Topic: Impacts of Values/Beliefs on Rehabilitation Processes

GOALS

- Understand influences of Asian beliefs and values on the rehabilitation process
- Identify strengths and limitations of current rehabilitation systems in providing services to AAPI with disabilities

READINGS

Chen, R. K., Jo, S., Donnell, C. M. (2004). Enhancing the rehabilitation counseling process: Understanding the obstacles to Asian American's utilization of services. *Journal of Applied Rehabilitation Counseling, 35*(1), 29-35.

Grove, N., & Zola, I. (1993). Multiculturalism, chronic illness, and disability. *Pediatrics, 91*, 1048-1055.

LECTURE OUTLINE

In this session, we will focus on how the Asian beliefs and values affect the rehabilitation process and discuss what we, as rehabilitation service providers, can do in terms of improving services to AAPI with disabilities.

Perceptions of Disability & Rehabilitation

How to define disability has been a heated topic in the field of disability studies and rehabilitation in the U. S. We have had several models such as the medical model and the social model. All these models tend to examine the disability issue from a "cause and effect" perspective. The traditional Asian thinking, on the other hand, took a different perspective - the balance between forces.

According to a traditional Asian belief, all living beings were composed of Yin & Yang. In a normal situation Yin and Yang within the body kept a relative balance. This means that the body was free from any *Xieqi* (unhealthy environmental influences) that might cause disharmony. When an imbalance between Yin and Yang occurred, the body was easily affected by unhealthy environmental influence, resulting in people suffering from diseases. A disability resulting from a disease or impairment was viewed as a pattern of disharmony that describes situations of distress or imbalance in a person's body and mind and between the person and his or her environment. Therefore, the goal of the healing or rehabilitation was to bring back to the balance so to restore harmony to the individual. This rebalancing included three levels: (1) intra-personal harmony, (2) interpersonal harmony, and (3) harmony between the individual and the nature.

At the intra-personal level, the imbalance of Yin and Yang within the body and mind would be analyzed and remedies that focused on regain balance within the body and mind would be prescribed. These might include herbs, acupuncture, acupressure, exercises, Qigong (a breath

control method that focuses on developing a clear, tranquil state of mind, with deeper self-awareness and harmony with nature), etc.

From the contemporary Western view, pursuing intra-personal harmony may have something in common with the medical model of rehabilitation in that it focuses on the individual. However, the Asian approach was not limited to intra-personal, it also explored the interpersonal perspective and harmony between human beings and nature as a continuum between mind and body.

With regard to the interpersonal harmony, the traditional Asian approach emphasized the analysis of relationships between the individual and other people in his or her environment and how the relationships affected the individual in terms of regaining the balance. Interestingly, the contemporary vocational and social rehabilitation counseling theories and practice also emphasize the importance of interpersonal skills of consumers in achieving their rehabilitation goals.

However, unlike the vocational and social rehabilitation theories that emphasize restructuring the environment in which the individual must function, the traditional Asian approach emphasized "going with the flow" or "making peace with the environment". No matter how unfair a situation might be, maintaining inner strength under all the circumstances was considered an expression of dignity, and therefore well adjusted. Although this kind of belief may help people focus on inner strength and bring about changes in a person's feelings about his or her existence and the relation to human society and the natural world, it may prevent the individual from taking actions to restructure the environment.

In addition, illness may be attributed to numerous causes not typically encompassed within concepts of Western medicine, including a weakness of nerves, a curse by an offended spirit, punishment for immoral behavior, exposure to unsuitable food or water or to changes in the weather, or less of the soul within the body, and contact with wind influences. This is not wind as defined by a westerner, but rather a force that enters the body when it is vulnerable and causes displacement of one's equilibrium. Arthritis is often attributed to a wind that has settled in the joints. Because different foods are classified as cold or hot or neutral, nutrition and dietary habits play a central role in the treatment of certain diseases and the maintenance of good health.

Furthermore, studies on attitudes toward disability among Asians and Asian Americans (Chan, Lam, Wong, Leung,& Fang, 1988; Chen, Brodwin, Cardoso, & Chan, 2002; Hampton & Chang, 1999; Lam, 1992; Leung & Sakata, 1988; Liu, 2001; Saetermoe, Scattone, & Kim, 2001; Tabora & Flaskerud, 1994; Wang, Thomas, Chan, & Cheing, 2003; Westbrook, Legge, & Pennay, 1993) revealed that some Asian beliefs may have negative impacts on attitude towards people with disabilities. The table below summarizes findings of these studies:

Research Findings about the Impact of the Chinese Culture on Perceptions of Disability

Traditional Beliefs	Perceptions	Consequences

The wholeness of the mind and body	The health of the mind and body is inseparable	Expressing personal and social distress through an idiom of bodily complaints
Family is the basic unit in society. To strive for harmony in the family, parents should have the highest authority and children should be obedient, have proper conduct such as controlling impulse and emotions and accepting social obligations.	Direct expression of emotions and complaining of worry, despair, or pain is not appropriated, being able to eat "bitterness" is a good virtue.	May not be fluent in verbalizing emotional feelings. Neglecting physical illness & delaying to seek help.
Harmony may only survive in a form of structured hierarchical relationships when each member of the unit is conscientious in following the requirements of his or her role.	Knowing one's duty as a member under the hierarchical system and sacrificing individual needs for the common good of the group are regarded as the good virtues. Putting one's interest first and complaining about one's situation is considered selfish and childish.	Relying on the kindness or mercy of others, particularly those who have power. Not even trying to advocate for one's own rights and benefits.
Xiao (filial piety, meaning loyalty, respect, and devotion to parents) & Ti (older siblings care for younger siblings & younger siblings respect older siblings) is a way of life.	Supporting one's elder parents and disabled siblings is one's duty	Adults with disabilities live with their parents or siblings.
The pervasive force in the world is Karma. Karma operates inexorably to reward good deeds with meritorious rebirths, and evil deeds with rebirth in one of the bad modes of existence.	Having a disability is perceived as punishment for immoral behavior or wrong-doing in one's past life, or by one's ancestors.	Feeling shameful & guilty when a child was born with a disability. Hiding the child from the public.

Perceptions of Rehabilitation Service Providers

Perhaps the most important issue is whether rehabilitation service providers are perceived as 'insiders' or 'outsiders'. If we are viewed as someone who represents the authorities, we may not be able to gain trust from Asian consumers who have had painful experiences with governmental authorities back to their countries of origin. If rehabilitation service providers are perceived as 'insiders'. Trust will be established and cooperation will follow.

For example, many AAPI have difficult discussing problems with outsiders, even with confidential professionals. However, if a client knows a counselor who understands the client's culture, talking to the counselor about his or her secret problems may be a better choice to the client than talking to a relative. This way the client does not have to feel a loss of face or a loss of family honor.

On the other hand, some AAPI such as Samoans may regard the authority of a rehabilitation counselor with great respect and do not want to be asked what their rehabilitation goals might be. They may want the rehabilitation counselor to be directive and give explicit guidance.

Another important issue is whether rehabilitation service providers can provide immediate and practical assistance. Those who are perceived as someone who can provide quick and tangible assistance are often welcomed.

Counselor Variables

In the previous sections, we have discussed beliefs/values of AAPI. Now, I would like to spend sometime to discuss rehabilitation service providers' perceptions of AAPI and how the perceptions affect the rehabilitation process.

Rehabilitation counselors do not live in a vacuum. Society's views of AAPI will no doubt affect our perceptions of this population. Several researchers found that counselors hold very much similar cultural stereotyping usually found in the general population. The stereotyping includes seeing AAPI as "shy", "good with numbers", "poor with words", etc. (Chan, Lam, Wong, Leung, & Fang, 1988).

Rehabilitation counselors are part of the counseling profession which emphasizes verbalization and confrontation of internal and interpersonal conflict. We are trained to use standard English and to observe both verbal and non-verbal behavior when working with clients. However, some of us are not familiar with the way AAPI conduct themselves. For example, AAPI may learned during socialization "not to speak until spoken to" as a way to show respect to elders and authority figures. In a counseling situation, AAPI may not initiate conversion or actions. This behavior may be misinterpreted as a lack of motivation.

Also, words carry more of the message for many European American counselors, who are learned during socialization to clearly and quickly verbalize their intentions. On the contrary, many AAPI tend to communicate indirectly. One notable aspect of communication in many AAPI cultures is the preservation of "face" or one's image in communicative interactions with important others. In any communicative interaction, speakers may be concerned with self-face (their own positive or negative image) and/or other-face (the image of others in the interaction). A great deal of guessing goes on in a relationship as people try to infer and understand intuitively what is actually being communicated. Because of this difference in communication style between AAPI and European American counselors, some AAPI may suffer frustrations in communication because of the assumption that "it need not be mentioned, everyone in the

relationship knows it". It is embarrassing to mention this "supposed-to-know" issue verbally. Both sides are often unaware of their different roles and expectations.

Another issue is eye contact. Rehabilitation counselors are trained to keep eye-contact with clients. However, avoidance of eye contact between persons of higher social status is an AAPI cultural norm and should not be misunderstood to indicate dishonesty or lack of confidence.

Time management is a skill rehabilitation counselors hold high. We are trained to schedule our time intensively and expect things to be done at a particular time. In contrast, many AAPI usually do not schedule their time as strictly. This difference in the perception of time between counselors and AAPI clients may cause frustration on both sides.

Additionally, many AAPI have problems expressing themselves in English. Unfortunately, the majority rehabilitation service providers are not bilingual. Communication barriers associated with AAPI include accents, grammar, and tone of speech, all of which may cause some counselors to be impatient and even prejudiced.

RECOMMENDATIONS

So far, we have discussed many differences in beliefs, values, and behavior between AAPI and the mainstreaming service systems and service providers. A question arise is that can we provide rehabilitation services and, at the same time, respect a different belief about the way of life (e.g., interdependence among family members)?

In the past, professionals tend to focus on helping consumers learn and accept the American rehabilitation concepts and systems. Some AAPI beliefs such as "imbalance between hot and cold" and behaviors such as expressing personal and social distress through an idiom of bodily complaints are considered a source of dysfunction or maladjustment. This approach alone seems not working well. The problem we have encountered is the under-representative rate of AAPI in consumers served by the rehabilitation systems. Another problem we have is the high rate of attrition or unsuccessful closure.

Previous studies of acculturation and resilience indicated that cultural values emerged as protective mechanisms for youths at risk (Elsass, 1992; Zimmerman, Ramirez, Washienko, Walter, & Dyer, 1995). Individuals actively utilize their familial bonds and cultural values to cope with environmental demands and challenges tend to be more resilient and have better adjustment compared to those who do not. By the same token, emphasizing the utilization of familial bond and cultural values may help AAPI with disabilities.

We may need to rethink the strategies of working with AAPI with disabilities. Helping AAPI with disabilities learn about the American rehabilitation concepts and systems is important. However, this may not be enough. We need also to help them identify the strengths in their own cultures and validate the cultural values that promote self-esteem, pride, acceptance, and well-being. To summarize, rehabilitation service providers should:

- Keep an open mind and learn different cultures and values

- Conduct ongoing self-examination
- Establish mutual respect (insider vs. outsider)
- Give voice to and share power with AAPI
- Identify and focus on strengths in AAPI cultures
- Leave clients with tools

ASSIGNMENT 3

Case Study

Charlie is a 23 years old Cambodian American who has mild mental retardation. He was born in a refugee camp in Thailand and came to the United States with his mother when he was one year old. Charlie speaks some English and has learned basic skills of activities of daily living (ADL, e.g., eating, dressing, cleaning, using toilet, etc.).

Charlie was referred to a state rehabilitation agency for services by the school system when he reached 21. Charlie's rehabilitation counselor believed that a supported employment would be a good choice for Charlie. She talked through an interpreter with Charlie and his mother about it and developed an Individually Plan for Employment (IPE) with a goal of a supported employment for Charlie. She then referred Charlie to a rehabilitation facility for the supported employment services.

Charlie and his mother did not quite understand what were supported employment and an IPE. However, they went along with the counselor because she was a nice governmental official. The supported employment program at the rehabilitation agency placed Charlie at a Home Depot store which was not on the bus line. Although the agency had an English-speaking job coach to help Charlie at the store, Charlie had difficulty understanding what he should do. Furthermore, both Charlie and his mother do not drive. To go to work, Charlie had to rely on the city's special bus service which was very unreliable. Charlie quit the job after trying for a week. The rehabilitation agency then placed Charlie in a supermarket which was on the bus line. However, Charlie still had problems understanding instructions. Again, Charlie quit the job. The rehabilitation counselor closed Charlie's case on the status of "failure to cooperate".

- In your opinions, what might be the reasons for the unsuccessful closure of this case?
- If you were Charlie's counselor, how would you do differently?

Write a short essay to address the above questions. The essay is expected to be logically organized, grammatically correct, proofread, and neat. It must be typed, double-spaced (approximately 2-3 pages), and in APA 5th edition style (see the Attachment for details).