Health and Health Care for
CHINESE-AMERICAN ELDERS
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DESCRIPTION

This ethnic specific module reviews the history of Chinese immigration to the US, health risks and specific disease incidences, and cultural influences that may impact on health care delivery to Chinese American elders. It is designed to be used in conjunction with the Core Curriculum in Ethnogeriatrics.

LEARNING OBJECTIVES

After completion of this module, learners will be able to:
1. Describe current population trends of Asian/Pacific Islanders.
2. Describe how acculturation to Western Society has impacted elder Chinese immigrants view of Western medicine.
3. Identify specific diseases that are prevalent among Chinese.
4. Identify the major influences in traditional Chinese culture and how they may impact Chinese elders view of life and Western medicine.
I. Introduction and Overview

A. Current Population

Today approximately 1.6 million Americans are of Chinese descent, the largest subgroup of Asian Americans. They are a heterogeneous population with regard to language, education, and socioeconomic status (Lum, 1995). Overall, Chinese immigration to the U.S. has dropped off since 1991. In 1997, legal Chinese immigrants numbered 41,000, the third largest group of the total number of 800,000 legal immigrants to the US. (http://goldsea.com/AAD/population) Approximately 66% of Chinese-Americans live in 5 states, California, New York, Hawaii, Illinois and Texas. About 63% are foreign born, more than 80% of elder Chinese Americans are foreign born. (Huff & Kline, 1999). Fifteen percent of Chinese American elders live in poverty and 47% live alone. (McBride, Morioka-Douglas, & Yeo, 1996). (For other characteristics of older Chinese Americans, see the chart in the Introduction section for the Asian/Pacific Islander modules.)

B. Religion and Language

There are four major traditional religions/philosophies in China: Confucianism, Buddhism, Taoism and ancestor worship. In addition to these religions, many Chinese Americans practice Christianity. Chinese language has many dialects. Mandarin is the official Chinese language, but many Chinese Americans speak Cantonese and other dialects. However, individuals who speak any of the Chinese dialects can read the Chinese written language that is not necessarily tied to the spoken languages. In 1990, 89% of Chinese elders in US indicated that they spoke a language other than English and 73% indicated that they spoke English poorly. (Lassiter, 1995; McBride, et al., 1996)

For more information on the size and characteristics of Chinese American elders, see the chart in the Introduction section to the Asian Pacific Islander modules.
II. Patterns of Health Risks

There is little specific data regarding the health status of Chinese-Americans. Prior to 1985, studies suggested a lower risk for death and disease in Asians and Pacific Islanders as a whole (Huff & Kline, 1999). However, newer studies see a trend towards poorer health status for this group in general, especially among those that live in poverty. The myth of the "Model Minority" (that all Asians are affluent and healthy) is misleading, as large segments are living in poverty, lack insurance, and do not access health care.

A. Role of Western Society on Health Status

The degree to which immigrants have adopted the culture and behaviors of Western society has impacted their health status in many cases. Comparisons of illness patterns show an increased rate of cancer of the breast, colon, and prostate in Chinese Americans when compared to Chinese living in mainland China and Hong Kong and Singapore.

B. Specific Diseases

1. Depression. Chinese-American women aged 65+ have three times the suicide rate of white women in the U.S. Among women aged 75+, the rate is seven times that of white women. With regard to suicide method, Chinese-American women tend to hang themselves, men tend to use medications. The majority of Chinese suicide victims are foreign born. Chinese-American elders are less likely to communicate the intent to commit suicide. Depression in Chinese-American elders is under-diagnosed and under-treated (Lum, 1995).

2. Alcoholism. In general, the rate of problem drinking in Asians is lower than the national average, but may be underestimated in some groups of immigrants. Chinese-Americans born in the U.S. consume more alcohol than immigrant Chinese-Americans (Huff & Kline, 1999; Sue, Zane, & Ito, 1979). Flushing and other vasomotor symptoms (due to acetaldehyde dehydrogenase type I deficiency) that occur with ingestion of alcohol by people of Chinese descent could be partly responsible for lower rates of alcoholism in Chinese (Lassiter, 1995).

3. Dementia. Vascular dementia is prevalent among Chinese-American elders, possibly more prevalent than Alzheimer’s disease in this group (Lum, 1995).
4. Infectious Disease

   a. **Hepatitis B.** There is a higher prevalence of Hepatitis B among Chinese-Americans, and hence, a higher prevalence of Hepatitis B-associated liver cancer. Hepatitis B infection is present in 80% of liver cancer cases (Chen, 1994).

   b. **Tuberculosis.** As a group, Asian and Pacific Islanders have a higher incidence of tuberculosis. In 1990, this incidence was ten times that of the general U.S. population. (Chen, 1994).

5. **Cancer.** Cancer rates vary with age, acculturation and location. Some of these differences may represent the influence of environment, such as diet and health habits, and therefore may be modifiable. (Reference for the section on cancer [www.nccc.org/pdf/Registries/monographs](http://www.nccc.org/pdf/Registries/monographs))

   a. **Liver Cancer.** Chinese-Americans have highest rate of liver cancer among all U.S. ethnic and racial populations. In the Chinese, it is associated with Hepatitis B. In whites, liver cancer is primarily associated with alcohol.

   b. **Nasopharyngeal Cancer.** Chinese-Americans have the highest rates in the U.S. Rates vary among Chinese living in mainland China, the U.S., Hong Kong and Singapore.

   c. **Breast Cancer.** The risk of breast cancer is higher in Chinese-American immigrants than in Chinese living in Asia. Breast cancer is the most commonly diagnosed cancer in Chinese females living in the US. Factors such as the use of estrogens, nulliparity, fewer births, older age of first birth and obesity may be responsible for rate differences in various countries. Chinese women are less likely to receive mammograms than white women.

   d. **Prostate Cancer.** The rate of prostate cancer increases sharply with age, and the rate of prostate cancer among Chinese-Americans is three to five times higher than Chinese living in Asia.

   e. **Colon Cancer.** The variable rates among Chinese living in various countries suggest diet related and other environmental risk factors. The rates are higher among U.S. and Hong Kong Chinese than in mainland China.

   f. **Lung Cancer.** These rates vary widely. The highest rates are in Chinese living in Hong Kong and Singapore, followed by mainland China, and then the US. This probably reflects the rate of smoking in the various areas.
6. **Smoking.** The rates of smoking in the U.S. as a whole have been declining. The average for U.S. adults is 30%. The rate of smoking in Chinese-American males is estimated at 28%. In some states, the rate of smoking among Chinese-American males is greater than in whites. Chinese-American women currently have low rates of smoking, but are being targeted by tobacco advertising. Smoking among Chinese-American women is greater than in their Asian counterparts (Chen, 1994; Huff & Kline, 1999).

7. **Cardiovascular Disease.** There is a tendency towards an increasing incidence of cardiovascular disease and hypertension in elderly Chinese-Americans (Lum, 1995; Yee & Weaver, 1994).

8. **Diabetes Mellitus.** There is a trend towards increasing rates (Lum, 1995; Yee & Weaver, 1994).

9. **Genetic Diseases.** Thalassemia and Glucose-6-dehydrogenase deficiency is high in Chinese-Americans. (Lassiter, 1995).

(Additional References for the section: Ryan, 1985; Yeo, 1995; Yeo & Gallagher-Thompson, 1996; [http://library.thinkquest.org/20619/Chinese.html](http://library.thinkquest.org/20619/Chinese.html)).

### III. Culturally Appropriate Geriatric Care: Fund of Knowledge

To provide culturally competent care for Chinese American elders, it is important for geriatric providers to have background knowledge of: 1) the traditional health beliefs and behaviors in the Chinese culture, and 2) the historical experiences that may have influenced the current cohort of Chinese American elders.

#### A. Cultural Beliefs and Practices

1. **Role of Confucianism.** Confucianism has played an important role in forming Chinese character and behavior. Its primary purpose is to achieve harmony, the most important social value. This is achieved by everyone having well defined roles and acting towards others in a proper way. It is interesting that there is no Chinese equivalent for the word "self".

There are five cardinal relations ("wu lun"): sovereign-subject, father-son, elder-younger brother, husband-wife, friend-friend. The family is the center and comes before the individual. The father is the undisputed head of the family. With regard to filial piety ("xiao"), sons, especially the oldest son, have specific obligations toward the family and are expected to respect and care for parents.
(McLaughlin & Braun, 1998). In pre-modern China, the act of suicide was not necessarily deviant behavior if it was associated with duty or loyalty to the family.

"Li", the "proper way" or "propriety", includes a set of rules for interaction with others and the role system. Control of emotions, restraint, obedience to authority, conforming and "face" are highly valued and important.

(Additional references for the section: Lassiter, 1995; Tseng & Wu, 1985)

2. Other Influences

a. Yin/Yang. General laws of opposing forces. Yin (female, negative energy, cold) and Yang (male, positive energy, hot). Illness results from imbalance of these forces. Foods are classified as "hot" and "cold", and a proper balance is required to maintain health. Illnesses and treatments are also classified as hot and cold.


c. Psychosomatic Integration. Organs are associated with various emotions and symbolic functions: lung (worry), gallbladder/liver (anger), heart (happy), kidney (fear), spleen (desire). (Lee, 1997)

d. Buddhism. Buddhist teachings also emphasize "face" or dignity. An individual's wrongdoing causes immediate family to lose face. Patients may not admit or realize they have health problems, especially mental health problems, as they may bring shame upon their family (Ryan, 1985). Other important teachings and beliefs include the concept of "karma".

e. Taoism ("the Way"). Emphasis is on selflessness, cleanliness, emotional calm, and conformity. Emphasizes the mystical aspects of human nature (Lassiter, 1995; Ryan, 1985).

3. Conflicts with Western Concept of Personality. Traditional Chinese values put the family and society over the individual. A traditional deference to authority may produce miscommunication. For example, patients may nod their head to indicate understanding and agreement; but they may be simply deferring to authority. It is important to be sure they understand what is being said and are not just being polite.

(Additional References for the section: Chen, 1994; Dai & Dimond, 1998; Huff & Kline, 1999; Loo, 1998; Lum, 1995; McLaughlin & Braun, 1998; Sue, et al., 1979;
B. Historical Influence on Cohort

1. **1850’s: Chinese, First Asian Immigrants to U.S.** The very first Chinese immigrants were wealthy merchants, skilled artisans and hotel and restaurant owners. However, starting in the mid 1800’s, large groups of unskilled “coolie” laborers immigrated to California, primarily to the “Gold Rush” areas and San Francisco. Others worked on the Central Pacific Railroad. In Hawaii, Chinese immigrated as Contract Laborers in the 1850’s to provide workers for the booming sugar industry. ([http://library.thinkquest.org/20619/Chinese.html](http://library.thinkquest.org/20619/Chinese.html))

2. **1870’s and 80’s: Growing Resentment toward the Chinese—”Yellow Peril”** Chinese Exclusion Act of 1882 prohibited family members of Chinese workers from coming to the U.S. Due to this and other acts, the already imbalanced gender ratio of 19:1 (male:female) widened. Thus the Chinese immigrants in the early 1900’s were essentially “bachelor societies” of predominantly old men. These Chinese clustered in groups forming ethnic enclaves of “Chinatowns”, where people still live, work and socialize. ([http://library.thinkquest.org/20619/Chinese.html](http://library.thinkquest.org/20619/Chinese.html)).

3. **Post WWII Immigration.** With the Repeal of Chinese Exclusion Act in 1943, wives and unmarried children were allowed to enter the U.S. The War Bride Act of 1945 further increased the number of Chinese women. After the 1970’s - new immigrants from Taiwan and Hong Kong arrived. They tended to be better-educated professionals and their families. A large proportion of Chinese immigrants from Southeast Asia were refugees (McBride, et al., 1996).

(For more information on historical influences on Chinese American elders, see the chart in Appendix A: Chinese Americans: Significant Dates and Periods in Immigration and History.)

IV. Culturally Appropriate Geriatric Care: Assessment

A. Chinese are Not All Alike, But Have a Lot in Common. (Chen, 1994). Many American-born Chinese, although not as traditional, may still retain values of respect for authority and elders, passivity, family values, and fatalism (Lassiter, 1995). There is a lack of culturally sensitive assessment instruments, so caution is advised in interpreting questionnaires and other instruments that have not been validated cross-culturally. (Lum, 1995)

B. Degree of Acculturation and Strength of Ties with Traditional Beliefs:

1. Respect/Protection of Elders/Filial Piety. May lead to not informing family members of illness to "protect" them, reluctance to place them in long-term care, reluctance to discuss Advance Directives (McLaughlin & Braun, 1998).

2. Karma. Bad luck to talk about illness or death, as it may cause it to happen (McLaughlin & Braun, 1998).

3. Psychosomatic Integration. Somatic complaints as indicators of mental illness. Somatization in traditional Chinese culture is an acceptable way to express emotional distress and obtain attention; patient may be perceived as a "hypochondriac" (Jung, 1998).

4. Formalistic Conformity/Deference to Authority. Patients may not verbalize anxiety or doubts regarding their medical care in front of medical personnel, but then not follow through with treatments. This can be misinterpreted as patient noncompliance or insincerity.

5. Decision Makers. Traditionally expected to be husband or oldest son.

6. “Saving Face”. May make it harder for patients to admit to having problems, especially mental health problems. They may not want to question or disagree with physician to their face, so they will not come back, "doctor shop", or not take medication as prescribed.

7. Concepts of Yin/Yang and “chi” or “qi” (vital energy). See section above.

(References for this section: Chen, 1994; Dai & Dimand. 1998; Jung, 1998; Lassiter, 1995; Lum, 1995; McLaughlin & Braun, 1998; Ryan, 1985; Yee & Weaver, 1994)
V. Culturally Appropriate Geriatric Care: Treatment

A. Role of the Health Care Provider:

The basic concepts of treating patients with respect, compassion, and honesty are still what are most important to patients, regardless of cultural/ethnic background. A better understanding of a person's cultural beliefs can improve patient compliance and the relationship.

There may be a conflict with Western concept of patient-physician relationship of partnership vs. the doctor as authority. Patients may hesitate to make direct eye contact, may hesitate to ask questions or voice opinions so as not inconvenience others or appear disrespectful. Physicians are expected to make decisions and give instructions. They must be viewed as trustworthy, caring and willing to help. To put the elder patient at ease, it is important to take a little time to "talk story" before beginning the clinical interview, to address patients with respect (Mr. or Mrs.), and to try to pronounce names correctly. (Elliot, Di Minno, Lam, & Mei, 1996) Some elders may feel uncomfortable with physical contact during conversations. Health care providers must be aware of their own stereotypes toward the Chinese and degree of acculturation of their patients.

B. Integration/Awareness of Traditional Chinese Medical Treatments/Beliefs:

Many Chinese still believe in traditional Chinese medical treatments, and a total disregard or lack of respect for these beliefs may lead to distrust. Open discussion and flexibility may go a long way in treating the elder Chinese-American patient (Lassiter, 1995). Examples:

- Acupuncture: meridians are pathways of energy, or "chi", which lead to various organs.
- Cupping: using heated bamboo cups to reduce stress, congestion, colds.
- Herbology: use of plant or animal parts in the treatment of illness and deficiencies and to stimulate the body's "chi".
- Yin/Yang concept: elders may avoid the cold, and may avoid certain foods considered to be "cold" foods.
- Meditation/Exercise: often used to help alleviate stress.

C. Cross Cultural Psychopharmacology.

Lower doses of psychotropic medications may be needed in Asians, due to lower body weight and differences in metabolism.
D. Psychotherapy

There should be an awareness that Western methods of psychotherapy may not be received well. Confrontation may make patients uncomfortable, and somatization is common. (Ryan, 1985)

E. Advance Directives/End of Life Issues:

Many Chinese may be reluctant to discuss these issues due to the belief that if you talk about something bad, it could occur (karma). Resistance toward organ donation may result from the concept of keeping the body whole for the afterlife, and out of respect. Attitudes can change depending on degree of acculturation. Some elders do not want to be a burden to their children. Medical professionals need to use care and be aware of their patient’s beliefs in approaching these issues with Chinese elders or their families. It is also important to ask about whether there is an accepted family decision-maker (Yeo, 1995).

F. Medications.

There is a high rate of non-compliance with Western antihypertensive medications in non-English speaking Chinese with hypertension (Huff & Kline, 1999). Many less acculturated Chinese-Americans may believe that Western medications are too strong and may not take prescribed doses. Elder Chinese-Americans may be at risk for drug interactions due to metabolic factors that alter the metabolism of drugs, and the concurrent use of herbs and other Chinese medications.

VI Access and Utilization

A. Health Care Utilization

The degree of utilization is dependent upon acceptance by patient and family, and barriers such as mistrust, money, saving face, and family responsibilities. Additional barriers to the U.S. health system include: lack of language and culturally competent services; geographic; and economic barriers. For example, conservatism with regards to sexual matters may be partially responsible for lower rates of mammograms in older Chinese-American women. In general, the fact that Asians and Pacific Islander Americans are less likely to see a physician may impact on the success of prevention programs, such as smoking cessation and breast cancer screening (Chen, 1994).
B. Use of Long Term Care

There may be reluctance to place parents in long-term care facilities out of respect and filial piety. Often a female family member (daughter-in-law or daughter) has the burden of care. Often the decisions regarding placement occur later, when the situation is extremely stressful. (McLaughlin & Braun, 1998) In 1990, about 1.4% of Chinese Americans 65+ lived in nursing homes, compared to the overall rate of 5% for all Americans 65+ (McBride, et al., 1996).

(Additional References for Treatment and Utilization Sections: Dai & Dimond, 1998; Jung, 1998; Lum, 1995; Tseng & Wu, 1985; Yee & Weaver, 1994; Yeo & Gallagher-Thompson, 1996; www.nccc.org/pdf/Registries/monographs)

INSTRUCTIONAL STRATEGIES

In addition to lecture and reading assignments, the following cases can be used for discussion or written assignments.

CASES

Case Study 1: A 65 year old Chinese woman who immigrated to the U.S. in 1995 to live with her eldest son and his American wife is brought in for a one week history of malaise, nausea and vomiting, and sudden jaundice. She is admitted to the hospital where diagnostic studies reveal an obstructive mass in the liver. Biopsy reveals hepatocellular carcinoma. Serologies show chronic active hepatitis B status. As the attending physician, you ask the son to help translate and break the news to his mother that she has cancer. He is very concerned about his mother's diagnosis and prognosis, but asks you not to tell his mother that she has cancer. You feel that it is important that the patient know her diagnosis, but he is firm that he does not wish his mother to know this. Despite his wife's recommending that she be told, he refuses. You try to discuss end of life issues such as hospice care and “do-not-resuscitate” (DNR) orders, but when you bring up these subjects, he tries to discuss other issues such as when can she go home.

Cultural Issues that may be involved in this case:
1. Protection of elderly
2. Karma - discussing an illness or death/dying is bad luck. By talking about something bad, it may come true.
**Case Study 2**: Mr. W. is a 75-year-old Chinese-American male who presents with vague and multiple physical complaints he reports he has had for several weeks. Prior to this he had been in good health and would come in only for periodic physical exams. His son tells you he has been complaining of “heart pain”, indigestion, and weakness. He had been seeing the herbalist, but has continued to complain to his son. The patient does not speak much English and his son interprets for him. During the interview you find out that Mrs. W., his wife of 50 years, died last year. His son is busy and sees him about once a month and will be moving to a job in another state. Your exam, laboratory and diagnostic tests are normal. On a return visit, you bring up the possibility that Mr. W. may be depressed. The son and the patient get very upset and vehemently deny any depression. The patient states that he is sick, not crazy.

Factors contributing to the patient’s and his son’s reaction:
1. Somatization
2. Saving Face
3. Filial Piety
STUDENT EVALUATION

QUESTIONS/ANSWERS FOR OBJECTIVE TEST:

1. The majority of Chinese in the US currently live in the following 3 states - California, New York and Hawaii. True or False?: Answer: True

2. List 2 belief systems that have had major influences on Chinese character and behavior:
   Answers: Confucianism, Yin/Yang, Buddhism, Taoism

3. Which is less prevalent in U.S. Chinese as compared with US Whites?
   a. Liver Cancer
   b. TB
   c. Alcoholism
   d. Suicide in elderly Chinese women
   Answer: C

4. The majority of Chinese immigrants in the mid 1800's were primarily skilled laborers, who settled in California and Hawaii. True or False?
   Answer: False

5. Acculturation into American/Western Society has led to a decrease in the incidences of prostate/breast cancer, hypertension and cardiovascular disease among Chinese immigrants. True or False?
   Answer: False

7. In traditional Chinese society, which of the following are true.
   a. Individualism is encouraged.
   b. Respect and protection of elders is valued.
   c. Obedience to authority is expected.
   d. saving "face" only relates to a person not bringing on embarrassment or shame to his/her self.
   Answer: b, c

7. Many Chinese-Americans, although they may have adopted Western culture and ways of life still retain traditional Chinese values to some extent? True or False?
   Answer: True
8. List 3 issues that could act as obstacles when discussing illness or death with Chinese patients.

Answers:
"karma" – discussing bad things may make them come true
protection of elders from bad news
consideration of possible decision making hierarchy that may be present in Chinese families: father, eldest son
language barriers
mistrust

9. In traditional Chinese society, somatization was an acceptable method of expressing emotional turmoil. True or False?

Answer: True
REFERENCES AND RESOURCES


INTERNET RESOURCES

http://www.fcmsdocs.org/7healthstatus.html

http://www.goldsea.com/AAD/population


http://www.mentalhealth.org/cre/

http://www.nccc.org/pdf/Registries/monographs
**Appendix A**

**CHINESE AMERICANS:**

**SIGNIFICANT DATES AND PERIODS IN IMMIGRATION AND HISTORY**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>PERIODS AND EVENTS</th>
<th>U.S. POP. (in 1000's)</th>
<th>RATIO OF MALES : FEMALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1850 - 1860</td>
<td>Sojourner male immigration from Southern China to Gold Mountain</td>
<td></td>
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<tr>
<td>1870's</td>
<td>Brutality and violence; discriminatory legislation</td>
<td>60</td>
<td></td>
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<tr>
<td>1879</td>
<td>California Constitution adopted with anti-Chinese provisions</td>
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<tr>
<td>1880</td>
<td></td>
<td>100</td>
<td></td>
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<tr>
<td>1882</td>
<td>Chinese Exclusion Act banning immigration of Chinese laborers</td>
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<tr>
<td>1882 - 1920</td>
<td>Declining immigration; decline of agriculture, mining, and railroad occupations; rise of urban service occupations; immigration of &quot;paper sons&quot; and &quot;treaty merchants&quot; through &quot;the Shed&quot;</td>
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<tr>
<td>1890</td>
<td></td>
<td>101</td>
<td>27:1</td>
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<tr>
<td>1900</td>
<td></td>
<td>90</td>
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<tr>
<td>1900 - 1930</td>
<td>Rise of family associations and &quot;tongs&quot; (secret societies)</td>
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<tr>
<td>1910</td>
<td></td>
<td>72</td>
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<tr>
<td>1920</td>
<td></td>
<td>62</td>
<td>7:1</td>
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<tr>
<td>1924</td>
<td>Immigration restrictions eased slightly</td>
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<tr>
<td>1930's</td>
<td>Pearl Buck novels portray Chinese peasants as heroes resisting Japanese invasion; &quot;mutilated families&quot;</td>
<td>75</td>
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<tr>
<td>1940 - 1946</td>
<td>16,000 Chinese Americans served in Armed Forces</td>
<td>78</td>
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<tr>
<td>1943</td>
<td>Repeal of all 15 Chinese Exclusion Acts; quota set at 105 per year</td>
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<tr>
<td>1946</td>
<td>Law passed allowing &quot;alien&quot; wives to immigrate</td>
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<tr>
<td>1947 - 1952</td>
<td>Over 9000 wives immigrated; increased educational attainment; continued discrimination; high birthrates</td>
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<td>1950's</td>
<td>Cold War, two Chinas; fear of Communist threat from Chinese Americans; half of Chinese Americans are American born; increased acculturation</td>
<td>107</td>
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<tr>
<td>1953</td>
<td>Refugee status available for 2000 if approved by Taiwan government</td>
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<tr>
<td>1960's</td>
<td>Continued discrimination in unionized employment</td>
<td>237</td>
<td>1.1:1</td>
</tr>
<tr>
<td>1965</td>
<td>New Immigration Act passed, persons with kin in U.S. favored</td>
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<tr>
<td>1970's</td>
<td>Two Chinese American communities: one suburban, well-educated; the other with little education and low income; immigration of Chinese from Vietnam</td>
<td>436</td>
<td></td>
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<tr>
<td>1980's</td>
<td>Image of &quot;model minority&quot;; heavy immigration from mainland China, Hong Kong and Taiwan including older adults</td>
<td>812</td>
<td></td>
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<tr>
<td>1990</td>
<td></td>
<td>1,079</td>
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</table>

(Source: Yeo et al., 1998)