissension. Her father is out of work and depressed most of the time. Her mother feels overburdened and ineffective. In the past, Carol has assumed responsibility for her family's problems and has done a great deal for her parents. However, she is convinced that if she were more hardworking and competent, most of her family problems would diminish greatly. The fact that she is increasingly unable to effectively change bothers her. Therefore, she is asking for counseling help.
>
> Zhang's (1994) American classmates all maintained that Carol was too submissive and should not continue to put family interests above her own. They encouraged Carol to think of her own needs first, leave her family, live alone and make sure not to let her parents override her wishes. They also suggested assertiveness training for Carol.
>
> Zhang (1994), a counselor from China, could not understand why putting the family's interests before one's own is considered not correct or "normal" in the American culture. According to the Chinese culture, a morally responsible son or daughter bears the duty of taking care of parents, even if it means sacrifice. To Zhang, it would be extremely selfish for Carol to leave when her family is in such need of her. In China, that kind of assertiveness is considered aggressive and immoral. Zhang thought the parents were the ones who needed change, not the daughter. He thought the parents needed to be more sensitive to their daughter's needs and more aware of the difficulties they had caused her. Zhang suggested inviting Carol's parents to come in for a family session. If the client feared that her parents would not tolerate having an "outsider" involved in this family matter, Zhang suggested inviting the client's relatives or friends to come in and discuss intervention strategies they could use to help the parents come to terms of the difficulties they have caused their daughter. Zhang reasoned that in Chinese culture, it is all right for an individual to stand up for one's own rights, however, one needs to do it in an indirect, subtle way, especially when dealing with one's elders, lest it cause others to "lose face."

Case Study 2

Jim is a 24 year-old, single male of Chinese descent. Jim was born in mainland China and immigrated to the United States with his parents in 1997. Jim's primary language is Cantonese. He also speaks Mandarin and is able to communicate about basic needs in English. Jim's only sister was not granted immigration status and therefore, still resides in Guang Dong (Canton), China. When he first came to the U.S., Jim had several jobs, such as waiting tables in Chinese restaurants and delivering newspapers for a Chinese newspaper company in New York City.

In July, 1998, one year after he came to the U.S., Jim's truck was struck by another truck and he sustained traumatic brain injury (TBI) as well as physical disabilities. He remained in coma for over six weeks. After emerging from coma, Jim was transferred from the hospital to a local medical center for inpatient rehabilitation. After two months of intensive rehabilitation, Jim was transferred to a skilled nursing facility with a TBI unit for extended care and further rehabilitation. Jim is geared to moving back to the community and back to work so he can help support his mother financially.

Jim's father was so disturbed by the accident that he returned to mainland China for psychiatric treatment. Jim's mother has to work seven days a week (five days a week in a Chinese restaurant and two days as a home attendant for a Chinese home care agency) to earn a living. Jim is determined to go back to work and has stated that if returning home with his mother means adding to her burden, he would rather remain in the nursing home for the rest of his life. He is also eager to help his sister immigrate to the U.S. and was referred to a local Chinese agency that handles immigration matters. His social worker made a referral to the Department of Health Traumatic Brain Injury Home and Community-Based Medicaid Waiver program. With the social worker's help, Jim chose a waiver service coordinator, who put a service plan together for community re-entry and worked with the TBI program's housing locator to find an apartment for him.

The plan was for Jim to move with his mother into a two-bedroom apartment. Jim told the service coordinator that he wanted to live in a

specific neighborhood in Brooklyn, New York, which is a predominantly African-American neighborhood. He selected that neighborhood was because his uncle and aunt resided there.

The housing locator was able to locate a spacious 2-bedroom apartment in the exact area Jim requested. When Jim's mother learned about this, however, she was very upset. She had never wanted to live there and she felt that as the head of the household, she had been left out of the picture.

She stressed that she wanted to live only in a Chinese neighborhood where she would be able to communicate since she does not speak a word of English. With that in mind, the service coordinator and housing locator started working with both Jim and his mother utilizing Chinese interpreters. The housing locator also started working with Chinese brokers and landlords in Chinese communities. Jim and his mother's questions were answered in Chinese and in a written format to allow them to comprehend, digest and refer to this information when convenient.

This case illustrates several lessons that should be kept in mind when providing services to consumers born in China:

1) Find persons who speak the consumer's and family members' native language to work with them. If it is impossible to find providers who speak their native language, work through translators/interpreters.

2) Understand the consumer's family structure and work around it. It is as important to work with the family, especially the caretaker and main advocate, as with the consumer himself/herself. Conduct meetings that involve the family, especially the older generation.

3) Explore services within the family's ethnic community. The city and county departments of health and Mayor's office of large cities usually have a department of minority or emerging majority affairs where you maybe able to obtain resource information about a specific ethnic group.

4) Refer the consumer and family to community organizations where staff speak their language and are able to address such special issues as immi gration with which you may not be familiar.

5) Provide the consumer and family with as many written materials in their native language as you can find or have a translator translate basic information about program offerings into their native tongue.

PART VIII. ROLE OF COMMUNITY

Confucian philosophy advocates that individuals put group needs above personal needs. Chinese have a strong sense of community. In mainland China, every large building complex or neighborhood has committees or associations formed by voluntary or selected residents - mostly retired residents or housewives - that address residents' family, environmental, recreational and other needs and issues.

In the example of the mental health system, Kaplan, Sobin, & Andors (1979) found that one of the major justifications for keeping China's formal mental health care system so small is that there are so many informal avenues to help people with the kinds of problems that might, under other circumstances, lead them to seek help from a mental health establishment. Among the social services provided by these informal committees and association is mediation of many family quarrels. Street clinics, the most immediate level of health care in urban neighborhoods, also serve as places where people with personal problems can go for discussion or help. Medical workers in these clinics receive much the same basic training as barefoot doctors of the Cultural Revolution era. Although their training in mental health is minimal their sympathetic ear is often what's needed to help solve everyday personal problems. More serious problems are referred to the local clinic or hospital. The informal system of problem solving has minimized the need for formal treatment (Kaplan, Sobin, & Andors, 1979).

The sense of being part of something greater than oneself gives the Chinese a feeling of belonging and security. They know that they do not stand alone (Sung, 1985). Lee (1996) believes that the community association model provides the psychological services of an extended family to many Chinese immigrants. In order to survive and make a better living in a foreign land, Chinese immigrants form many unique communities where they all speak the same language, shop at Chinese supermarkets or stores and have an understanding of each other's religion, culture, and beliefs. Each of these communities has advocacy groups, churches/temples, and non-profit organizations that address immigration, legal, medical, educational, disability, vocational, and many other needs. Due to their unfamiliarity with and lack of understanding of western medicine and/or the medical, social and rehabilitation system, community members prefer to seek medical help first from a Chinese doctor in their community. Some feel nervous, even skeptical when referred to an American medical professional outside that community.

Case Study 3

Joe is a 55-year-old man who sustained a traumatic brain injury (TBI) from a gunshot wound when he was mugged on the way home from work in 1991. He is of Chinese descent and immigrated to the U.S. in his high school years. He lived with his parents and sister in an apartment he now shares with his sister, as both his parents are deceased, his mother, one year after he sustained his TBI. Joe worked in the food service industry prior to his injury and is extremely eager to resume work. He speaks Cantonese and Chao Shang dialect with his sister at home but also speaks English fairly well. Since his injury, his younger and only sister Sue has been his primary caretaker and advocate. She is very involved in Joe's care but often feels a lack of support from social workers and therapists. She commented that the social worker at the hospital told her to apply for benefits and services on her own, saying, "You speak English very well. You can do all this." Sue feels that she really doesn't understand the medical, rehabilitation or social systems and is at a loss when dealing with all the jargon. She is often depressed since she has been struggling to do her best, but feels she gets little cooperation and appreciation from Joe. Joe, on the other hand, is very frustrated about his dependence on his younger sister. As the older brother he thinks he should support the family and be the one to give orders. He cannot accept the fact that due to his memory loss, he has to depend on Sue to remind him to do things and give him advice. As a result, Joe often yells at Sue, "I don't need you telling me what to do!" He uses his sister as outlet for his anger since as he has nowhere else to release his temper. Joe and his sister fight all the time but are inseparable.

Joe's main focus is to get a job. Because he is so eager to be gainfully employed, he tends to put considerations of all his cognitive, medical and physical limitations aside. This hinders his vocational rehabilitation. His service providers and vocational counselors find it very difficult to work with him since they can neither set realistic goals with him nor motivate him to achieve one step at a time. They complain that Joe wants to find a paid job right away but does not want to go through any training. Joe feels, however, that no one ever clearly explained in language and terms he can understand, why the training is so essential.

Joe lost all his former friends after his injury but he has been visiting Chinatown on a daily basis and has formed some new "tea friends," friends with whom he drinks tea and chats. He does not trust or like most of his service providers. One of the few providers with whom he relates well is his primary care physician (PCP), a Chinese doctor in Chinatown. This doctor has limited knowledge about the identification,

treatment and resources for TBI, however, Joe's service coordinator thought that Joe would be better served by a doctor who specializes in working with individuals with TBI. So she changed his PCP to an American doctor who specializes in TBI. After seeing his new PCP once, Joe asked to be transferred back to his Chinese doctor since he felt much more comfortable with her.

Joe was confused about many referrals his new PCP had made on his behalf. Even though he was had been assured of the good intentions of his new doctor and the purpose of the exams, Joe strongly felt that he had been better informed by his Chinese doctor and could trust only her. A couple of weeks later, Joe was transferred back to his Chinese PCP which pleased him and his sister. At present, Joe would like to move out of his current apartment and live by himself within a Chinese community.

This case illustrates several good lessons:

1) Do not assume that immigrants who came to this country decades ago and speak English well know the American medical, social and rehabilitation concept or systems well. This may not be the case.

2) Be aware of family structure and conflicts. Find out what shapes the struc ture of the family and what causes the conflict.

3) Acknowledge culture as a predominant force in shaping behaviors. According to the Chinese tradition, the oldest son of the family is considered the head of the household particularly if the father is deceased. He is expected to take charge of everything. It is considered extremely shameful for an older brother to depend on his younger sister for a living and for advice.

4) Be sensitive and understanding of the consumers' needs and be respectful of their choices. As a professional, it is very tempting to refer the consumer to the best medical professionals and services you know. It is important, however, to find out from the consumer which medical professionals he/she wants. Your consumer may want remain with a doctor with whom he or she feels comfortable and who speaks the same language even if that doctor is not be the expert you prefer. Find a way to involve the doctor the consumer chooses instead of forcing the consumer to change.

5) Be aware of the consumer's community and try to find services within that community.

6) Acknowledge that cultural differences can have an impact on service deliv-

ery. In this case, being the oldest son and the only surviving man in the family, Joe's strong desire to work and be the family bread winner could hinder his vocational and rehabilitation process. Counseling could address his issue, his role in the family and his expectations related to vocational services.

Part IX. Role of Religion

China is a multi-religious country. The majority Han nationality, the largest ethnic group in mainland China, practices Buddhism, Christianity and Taoism (China Today, 2000) and all Chinese are greatly influenced by Confucianism as well. Chinese philosophies promote harmony. Taoism and Buddhism, the most popular religions in China, have some differences between them but no conflicts (Lam, 2000). Based on Dao De Jin, Taoism promotes the belief that a person will gain power and strength if he/she behaves in harmony with the nature of universe and will suffer later in life if he/she acts against the nature of the universe (Lam, 2000).

For instance, mental illness is viewed as being caused by deeds from past lives or acts against the nature of the universe. In traditional Chinese medicine, humankind is viewed as a microcosm within a universal macrocosm. The energy in each human being interrelates with the energy of the universe. If there is imbalance of the yin and yang, then the immune system of the body is disturbed and the body is susceptible to illness. (Lee, 1996).

In Lam's (2000) analysis, Confucianism is the philosophy that guides Chinese in governing behavior. It emphasizes the importance of family and social order (i.e., children must respect and be obligated to their parents and grandparents; junior follows the senior; servants serve the rulers, and so on).

Buddhism was introduced to China from India. Lam (2000) maintains that the reason for the wide acceptance of Buddhism in China is the concept of rebirth and its reinforcement of the principles of Taoism and Confucianism. Buddhism is a man-centered religion, not god-centered. It tells people that life is suffering. No one but yourself can save you from suffering. Craving is believed to be the cause of all sufferings. To overcome happiness, one must overcome craving, desire, or endless wanting, hatred and complaints.

Many Chinese are Buddhists and attend occasional services, practice rituals, and visit a temple on a regular basis. It has been estimated that more than 68 million Chinese still consider themselves Buddhists, though it is not likely that they all practice the religion regularly (Compton's Living Encyclopedia, 1995).

Islam was brought to China mainly from central Asia, and by 1995, there were believed to be more than four million Chinese Muslims (Compton's Living Encyclopedia, 1995). Islam insists that their god is the only god in the universe (Lam, 2000). This belief is somewhat contradictory to that of Buddhism, but the two religions co-exist peacefully in China.

Christianity arrived in China with Jesuit missionaries in the early 17th century. It is believed that as many as two million Christians practice their faith in China (Compton's Living Encyclopedia, 1995) and a great many Chinese converted to Christianity after immigrating to the United States. Chinese Americans formed churches/temples within their communities, where they worship in English or Chinese, depending n preference.

It is common for Chinese to honor their ancestors, especially during major holidays like the Chinese New Year. Incense burning and the eating of special foods usually occurs on special occasions. Good luck symbols may be displayed in homes

Part X. Gender

People's Republic of China

The role of women in China changed dramatically when Mao "equalized" the sexes immediately following the founding of People's Republic China in 1949. Many women were instrumental in the fight to liberate the country from the nationalists and from foreign domination and were prominent in the party and in the state administration throughout the country.

Chinese women hold positions as factory workers and managers in significant numbers, although it is still uncommon for a woman to be a general manager or board member of a state enterprise or a director of a Chinese institution or agency. A growing number of women, however, have become entrepreneurs. The self-perception of Chinese women may be the most noticeable psychological change in China since the open door policy that began at the end of the 80's (Engholm, 1994).

The majority of women who join their husbands in the U.S. are well educated and employed in respectable professions in China. These women are usually unable to resume their professions in the U.S. due to language and cultural barriers, and/or immigration status. Therefore, they may encounter more difficulties in acculturation than women who originally held the traditional roles of housewife and mother (Liu, 1997). Because of their educational and professional

backgrounds, however, such women are more susceptible to western medicine, medical and rehabilitation systems. If approached in a positive, informative and sensitive way, they will be very supportive and involved in the treatment and/or rehabilitation process.

There is also a limited number of well-educated women whose English proficiency is at a level that allows them to pursue advanced education or careers similar to those they had in China. These women tend to adapt to American society quickly and successfully. Hence they are more independent and better informed and are likely to be active advocates for a loved one in need.

Taiwan

Taiwanese women have been struggling for their independence and equality for about 20 years. Statistics indicate that their status has improved impressively. The increase in the percentage of college-educated women is greater than that of men (seven percent versus five percent). In the economic sphere, more and more women maintain jobs after they are married. The ratio of white-collar to blue-collar women is about one to one. The growth in the number of women civilian officials is also quite remarkable. Women tend to defer marriage and the divorce rate has increased (Rubinstein, 1994). This author has encountered many women from Taiwan who joined their husbands in the U.S. over the past few decades. Due to language barriers and lack of socialization they often lack knowledge of the U.S. social and medical system and tend to depend on their husbands or children to maneuver through the rehabilitation system. Those who came here independently to pursue higher education are much savvier.

PART XI. HOLIDAYS

Official Chinese Holidays (celebrated in the mainland China)

New Year's Day (January 1)
Employees enjoy a paid day ff and families visit each other. There are parties everywhere, - in parks, dancing halls and universities, where students will soon leave for their winter vacation.

International Women's Day (March 8)
Women employees get a whole or a half paid day-off to celebrate women's independence.

Tree-Planting Day (April 1)
This day has been highly promoted since the late 70s by the reformist government but has yet to be firmly established. It marks the beginning of the annual campaign for a "green nation."

International Labor Day (May 1)
Employees enjoy a paid day off. A large number of urban citizens visit parks as a family to celebrate.

Youth Day (May 4)
This is a day that marks the first mass student movement in 1919, a movement touched off by the then-Chinese government, which acquiesced to the Japanese government's attempt to colonize Shandong Province. It was also an anti-Confucian movement as well as one that promoted western scientific and democratic ideas.

Children's Day (June 1)
With the establishment of the "one couple, one child" policy, this day is emphasized more than ever before. This is a happy and memorable day for Chinese children. Kids of all ages dress in their best and enjoy all kinds of entertainment in places such as movie theatres, parks, children's museums and palaces, which are open to them for free.

The Chinese Communist Party's Birthday (July 1)
This marks the founding of the Chinese Communist Party in 1921 in Shanghai and is usually characterized by front-page editorials in major government newspapers.

Army Day (August 1)
A communist-led army staged the first armed uprising in Chinese communist history against the Nationalists on August 1, 1927. This event is regarded as the beginning of the Red Army (later the People's Liberation Army). Now the anniversary is often used to promote better relationships between the army and the civilians, relationships believed to have helped defeat the Nationalists in the 1949civil war.

Teacher's Day (September 1)
It was started in the early eighties as an effort to reverse the anti-intellectual sentiment nurtured by the "Cultural Revolution". Students usually give teachers cards with personal expressions to thank them for their hard work.

National Day (October 1)
This is the anniversary of the founding of the People's Republic of China in 1949. There used to be grand parades at famous squares in major cities, the largest and

most famous of which was the Tiananmen Square parade. Now celebrations usually take the form of parties in amusement parks by day and fire-works and grand television programs at night. Employees enjoy two paid days off.

Chinese Traditional Holidays

The calendar the Chinese traditional holidays follow is organized according to a unique lunar-solar system, different from the western calendar.

Spring Festival (The Chinese New Year) (1st day of the 1st month)
This is the biggest and most celebrated festival in China and sections of east and southeast Asia. The Chinese New Year is popularly known as the Spring Festival because it marks the beginning of spring. The new year season extends from the mid-twelfth month of the previous year to the middle of the first month of the New Year. Just December in America, this is the best business season of the year and people will pour out their money to buy presents, decorations, food and clothing. Many people will travel home for a family reunion from all parts of the country.

Days before the new year begins, every family is busy giving the house a thorough cleaning, to sweep away all the ill-fortune there may be in the family and make way for good luck in the new year.. They decorate the doors and windows with paper-cutouts and posters with the popular themes of "happiness," "wealth," "longevity" and "satisfactory marriage with more children."

The eve of the new year is very carefully observed. Supper is a feast, with all family members together. After dinner, the whole family sits up for the night while having fun playing cards or board games or watching t.v. programs dedicated to the occasion. At midnight, the whole sky will be lit up by fireworks and fire-crackers.

Very early the next morning, children greet their parents and receive "Hong Boa," cash wrapped up in red paper packages. Then the family sets out to offer greetings to their relatives and neighbors. During and several days following the new year's day, people visit each other and exchange gifts. Advice for medical, social and rehabilitation personnel: avoid scheduling any meetings and/or appointments during this holiday season, i.e., a couple of days before and a few days after the Spring Festival.

Lantern Festival (15th of the 1st month)
The Lantern Festival marks the end of the New Year season. The spirit underlying the diverse celebrations of the Chinese New Year is the same: a sincere wish of peace and happiness for the family members and friends. Lantern exhibits, lion and dragon dances, and eating Tang Yuan (ball-shaped boiled sweet sticky

rice dumplings with delicious fillings) mark this day.

Qing Ming (means "Pure & Bright" in Chinese) (5th of the 24 Solar Terms)
Originally this was a celebration of spring. People customarily went on an excursion to "ta Qing" (step on grass). Later it became the day dedicated to late loved ones. Tidying up ancestor's tombs is its major event.

Duan Wu (Dragon Boat) Festival (5th of the 5th month)
This festival is said to honor the memory of Qu Yuan, a great patriot poet of the State of Chu during the Warring States period (475-221 B.C.). Qu Yuan drowned himself to protest the actions of his emperor who had given in to the bully state of Chin. For fear that fish might consume his body, the people of Chu rowed their boats to the place of his death and threw rice dumplings wrapped in bamboo leaves into the river to feed the fish. Now the big event of dragon boat contest is a legacy of such activity. People still eat rice dumplings wrapped in bamboo-leaves on that day.

The Seventh Eve (7th of the 7th month)
This originates from a beautiful legend about a cow herder and a fairy who were cruelly separated but reunite once each year, making this a happy and sad occasion.

Mid-Autumn Festival (15th of the 8th month)
This is somewhat like the American Thanksgiving as it is a day for the entire family to gather together. Instead of turkey, the Chinese family feasts on good wine, moon-cakes and other delicacies. More romantic than Thanksgiving, the whole family feasts under the fullest and brightest moon of the year. There is also an interesting story behind this. Folklore tells of a beautiful fairy living on the moon in a spacious but cold crystal palace with her sole companion, a jade rabbit. A heavenly general and friend would occasionally pay her a visit, bringing along fragrant wine. She would then dance a breathtaking dance.

Note: Edited from Haiwang Yuan's web page on www.chinasacpe.org.

PART XII. FOOD PRACTICES

Usual meal pattern: Chinese usually eat three meals a day, the largest at dinner (Chin, 1996). There is a traditional saying among the Chinese: "eat well in the morning, eat full at noon and eat well in the evening."

Special utensils: Chopsticks. The Chinese family usually shares all the dishes.

Food beliefs and rituals. Food is viewed as important in maintaining balance of Yin (cold) and Yang (hot) in the body. Imbalance of yin and yang is believed to cause illness. For instance, consuming cold fluid while having oily food is believed to cause diarrhea. Yin foods include fruits, vegetables, cold liquids and beer. Yang foods include meats, eggs, hot fluids and oily and fried foods. Some foods are used to treat illness or disease (Chin, 1996).

Usual Diet. The northern Chinese favor wheat and flour products while southerners prefer rice and noodles. Meat usually is not eaten in large quantities and beef is cooked until well done. Vegetables are frequently mixed with meat to maintain the balance of Yin and Yang. Chinese prefer vegetables cooked, not raw. (Chin, 1996).

Fluids. Chinese people drink plenty of hot liquids, especially tea and chicken soup, when sick. Hot beverages are preferred due to belief that cold water shocks the system (Chin, 1996). Sick people with fever and/or stomach problems are advised to avoid cold fluid and food. It is forbidden for a mother who just gave birth to a baby to drink ice water. Traditionally, the mother is not allowed to drink or eat anything cold for the first month after she gives birth.

PART XIII. RECOMMENDATIONS TO REHABILITATION SERVICE PROVIDERS

Be Aware of Cultural Variables That Affect Clinical Practice

The contrasting concepts of the Western individualistic (i.e., independent) versus the Chinese collectivistic (i.e., interdependent) orientations have a strong impact on providing rehabilitation services to Chinese-Americans with disabilities. The client- centered approach used by many rehabilitation counselors in the United States may create discomfort and confusion for some Chinese consumers since this approach lacks the structure that they may expect and are used to. Moreover, Chinese-Americans tend to view counselors as authorities and expect them to help or simply solve their problems for them as opposed to offering empathy and nurturance through the counseling experience. Since rehabilitation counselors may be viewed as authority figures and Chinese culture emphasizes controlling one's emotions, it may be very difficult for Chinese consumers to initiate conversations (Chan, Lam, Wong, Leung, & Fang, 1988). Chan et. al. (1988, p. 23) concluded that "these different expectations of counseling and low levels of self-disclosure and emotional expressions are often in direct conflict with the expectations of individual western therapists."

The Language barrier is another problem when counseling Chinese Americans in light of the verbal interaction and rapport building function of the counseling relationship (Chan, Lam, Wong, Leung, & Fang, 1988). Interpreters can help with this issue but greater success maybe ensured if the service provider bears in mind the recommendations listed below.

Recommendations

1. **Accessing the Community**

When accessing the community beware of the following:

- There are sub-cultures within the general Chinese culture. That is, there are differences between people who originated in Hong Kong versus those who originated in mainland China or Taiwan. In addition, the cultural values/beliefs can be quite different between first-, second-, third-, and fourth- generation Chinese Americans. Questions such as "which part of China did you come from?" or "how long have you been in the U.S.?" are important to ask because China consists of so many varieties of linguistic, cultural, political, economics, health and rehabilitation systems.

- There are differences in the availability of community organizations to minority groups in urban and rural areas (OMRDD, 1994). There are dozens of Chinese organizations, associations and groups in New York City, for instance, but rarely will you find any in most rural areas, even in places close to large cities.

- Hire Mandarin/Cantonese speaking staff directly from the communities in need.

- Use Chinese media, such as Chinese newspapers, radio stations and TV channels when conducting outreach.

- Conduct outreach in schools, senior centers and churches/temples.

- Collaborate with existing community organizations and service providers.

- Develop educational materials to be distributed to community members/organizations in the Chinese language.

2. **Accessing Family**

- Involve family members in the intake and treatment/rehabilitation process. Keep family members well-informed of the process.

- Provide services to families in ways that do not conflict with their beliefs, customs, and cultural values (OMRDD, 1994).

- Be aware of differences in cultural beliefs, traditions, religions and values.

- Work with interpreters and/or translators. These professionals should have both bilingual and bi-cultural skills as well as knowledge of rehabilitation vocabulary and concepts so that they can provide accurate translation. It is highly recommended that service providers meet with the interpreter before meetings with consumer/family to keep the interpreter abreast of the purpose and content of the meeting, familiarize them with relevant terminology and obtain information about acceptable communication (both verbal & nonverbal) that may be appropriate for the particular consumer/family.

- Expand family care programs to include relatives as providers (OMRDD, 1994).

- Promote respite, camping and recreational programs that are sensitive to cultural needs of Chinese communities (OMRDD, 1994).

3. Accessing Individuals
- Recognize individual differences. Be careful not to make stereotypical assumptions about a consumer who is of Chinese heritage.

- Provide bilingual services. Languages differ among the cultural groups and within the cultural groups. It is highly important to acknowledge and respect the dialectal differences among Chinese people (OMRDD, 1994).

- Be aware of interpersonal skills and non-verbal communication cues (OMRDD, 1994). For instance, when invited into Chinese homes and offered something to eat or drink, remember that it is considered impolite to say no. s

- Promote consumer participation in choice of services.

4. **Simplify process and protocols** (OMRDD, 1994).

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REFERENCES

Asian American Health Forum. (1990). Asian and Pacific Islander American Population Statistics (Monograph Series 1). San Francisco: Author.

Bond, M. H. (Ed.). (1986). The Psychology of the Chinese People. Hong Kong: Oxford University Press.

Bureau of East Asian and Pacific Affairs U.S. Department of State (2001). [on-line]. Available: www.state.gov/index/cfm.

Chan, S. (1998). Families with Asian Roots. In Lynch, E.W., & Hanson, M.J. (Eds.), Developing Cross-Cultural Competence. (pp. 251-355). Baltimore, MD: Paul H. Brookes.

Chen, Y. (1995). Mental Health in China. World Health. 48(5), 20.

Chin, P. (1996). Chinese Americans. In Lipson, J., Dibble, S., & Minarik, P. (Eds.), Culture and Nursing Care: A Pocket Guide (pp. 74-81). San Francisco: UCSF Nursing Press.

China Disabled Person's Federation. (2000). [on-line]. Available: www.geocities.com/cdppat-ustour/cdpf.html.

China Today. (2000). [on-line]. Available: www.chinatoday.com.

Chung, E.L. (1996). Asian Americans. In Julia, M.C. (Ed.), Multicultural Awareness in the Health Care Professionals (pp. 77-110). Needham Heights, MA: Allyn & Bacon.

Compton (1995, August). Chinese Cultural Studies: Philosophy and Religion in China. Compton's Encyclopedia on line. [on-line]. Available: http://acc6.its.brooklyn.cuny.edu/-phalsall/tests

Copper, J. F. (1999). Taiwan: Nation-State or Province? Boulder, CO: Westview Press.

Dong, T. (2000, July 2). Hospitalized for 27 Years, Lan Mao Is Finally Discharged. World Journal. p.2.

Engholm, C. (1994). Doing Business in Asia's Booming "China Triangle". New Jersey: Prentice Hall.

Hall, E.T. (1976). Beyond Culture. New York: Anchor Express.

Her, K. (1999). Paradise Regained: Taiwan's Garden of Eden. Free China Review. 49(1), 33-39.

Hernandez, M. & Isaacs, M. (1998). Promoting Cultural Competence in Children's Mental Health Services. Baltimore, MD: Paul H. Brookes Publishing Co.

Kaplan, F. M., Sobin, J. M., & Andors, S. (1979). Encyclopedia of China Today. Fair Lawn, NJ: Eurasia Press.

Lam, C. (1992). Vocational Rehabilitation Development in Hong Kong: A Cross-cultural Perspective. Stillwater, OK: National Clearing House of Rehabilitation Training Materials.

Lam, J. (2000). Philosophies and Religions. [on-line]. Available: www.intex-china.com.

Lee, E. (1996). Chinese Families. In McGoldrick, M., Giordano, J. & Pearce, J. (Eds.), Ethnicity Family Therapy (pp. 248-267). (2nd ed.). New York: Guilford Press.

National Health Insurance Profile. (1999). [on-line]. Available: www.nhi.gov.tw/english.htm.

OMRDD (1994). Best Practices: Outreach Strategies in Multicultural Communities. New York State Office of Mental Retardation and Developmental Disabilities.

Ong, W. (1993). Asian American Cultural Dimensions in Rehabilitation Counseling. San Diego, San Diego State University.

Pan, L. (1990). Sons of the Yellow Emperor: A History of the Chinese Diaspora. Boston, Toronto, London: Little, Brown and Company

Procedure of Shanghai Municipality on the Dispersed Placement for the Employment of the Handicapped. (2000). [on-line]. Available: www.shdisabled.online.sh.cn/english/ document88.htm.

Rubinstein, M. (Ed.). (1994). Women's Liberation: The Taiwanese Experience. The Other Taiwan - 1945 to the Present. New York: M. E. Sharpe, Inc.

Shanghai Cishu Chu Ban She. (1994). Shi Yong Zhu Can Bai Ke-Ai Xin De Feng Xian. Shanghai, China: Shanghai Cishu Chu Ban She. [Shanghai Books Publisher. (1994). Encyclopedia of Practical Help for Individuals with Disabilities-the Dedication of Love. Shanghai, China: Shanghai Books Publisher.]

Smith, E.J. (1981). Cultural and historical perspectives in counseling Blacks. In D.W. Sue (Ed.), Counseling the culturally different: Theory and Practice (pp. 141-185). New York: John Wiley.

Sue, D. (1997). Counseling Strategies for Chinese Americans. In Lee, C. C. (Ed.), Multicultural Issues in Counseling: New Approaches to Diversity. (2nd ed.). Alexandra, VA: American Counseling Association.

Sue, D. W. & Sue, D. (1999). Culturally Appropriate Intervention Strategies. Counseling the Culturally Different: Theory and Practice (pp. 74-96). (3rd ed.). New York: John Wiley & Sons.

Sung, B. L. (1985). Bicultural Conflicts in Chinese Immigrant Children. Journal of Comparative Family Studies. 16(2), 255-269.

Ting, H. & Fitzgerald, M.H. (1996). Rehabilitation Market Segmentation and Positioning of Rehabilitation Providers. Journal of Rehabilitation. 62(2), 36-44.

U.S. Bureau of Census (2000). Resident Population Estimates of the United States by Sex, Race, and Hispanic Origin: April 1, 1990 to July 1, 1999, with short-term Projection to March 1, 2000. [on-line]. Available: www.uscensus.com.

Wang, M-H, Chan, F., Thomas, K.R., Lin, S-H & Larson, P. (1997). Coping Style and Personal Responsibility as Factors in the Perception of Individuals with Physical Disabilities by Chinese International Students. Rehabilitation Psychology. 42(4), 302-316.

Wong, W. (2000, April 30). Beijing Teenage Girl with Mental Retardation Was Elected to Be the Global Friendship Ambassador. World Journal. p. 2.

Wu, X. (2000, July 2). Transmitted AIDS from Blood Transfusion.... Schools Rejected, Neighbors Ignored. A Nine-Year-Old Boy, Ning Li's Miserable World. World Journal. p. 2.

Yamashiro, G., & Matsuoka, J.K. (1997). Help-seeking among Asian and PacificAmericans: A multiperspective analysis. Social Work. 42, 176-186

Yuan, H. (1995). Chinese Holidays and Festivals. [on-line]. Available: http://www.chinascape.org/china/culture/holidays/hyuan/holidays.html.

Zhang, W. (1994). American Counseling in the Mind of a Chinese Counselor. Journal of Multicultural Counseling & Development. 22(2), 79-86.