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**Institute *for* Asian American Studies**

*An Occasional Paper*

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# Quality of Life As Defined by Chinese Americans with Disabilities

## *Implications for Rehabilitation Services*[1]

**NAN ZHANG HAMPTON**
**VICKIE CHANG**

Quality of life (QOL) began as a political slogan in America during the 1950s and was recently adopted by counselors as a rehabilitation goal for people with disabilities (Chubon, 1985; Livneh, 1988; Roessler, 1990). Livneh (1988) suggested that rehabilitation goals were hierarchical and multifaceted. At the top of this hierarchy is the improvement in quality of life of people with disabilities. Under this ultimate goal, there are two objectives: community and labor force memberships. QOL has been defined in a variety of ways. In the field of rehabilitation, many researchers agreed that QOL was a subjective perception of the happiness and life satisfaction of a client (Boswell, Dawson, and Heininger, 1998; Chubon, 1985; Pain, Dunn, Anderson, Darrah, and Kratochvil, 1998). From this perspective, Chubon (1985) conducted several studies in which he asked people with a variety of disabilities (e.g., cancer, diabetes, heart disease, multiple sclerosis, spinal cord injury, muscular dystrophy, epilepsy, and blindness) to identify components of QOL. The results of these studies indicated that QOL contained ten dimensions, including: work, leisure, nutrition, sleep, social support, earnings, health, love/affection, environment, and self-esteem (Chubon, 1985).

Similarly, Pain et al. (1998) identified four domains, namely: emotional health, relationships, maximizing potential, and having an

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enjoyable/meaningful life, as the major contributors to the QOL of individuals with physical disabilities. In a qualitative study, Boswell et al. (1998) reported that attitudes toward life, opportunities to work, and the level of resources were the common themes of the QOL identified by people with a spinal cord injury. Further, the literature indicated that age, age at the time of injuries, educational levels, social support, health, and employment and marriage statuses were correlates of the QOL in people with disabilities (Mehnert, Krauss, Nadler, & Boyd, 1990; Schulz & Decker, 1985).

In addition, researchers pointed out that the concept of QOL could not be segregated from a thorough understanding of a client's culture (Keith, Heal, & Schalock, 1996). That is to say, a person's cognitive evaluation of his or her life may be influenced by the values the person holds and these values are learned through socialization in the culture he or she lives. In line with this position, social psychologists found that self-discipline, social justice, enjoying life, success, and protecting the environment were the common values underlining the perception of QOL cross culturally (Diener, 1995; Schwartz, 1992, 1994). However, each culture varies in how much it emphasizes these values. Particularly, members of different cultures differentiated among and attached varying degrees of significance to individual life facets (Mallard, Lance, & Michalos, 1997). For example, Diener and Diener (1995) reported that satisfaction with self, family, friends, and finances were related to life satisfaction across all college students in 31 countries. The size of the correlation between life satisfaction and satisfaction with the self, however, was stronger in a highly individualistic culture like the mainstream American culture and weaker in collectivistic cultures like the Chinese culture.

Since perceptions of QOL appear to be affected by culture, investigations on the meaning of QOL for people with disabilities from different cultures may be necessary. However, most of the published studies on QOL in the rehabilitation field have focused on White American clients, though we have become aware that people from other cultures such as a Chinese culture may hold a different view of QOL.

Leung and Sakata (1988) reported that Asian Americans were the fastest growing ethnic minority group in the United States. This is due to births by residents and continued immigration. According to the U.S. Census Bureau (1998), Asian Americans constituted 4% of the U.S. population in 1997 and about 24% (2.3 million) of this group were Chinese Americans. Using a method suggested by Chan, Lam, Wong, Leung, and Fang (1988), it is estimated that one out of seven of working-age Chinese Americans (1,679,000) may have a disability. In other words, approximately 117,530 Chinese Americans with disabilities may need rehabilitation counseling services. To help clients of a Chinese origin achieve the ultimate rehabilitation goal of QOL, rehabilitation counselors need to better understand Chinese culture and how it would influence the perception of QOL.

In contrast to the individualistic orientation of mainstream American culture, Asian cultures including Chinese culture emphasize sacrificing one's own interests for the common good of a group (Chan et al., 1988). Generally, Asian children including Chinese children are taught to follow certain social rules such as: to control emotion and impulse, be obedient to parents, work hard to achieve, and accept one's social obligations (Chan et al., 1988). Further, group membership is fundamentally significant for the Chinese. Individuals' satisfaction depends heavily upon acceptance by the ingroup. In other words, the Chinese are socialized to fit into the community, compared with the individual oriented socialization process in the mainstream American culture that focuses on individuals' needs and satisfaction.

Although Chinese people have been migrating to the U.S. for more than 150 years, many of these immigrants remained distinct and culturally attached to their homeland even after several generations (Chan et al., 1988; Fong, 1965). For instance, Feldman, Mont-Reynaud, and Rosenthal (1992) investigated the acculturation of values of Chinese youths (aged 15.5 to 28 years) in the U.S. and Australia. A questionnaire containing eight domains of values derived from Chinese and Western value scales was administered to White Americans, first and second generation Chinese Americans, and Chinese youth in Hong Kong. As predicted, the values of both the first and the second generation Chinese Americans were more similar to youths in Hong Kong than to their White American counterparts. Similarly, McCrage, Yik, Trapnell, Bond and Paulhus (1998) conducted a cross-cultural study to examine personality of college students in Hong Kong and Canada. Again, Chinese-Canadian students were found more like Chinese students in Hong Kong than their White counterparts.

In line with the above mentioned studies, we hypothesized that Chinese Americans with disabilities may remain culturally attached to their ancestors' homeland and this cultural attachment may have influences on the concept of QOL. That is, QOL may be perceived, by Chinese Americans with disabilities, not only as an individual's satisfaction with his or her life, but also the person's fulfillment of his or her responsibilities to his or her family and community. Of course, this hypothesis needs to be examined. Such an investigation may provide rehabilitation counselors with insights into the meaning of QOL from the viewpoint of Chinese Americans with disabilities. It may also point out the directions of how to improve rehabilitation services to this population based on an understanding of the Chinese culture and its influences on rehabilitation goal-setting of Chinese Americans with disabilities. Accordingly, the purposes of this study were (a) to identify dimensions of QOL perceived by Chinese Americans/immigrants with disabilities and (b) to explore the presumable influence of cultural factors in the QOL of these individuals.

## METHOD

### Participants

Participants in this study were 43 Chinese Americans/immigrants from a large East coast city in the U.S. The criteria for participation required that an individual (1) be 18 years old or older; (2) be a Chinese American or a Chinese immigrant, and (3) have a permanent physical disability that limits his or her ability to be employed or to perform daily activities.

A purposive sampling method was used. All Chinese organizations listed in the Directory of Asian American Organizations in the city were contacted. Posters or flyers were posted or distributed at social workers' offices at hospitals or day care centers that served Chinese patients/clients. All participants were

Table 1. Participants' Disability Types

| Disability | Number | Percentage |
|---|---|---|
| Amputation | 1 | 2.3 |
| Arthritis | 8 | 18.6 |
| Asthma | 1 | 2.3 |
| Cancer | 8 | 18.6 |
| Diabetes | 5 | 11.6 |
| Glaucoma | 3 | 7.0 |
| Heart diseases | 6 | 14.0 |
| Hypertension | 8 | 18.6 |
| Hyperthyroidism | 1 | 2.3 |
| Polio | 2 | 4.7 |

recruited from either outpatient programs of hospitals or community day care centers in the city.

Of the 43 participants, 17 were males and 26 were females. Their age ranged from 35 to 81 years old with an average age of 61 (*SD* = 10.4). Approximately 37% of the participants were below 65 years old. All participants were born in China, but have lived in the U. S. for more than 10 years. Of them, about 10% were U.S. citizens and 90% were permanent residents. The educational level ranged from 0 to 16 years with an average of 6 years (*SD* = 4.5). The majority of the participants were married (63%) or widowed (26%). Only a small proportion was separated (5%) or single (6%). Sixty-five percent of the participants had an annual family income of $7,500 or below, 30% had $7,501 to $15,000, and 5% had $15,001 to $25,000. In terms of employment, 11% of the participants had full-time jobs, 26% were unemployed, and 63% were retired. Most participants (83%) lived in the city's Chinatown area and about 17% lived outside the Chinatown area. Twenty-three percent of the participants lived alone, 14% lived with their parents/adult children, 54% lived with spouses, and 9% lived with relatives.

All of the participants have a physical disability caused by a variety of chronic diseases, including arthritis, diabetes, cancer, polio, etc. The types of the disabilities are listed in Table 1. Due to limited funding, we were not able to include people with psychiatric disabilities in this study. The age of the onset of the disability ranged from six months old to 78 years old with an average age of 52 years old (*SD* = 18). Ten percent of the participants had private medical insurance through their employers, 41% had Medicare, 46% had Medicaid, and 3% did not have any type of medical insurance. About 34% of the participants were hospitalized during the past year. The majority of the participants (77%) never heard of the Americans with Disabilities Act (ADA). The others knew only a little about the ADA. Of all the participants, only one person had heard of the State's Rehabilitation Commission and one person had heard of the State's Commission for the Blind. However, none of them had sought services offered by the commissions.

### Procedures

A research protocol form was developed. The protocol contained the following eight open-ended questions: (1) In your opinion what is quality of life (what is a good life)? (2) When someone asks you whether you have a good life, what things do you think about or what are important things that you have to have in order to live a good life? (3) What is the biggest change in the quality of your life in the past five years? (4) What about your current life? Is there any difference from your current life to the quality of life you would like to have? (5) If the answer is "yes" to the previous question, then, in what areas of your life do you want to change? (6) How can you enhance the quality of your life? For example, what kinds of things do you need to do and in what areas do you need help? (7) Have you changed your opinion about what is quality of life since you had your injury/disease? (8) As you grow older, has your perception of quality of life changed? Expert panel review was used to address the validity of this protocol. Four experts with doctoral degrees in counseling psychology or related field reviewed the protocol and confirmed that the protocol was consistent with the purposes of this study.

Five focus group discussion sessions were conducted in the conference rooms at a hospital or day care centers. The discussion groups were conducted over a three-month period. In each group, the number of participants ranged from 7 to 12. At the beginning of each session, the purpose of the study was explained. Participants signed a consent form and completed a demographic questionnaire.

The group sessions lasted from 1 hour 45 minutes to 2 hours and were audio taped. Each group was led by two bilingual investigators; one served as a principal moderator and the second served as a recorder throughout the sessions. The language used in the focus group discussions was Chinese (Mandarin or Cantonese). At the end of each group session, a free lunch was provided and each participant received $10 for his or her participation in the study. Further, an open-ended questionnaire was given to the participants after the group sessions. Participants were requested to complete the questions and mail the questionnaire back in a self-addressed-stamped envelope to the investigators. This open-ended questionnaire was used to supplement the data collected through group discussions.

### Data Analysis and Interpretation

Audio taped group discussions were transcribed verbatim and analyzed by the two investigators. First, each investigator read the transcripts line by line and word by word independently. Responses that identified attributes of a phenomenon within a sentence or paragraph were coded by categories and subcategories (Miles & Huberman, 1994). Summary response statements were provided for each category and subcategory. After independently coding the data, the investigators compared their coding of the responses. The inter-rater reliability between the two investigators was 96% using a percent of agreement method. Finally, the summary response statements for each category and subcategory were translated into English using a back translation method.

In addition, three steps were taken to assure validity and reliability of the study.

First, a data triangulation (the use of a variety of data sources such as transcripts of group discussions, an open-ended-questionnaire, and field notes) was used to examine the materials. Second, respondent validation was provided to 20% of the participants to obtain their feedback on interpretations of the transcripts. Finally, peer debriefing was used to test the investigators' insights against an uninvolved peer (Lincoln & Guba, 1985).

## RESULTS

### Dimensions of QOL

The dimensions of QOL identified by the participants were arranged into nine categories: Contributing to society; self-reliance; enjoying the same rights as others; not having to worry about food, clothing, housing, and transportation; physical health; emotional health; a good relationship with family members; individual safety; and stability and prosperity of the nation. Below we present sample quotations followed by the descriptive information:

> Contributing to society:
>
> *What is QOL? I think one aspect of QOL is to be able to contribute to society no matter where I live. If everyone did more for society and others but demanded less return from society and others, the QOL of everyone would be better. You make others happy, and you will be happy. I do not think that I have QOL because I cannot contribute to society due to my illness. Although I have SSI and Medicaid, I am not happy. I feel that I am a useless person who is useless to society and others. I want to go back to work. I do not mind doing entry level jobs although I have a college degree.*

Contributing to society consisted of three subcategories: Employment, voluntary work, and helping adult children take care of grandchildren. All of the groups talked about the importance of being able to contribute through paid or voluntary work, or through helping their adult children take care of grandchildren. They also emphasized that no matter where a person lives (in China/Taiwan or the U.S.) he or she should not just take from, but also give back to that country.

> Self-reliance:
>
> *I think QOL is to be able to support oneself and do not rely on others for living. In other words, I do not want to become a burden to my daughter or others.*

Self-reliance included three subcategories: Being able to support oneself, not becoming a burden to others, and working hard to meet one's needs. All of the groups talked about the importance of supporting oneself and not to burden others in achieving satisfactory QOL. Three groups mentioned that one should find a job and work hard to meet one's own needs.

> Enjoying the same right as others:
>
> *My wife and I have cancer. We have received information from different agencies and organizations about the services provided by them. This is very important to our lives because I believe that we Chinese Americans should enjoy the same right as others in the U.S. and have equal opportunities to services offered by the government. However, we do not understand English and the system. We gave up many things to which we are entitled.*

Enjoying the same right as others included four subcategories: The right to receive Social Supplemental Income (SSI) and Medicaid, access to low-income housing, access to education, and access to employment. All of the groups talked about the importance of becoming American citizens so they would receive the same benefits as others. They also felt the law that denied the right of legal immigrants to receive SSI and Medicaid was unfair. Three groups discussed racial discrimination against Chinese immigrants in the workplace with respect to work assignments, salary levels, and promotions. The participants also commented that the discrimination was often more subtle than overt.

Not having to worry about food, clothing, housing, and transportation:

All of the groups talked about meeting the basic needs of a human being such as having food, clothing, a place to live, and transportation.

> *To me, QOL means food, clothing, a place to live, and not worry about how to get to the hospital or supermarket. I do not need a lot of money because a millionaire may not have a good life. However, if I worry about food and housing all the time, I do not have QOL either.*

The majority of participants were living either in a low income apartment or on the waiting list for such an apartment. Most participants do not drive and rely on the public transportation.

Physical health:

> *Health is very important. If you do not have good health you cannot do many things although you want to do. For example, I want to work but cannot do it because I had a brain tumor that destroyed my vision. Although I can take care of myself, but I cannot do any work or activities that require strength or ability to see. Even if I want to pursue jobs that do not require strength my brain does not work the same way like before. It is like you have a will but have no way to accomplish it.*

All of the groups emphasized that physical health was a fundamental component of QOL. They also pointed out that appropriate medical care is the key to physical health. People need to exercise to maintain health. They also need medical care when they are sick. This prevents a small physical problem from becoming a serious one that may cause permanent impairment to one's body.

Emotional health:

> *I am not satisfied with my life here in the states because I am not happy. I have lived here for many years. The living conditions in the states are much better than in China. I have hot water 24 hours a day, air conditioning in the summer and heat in the winter. However, I feel very lonely and unhappy. The most difficult thing is that I lost the connections with my friends in China.*

Emotional health included three categories: Being free from worry and pressure, friendship, and faith. All of the groups talked about feeling lonely, lacking friends, and worrying about benefits. Some said that believing in God was an important component of their quality of lives.

A good relationship with family members:

> *I came to the states to be close to my daughter after my husband passed away. In fact, I still live with my daughter and her family. I help her take care of her children and she takes me to see doctors. We live in a community where the public transportation is not good. So each time when I go to see my doctor, my daughter takes me over there. She is my driver and interpreter. I am her cook and baby sitter. We get along very well. This (getting along with my daughter) is a very important thing in my life.*

All of the groups talked about the importance of having a good relationship with their family members in their lives. It is noted that in the participants' eyes a family not only consists of one's spouse and children, but also includes one's grandchildren.

Individual safety:

> *Safety is a very important issue in QOL. I have been robbed twice in the past three years and I do not feel safe in my own apartment. I do not have a good life because I worry about my safety all the time even when I am at my own home.*

All of the groups talked about the safety issue. Participants of two groups mentioned that they feel safe when they walk around in Chinatown. However, they are afraid to go outside of Chinatown because some of them have been robbed at a knife point just a couple of blocks away from Chinatown.

Stability and prosperity of the nation:

> *The stability of society is the key to QOL. If the society is not stable, you will have war or turmoil all the time. Then, no one will pay attention to old or disabled people. No one will be safe and happy.*

All of the groups emphasized the importance of the stability and prosperity of the nation. Many members of all the groups quoted an old Chinese saying which went 'Guo Tai Min An', meaning the stability and prosperity of the nation and the security and happiness of individuals goes hand in hand.

### Factors Influencing QOL

The most frequently mentioned issue that affected the QOL of the participants was a language problem. The majority participants do not speak or read English. The lack of English proficiency has prevented them from seeking employment outside Chinatown. It also prevents them from getting appropriate medical and rehabilitation services.

The second issue identified by the participants was the right to receive SSI and Medicaid. Non-citizen participants expressed their deep concerns about losing their benefits and the consequence of the loss. The majority of the non-citizens are willing to become naturalized citizens. However, they are afraid of taking the naturalization test due to the language problem. On the other hand, participants also pointed out that the current social security law does not encourage people to go to work. The cut off point for income is too low. If they start working, they may not be able to keep their medical benefits.

The third issue identified was a health problem. Participants felt that their health conditions were deteriorating and they were limited in their abilities to perform paid or voluntary work due to poor health. Participants believed that health problems had more impact on their QOL than aging.

The fourth issue was social isolation. Many participants expressed their feelings of loneliness and isolation. They missed their lives in their homeland where they had friends with whom they visited whenever they wanted.

The fifth issue identified was transportation. The majority of the participants do not drive, and rely on public transportation that is not convenient. Some participants use wheelchairs and the special bus service in the city is notoriously unreliable.

The sixth issue was housing problems. Participants complained that they had to wait for a long time in order to get a low income apartment. Because of the language and transportation problems, they prefer to live in the city's Chinatown. However, there is a long waiting list. They are worried that they may not be able to get an apartment before they die.

## DISCUSSION

The primary goal of this study was to explore dimensions of QOL perceived by Chinese Americans/immigrants with physical disabilities. We found some dimensions identified by the participants were similar to the findings of the previous studies with Caucasian Americans with physical disabilities (Chubon, 1985; Pain et al., 1998). For instance, physical health, emotional health, and relationships were the common themes identified by both Chinese and Caucasian Americans. This means that having physical and emotional health and enjoying good relationships with others are important components of QOL for people with physical disabilities regardless of their cultural origins. In other words, the basic core dimensions of QOL are probably pretty much similar for all people whatever their origins.

On the other hand, several unique dimensions of QOL were identified by the participants. These dimensions appear to be related to Chinese culture and immigration. First, as predicted, the participants identified contributing to society as a dimension of QOL. This is consistent with the emphasis on the common good of society in Chinese culture. However, it should be noted that the ability of Chinese Americans with disabilities to contribute to society (e.g., to find a job) has been affected by their lack of English proficiency. Because of this language difficulty, Chinese Americans/immigrants with disabilities can only work in Chinese restaurants or factories (e.g., garment factories) where Chinese is spoken. According to the participants, finding an appropriate job in these places is very difficult for them due to their disability. It appears that restaurant or factory owners in the city's Chinatown tend to hire "younger" and "healthier" workers. The attitude of Chinese employers further limits employment opportunities for Chinese Americans/immigrants with disabilities.

The lack of English proficiency not only limits the ability to seek appropriate employment, but also prevent Chinese Americans/immigrants with disabilities from developing meaningful relationships or receiving support from those outside of their ethnic group. For instance, most support groups for people with disabilities use English as the mean of communication. Chinese

Americans/immigrants with disabilities may not be able to participate in any activities of these groups due to language difficulties. Anxiety and loneliness resulting from functional limitations of a disability may be compounded by the feelings of isolation caused by language difficulties. As the participants pointed out, social isolation was a major factor affecting their QOL.

Second, the participants identified self-reliance as a component of their quality of lives. Although this theme has been identified by White Americans with disabilities, it should be noted that the motivation of being self-reliant may be very different in different cultures. According to Triandis and Gelfand (1998), self-reliance was associated with competition in individualistic cultures (e.g., the White American culture) but was linked to avoiding being a burden on the in-group in collectivistic cultures (e.g., the Chinese culture). For the participants of this study, the motivation for being self-reliance is clear, they do not want to become a burden on their families.

Third, the participants believed that enjoying the same rights as others constituted an important part of their quality of lives. They are concerned about "not openly expressed racial discriminations" in the workplace. They are unhappy about the changes in the Social Security Act regarding the right of legal immigrants to receive benefits. In other words, the QOL of the participants has been affected by discriminations against Chinese Americans/immigrants in society. Perhaps, other immigrant groups have been affected in the same way. However, further investigations on this issue are needed.

Fourth, the participants emphasized that "not having to worry about food, clothing, housing, and transportation" was an important component of their quality of lives. Asian Americans, including Chinese Americans, have been regarded as the "model minority". A popular opinion regarding Asian Americans is that "they have made it", meaning Asian Americans have succeeded in American society. Do all Asian Americans, particularly those with disabilities, succeed? We really do not know because the information regarding the employment and economic statuses of Asian Americans with disabilities is virtually absent from the literature. Consequently, problems facing this population (e.g., how to survive in the U.S.) may have been ignored.

The results of this study indicate that Chinese Americans/immigrants with disabilities are still struggling to meet the basic human needs such as getting food, clothing, and a place to live. A considerable proportion of the participants were unemployed. The family income of all participants falls into the lower categories (less than $25,000) or below the poverty line. It should be noted that a purposive sampling method was used in this study, and therefore the generalizability of the results is limited. However, the participants of this study were from low income families with limited resources. They may represent people who are indeed need vocational rehabilitation services. Perhaps, future studies may further investigate this issue using a stratified sample.

Finally, participants of this study pointed out that the stability and prosperity of the nation were key components of their quality of lives. All the participants were born in China or Hong Kong. Before they emigrated to the United States, they had experienced wars and social turmoil which were the common scenes in China from the turn of the 20th century to the end of 1970s. In fact, many of them talked about what happened to them and their families during the civil war in the late 40s and the "cultural revolution" in the 60s in China. It is not surprising that they valued the peace in the world and stability of the nation so much.

### Implications for Rehabilitation Counselors and Researchers

The findings of this study have implications for rehabilitation counselors and researchers. First, Chinese Americans/immigrants with disabilities are motivated to work. As indicated in this study, Chinese Americans with disabilities wanted to work but they did not know where they could get help. In fact, only one person in this study had heard of rehabilitation services and none of them had sought help from the local state rehabilitation agencies. One of the major problems that prevents them from seeking rehabilitation services or becoming employed is the language barrier. This issue may be addressed by providing language training for clients of Chinese origin. On the other hand, a systemic approach may be taken in order to address this issue. This can be done by training and hiring more bilingual counselors who will attract more Chinese clients. Further, state rehabilitation agencies may encourage their counselors to learn a second language (e.g., Chinese) by giving credits for such an effort. For instance, salary raises or promotions may be granted when counselors master a second language.

Second, given the lack of knowledge of their civil rights among Chinese Americans with disabilities, rehabilitation counselors should educate their clients of Chinese origin on this matter. For instance, they may provide the client with the information regarding the laws (e.g., Americans with Disabilities Act) that protect the right of people with disabilities. In areas where there is a high concentration of Chinese Americans (e.g., Boston, New York, San Francisco, etc.), state rehabilitation agencies may establish a disability education program in the Chinese American community. They may set up booths and talk about the right of people with disabilities in the U.S. at these cities' Chinatown's celebration ceremonies during Chinese New Year or other Chinese festivals. On the other hand, rehabilitation agencies and counselors should work on educating society about the reality of the life of Chinese Americans with disabilities and the responsibility of society for the well-being of those people. This can be done by continuously providing the media with the information collected while working with Chinese Americans with disabilities.

Turning to the implications for research, it is worthwhile to note that filial piety (meaning loyalty, respect, and devotion to parents) is a way of life in China. In fact, supporting one's elder parents is mandated by the Chinese Constitution. Because of this, many Chinese adult children live with or provide economic support to their parents or siblings who have disabilities. This kind of value and practice, however, is not in line with the mainstream culture in the U.S. Interestingly, the majority of the participants in this study lived with their spouse or alone and only a small proportion of them lived with parents/adult children. We do not know whether this is due to the participants' personal choice or other factors. Also, we do not know how the living arrangements influence feelings of loneliness and social isolation. Browne & Broderick (1994) reported that the most disturbing issue for Asian-American elderly was the loss of the traditional cultural value of family relationships they had in their native countries. Future studies should investigate if living arrangements are factors that affect the QOL of Chinese Americans with disabilities.

In summary, the present study was the first study of QOL of Chinese Americans with disabilities. Participants of this study identified several unique dimensions of QOL in this population and pointed out problems that affected QOL of these individuals. From a Chinese perspective, the problems faced by Chinese Americans/immigrants with disabilities are detrimental or dangerous to their quality of lives, but also give them opportunities to overcome their problems and to lead a fuller life in this country. However, American society, including the vocational rehabilitation system, should create an enriched environment in which Chinese Americans with disabilities will be able to turn the dangers to opportunities and thus become successfully rehabilitated.

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