

Narrating in Difficult Times

Introduction to a Dual-Self Model

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ABSTRACT: In times of difficulty, people rely on their narrating self, not only to release what they are going through but, more importantly, to express an intention of how they want to live given the presence of a particular problem, thereby living accordingly upon that intention. The Narrating Self is not the problem solver. Instead, it is the living supporter.

KEYWORDS: narratives, narrating self, experiencing self, living with the problem, intention

There is an abundance of heroic narratives about extraordinary lives overcoming an extraordinary situation. Some people, however, are not fortunate enough to escape from it, no matter how hard they try. That is when the Narrating Self surfaces in them to help themselves explore alternative ways of looking at the situation, and in the end, arriving at a particular way to explain the situation to themselves and others. This particular way gives what Jerome Bruner call “illusions of (the) reality” (Bruner 2002, 11), in which the extraordinary situation appears to be “unproblematic” to their everyday life. Whether the story told by the Narrating Self is verifiable or not does not matter much to them. What matters to them is whether or not the Narrating Self offers a story that is believable and acceptable to them and others within their culture.

1. Everyday Life

Everyday life is an important context to understand how the Narrating Self works. According to Peter Berger, it is “a reality interpreted by men and subjectively meaningful to them as a coherent world” (Berger and Luckmann 1967, 24). Firstly, everyday life is “subjectively meaningful” because it is “an exercise of our subjective preferences” (Vu 2018). What one likes over others, what he chooses over others, and the meanings he sees in that choice create a personal lifestyle of his own, an “integrated set of practices” (Giddens 1991, 82). One’s lifestyle is, therefore, personal and very different from one another. Secondly, that lifestyle provides him with a “certain unity– important to a continuing sense of ontological security– that connects options in a more or less ordered pattern” (Giddens 1991, 82). Thirdly, thus, his everyday life reflects not only what he does and what he values, but also what he is through the choices he makes to create his style of living. Once it is established in everyday life, the lifestyle not only “fulfil[s] utilitarian needs” but also “give[s] material form to a particular narrative of self-identity” (Giddens 1991, 81), which is a “coherent world” of his own.

For the reasons above, it should not be surprising that one is sensitive to any sign of deviation from that lifestyle, especially an “extreme transition” (Berger and Luckmann 1967, 23) that may “pertain[s] to a different reality altogether.” When one cannot avoid such a situation, which Berger calls “non-everyday experience,” he would find possible ways to solve and overcome the situation. What happens to him if choices for solutions are not available, the choices available are too difficult to make, or are not within his reach? Berger suggests a distortion of that difficult situation by using “the common language” to make the situation appear “unproblematic” again and “translate” the “non-everyday experience back into the paramount of everyday life” (Berger and Luckmann 1967, 26). And it is the work of the Narrating Self, and through this Narrating Self, that “we negotiate every day our preferences, that is, the meaning we attach to a given behavior of ours as it interacts with others, with the environment in which we behave, *and* with the other things we do” (Vu 2018). Bruner offers a virtually parallel argument. Narrating is an “astonishing narrative gift” (Bruner 1998, 95) to human being for its “peacekeeping functioning” through “presenting, dramatizing, and explicating the mitigating circumstances surrounding conflict-threatening breaches in the ordinariness of life,” (Bruner 1998, 95) hence he can “domesticate [a problem], to get things back on a familiar track.” (Bruner 2002,

89). The Narrating Self, in sum, makes it easier for us to continue living even when there is no obvious way for extricating ourselves from the difficult situation.

2. A Dual-Self Model

In our view of a Dual-Self, we call attention to another Self, which necessitates Narrating Self in the first place.

The Dual Self Model includes the experiencing Self and the narrating Self. The model postulate that people, when experiencing a problem to which there is no solution (yet), rely on their narrating Self – their capability to imagine – to explain the situation in order to comfort their living with the problematic experience. Good examples of such experiences include people living with terminal illnesses, people living in high risk-prone areas, disabled people, to name a few.

Paradigmatic Mode and Narrative Mode

We build the Dual Self Model making use of Bruner’s two modes of thoughts (Bruner 1986). The two modes of thought, the paradigmatic mode and the narrative mode, provide “distinctive ways of ordering experience, of constructing reality” and they are not necessarily “irreducible to one another” (Bruner 1986, 11)

The Narrating Self relies on both to explain the problem that the Experiencing Self is going through. When in the paradigmatic mode, the mode of science, the Narrating Self relies on existing paradigms, “universal truth conditions” that “transcend the particulars,” (Bruner 1986, 12) for logical explanations in the attempts for according solutions to a problem. With the flourish of science, technology, and expertise, the paradigmatic mode of thought prevails and dominates the Narrating Self, even for his daily concerns. From vocational training to higher education, education reinforces that mode. One’s personal experience is now explained and governed by “modes of technical knowledge which have validity independent of [those] who make use of them” (Giddens 1991, 18). One immediate consequence of the dominance of this paradigmatic mode is: one becomes less autonomous over his own experience. Once the mode of thought cannot help him explain the problem, he is at a loss.

The Narrative mode, on the other hand, is an act of particular individuals, their particular intentions (needs, wants, goals, and desires) and particular meanings that the individuals produce. It is important to note that the Narrative mode does not necessarily stand in opposition to the Paradigmatic mode. People rely on this mode to explain to themselves events that are “ambiguous and resistant to paradigmatic efforts to understand them” (McAdam 1993, 29). Another distinction between the Narrative mode and the Paradigmatic mode is that the former “exhibit[s] an explanation” while the latter demonstrates the explanation” (Polkinghorne 1988, 21). The function of the Narrative mode is, while not trying to deny the actual problem that the Experiencing Self is facing, “to find an intentional state that mitigates or at least makes comprehensible a deviation from a canonical cultural pattern” (Bruner 1998, 49-50). By coming up particular ways to connect different, discontinuous, or even conflicting, events, the Narrative Self places the problem in a different structure, a meaningful one, to create what Bruner calls a verisimilitude – a truth-like story (Bruner 2002, 11). Although the verisimilitude is, in a way, an “illusion of reality,” it appears more real to people because the materials for their stories are from the culture (religion, belief, folklores, among others) to which they belong. Within that culture, this “illusion” is shared, accepted, and sympathized, and therefore, it is closer to home than the reality itself.

In addition to that, one “accomplish[es]” identity, according to Mc Adam, only through the narrative mode. The mode integrates differences, and even conflicts, either synchronically (e.g., when I am at home, I am a quiet person, but when I am outside with friends I can be very hyper) or diachronically (e.g., I used to want to become a doctor, but now I am a social worker), and places them “as integral parts of the same self-configuration” (McAdam 2001). The narrative mode “situates him or her into a meaningful psychosocial niche and provides his or her life with some degree of unity and purpose” (McAdam 2001).

The Dual Self model

In our Dual Self Model (Figure 1), while the Experiencing Self is emotional and unstable due to the problem that it is experiencing, the Narrating Self is the more stable one. The Narrating Self, through acts of verbalizing (e.g., talking, writing, or thinking), constantly converses with the person, thinking for him, discussing with him, or representing him to talk with others about the experience. The Narrating Self not only tells about what the Experiencing Self is going through but also tells the person's intention of how he wants to look at the experience. Narrate, as Bruner reminds us, derives from both “telling” (*narrare*) and “knowing in some particular way” (*gnarus*) – the two tangled beyond sort” (Bruner 2002, 27). This intention is his stable plot in explaining the experience, and giving a direction for his living everyday life, despite the ups and downs of the Experience. A “line” (quoted in Iyanga 2010, 20) would accurately summarize “points”: “we live entirely ... by the imposition of a narrative line upon disparate images, by the “ideas” with which we have learned to freeze the shifting phantasmagoria which is our actual experience.”

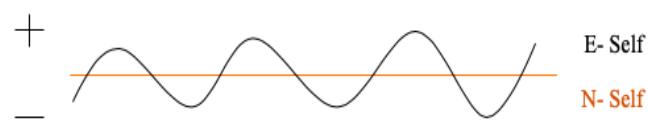


Figure 1. *The Dual Self Model*

3. The Narratives from the Field

Phu Cat is a vast District with a small population in a central-coastal Binh Dinh Province, Vietnam. The U.S. sprayed a large quantity of Dioxin-yielding herbicides in the area during the Vietnam War, and turned it into one of the three “hot spots,” along Bien Hoa further to the south and Da Nang to the north. The District has also witnessed a large number of health abnormalities among the residents of postwar generations. During the observation, we have interviewed over 100 families that have at least one child with disabilities (they are casually called Dioxin/Agent Orange victim families), half of whom we keep close contact with. We interviewed many of these families multiple times, which helped us decipher the hidden and sub-textual messages in the families’ narratives.

Narrative 1

Tu is 26 years old. Her medical condition can be casually described as follows: deformed face, speech impediment, limited perceptibility, inability to perform daily activities. Tu is entirely dependent on her parents and siblings for her daily activities. When her family members have other obligations elsewhere, they need to lock up Tu inside the house. We went back to visit the family on the afternoon of August 2018 (we have frequented our visit at least once a year since we first knew the family in 2016). Thuan, Tu’s younger sister, then 17 years old, in her final year at high school, was the only one at home with Tu at the time. During the chat, we dropped a casual question, “are you willing to take care of your sister later?” “Of course, I will,” without any hesitation, Thuan replied and added, “My sister (Tu) has shouldered the burden on behalf of our family. That burden could have been on any member of our family.” Fate narratives from families of similar situations are familiar to our ears after years of researching this area: “It is our Fate [to have a disabled child.]” This time, we found a new twist to this line of narrative. Having a disabled member in the family, without doubts, is a burden, financially and mentally, for the family, especially when the burden is not shared beyond that family network. From what the younger sister told us, the problem was not Tu with her disability. The problem was the disability that was believed to be imposed on her family as a whole. Given that, Tu “shouldered the problem” for her family, and she became what she is- disabled. In the eyes of the family, Tu is not a burden. Instead, she is their *heroine*, *their savior*, and for that, Thuan, and

probably the whole family, finds it natural and obvious in their obligation to take care of Tu in order to return the “debt” they owe her.

Narrative 2

Nga (47 years old) and Phuong (46 years old) are neighbors at Cat Hanh commune (Phu Cat District, Binh Dinh Province, Vietnam). Both are mothers to two disabled sons, Thai – 14-year-old, brain-damaged and epileptic seizure, and Hoang – 13-year-old, diagnosed with down syndrome (although his conditions looked worse than that). On February 20, 2019, we visited the two families the first time. The two mothers told us uncanny (to us) narratives of how they “domesticated” their extraordinary experience of living with their disabled son.

At Nga’s household (9 am): *“It (having a disabled child) is Fate. But it is good that he is healthy and can communicate verbally. That family (she referred to the other mother Phuong) also has a disabled son, but unlike Thai, their son can’t speak, and no one can’t understand what he wants.”*

At Phuong’s household (1:30 pm), about 5 minutes away by car from Nga’s house. *“What else can I do, my son’s life is numbered [...] Everyone has to keep an eye on him all the time. No one can reach him. He even destroys fruit offerings in the family altar [...] But I am still lucky that my son is healthy, he doesn’t get sick that often.”*

During the two hours we spent with each mother at their households, each shared with us many episodes in raising their disabled sons, e.g., the despair when they found out their sons were not only sick but disabled, the pain when signs of abnormalities became more evident as the boy grew, and the humble joy when they said *“but he can write letter 0,” “he can at least walk,” “he actually understands what I say.”* The most striking to us was the way they both cleverly crafted their experience by giving a whole new meaning to the notion “disability.” *“It is good that he is healthy,”* said mother Nga. *“I am lucky that he is healthy, he doesn’t get sick often,”* said mother Phuong. By “healthy” and “doesn’t get sick often,” they meant their sons were rarely in situations where emergency treatment (like rushing them to hospitals) was required.

“Disabilities,” once sentenced by medical experts as *“incurable,” “no way out,”* now also embrace *“healthy,” “good,”* and even *“lucky.”* The local medical experts gave up on their sons for not being able to remove their acute health problems. Other social institutions (e.g., rehabilitation centers, special schools) are not available to help them become less disabled. These mothers, out of despair, learned how to make their children, if not less disabled, improve with their own ways. Mother Nga even made an extra effort to make the condition of her disabled son look *better* in her eyes by referring to the son of Phuong – her five-minutes-drive-away neighbor, *“their son can’t speak, and no one can’t understand what he wants.”*

What is interesting is that the two mothers were very consistent in how they narrated about their son even on our second visit (August 2019), half a year since the two sons were sent the weekend class¹ that we opened for children with disabilities in the area.

Mother Nga: *“That boy [the son of Mother Phuong] may be calmer [than my son] but he doesn’t know anything.”*

Mother Phuong: *“What is good about this boy [her own son] is that he is more mature than that boy [Mother Nga’s son]”*

¹ We began the project in 2012, making use of classrooms at weekends at local primary schools and relying on scores of volunteer teachers from the same schools to offer basic training (writing, math, singing, physical training, and socializing) for the disabled children. The purpose was to secure space and time for disabled children to develop sociability, and medical treatment is not in its scope of activities. The children attend this weekend class, *Lop Hoc Uoc Mo* (Dream Class, as the volunteer teachers call them) once a week. We have four classes in four communes, and more are on the way.

This time, not only mother Nga, but also mother Phuong uses the similar comparative trick (“*calmer*”, “*more mature*”) to create “illusions” of their disabled sons. We did not detect any bad intention towards each other in the way they narrated. They were simply searching something “better” in their own sons.

4. The Narrating Self

“It is Fate,” “He is really good. He can understand what I said,” “he doesn’t get sick often,” “his conditions are still better than others.” We heard these same or similar narratives about Thai and Hoang also among other parents of similar situations. The narratives, for one thing, are not necessarily meant to counter the “sentence” indicted by the medical doctors – the experts – who once told them: *“there is no cure.”* To these parents, medical doctors are the authority that they have no means to challenge but trust them. The only concern they have is the truth from these experts is far too disruptive to bear, as Yen (35 years old), the mother of a 10-year-old down-syndrome boy, said, *“the whole world crumbled at our feet. My husband and I trembled so hard that we could barely hold our baby,”* after they were told by their doctor, *“even in the world, there is still no cure for the ailment that your son has.”* Like the mothers of Hoang and Thai, she said, *“but he is a good son. He can eat anything, and he can understand what I tell him.”*

The “other meanings” that Yen and the other mothers used to describe are truths that cannot be verifiable. They are the “*illusions of reality.*” Nonetheless, they seem more real to their everyday life, and more importantly, they help their living with the problem a little easier. The illusions, obviously, cannot fix the health conditions of their children, but they show an immediate efficacy: the parents feel better and relieved. Having a disabled child makes the parents an outlier in their clan and their community, but the belief that having a disabled child is the pre-determined arrangement of Fate makes their mishaps comprehensible and the cause for sympathy in the community. For the case of Tu, her sister’s narrative about Tu receives not only sympathy, but also the worship for her “*sacrifice.*”

The enormous disruptions to families with disabled members are not only about the adjustments in their lifestyle but also the adjustment in the hope they have about the future. There is a simple acceptance of social norms to have “expected utilities” of having a child in “normal” families: entertainment, security, and labor (Leibenstein 1974). They see children as an investment to hope for returns in “labor and security” in the future. Having disabled children closes the door to that hope, and leaves them with new insecurity, *“who will take care of him/her when we go?”* The Narrating self, by keeping the meaning of living from falling out of the boundary of everyday life, provides them with a “sense of unity” by integrating different and conflicting events in their life. It cleverly guides people’s attention from the disruptive truth “disabled therefore...” to myriads of possibilities of “disabled but...” narratives: “disabled” but “not get sick”, “disabled” but “healthy”, “disabled” but “I feel good/lucky”, “disabled” but “she saves our family.” The narratives are beyond those of verification and rationalization, and, as said above, cannot change the disabled conditions of their children. Nonetheless, they offer possible ways of looking at “disability” for the families and navigate the experience to the new realm of different and new meanings. Whether their narratives are true or not matters less to the families. What matters is what they believe to be true, and they need to rely on these “illusions” to make the experience less problematic and keep their living still consistent and continuous within the totality of everyday life.

5. The breeding ground for their narratives

One question: why do people need to create “illusions of reality” for themselves? Is it because of the despair of having a child with disabilities or the despair of having no way to help him/her? The answer lies in the latter in the cases we found in Vietnam.

Since the end of the 1980s, Vietnam has recorded remarkable economic development, with an annual growth rate always in the neighbourhood of 7% to 9%. Public spending on social services has also increased accordingly. However, the development has come with the usual distribution problems such as the widening income gap, especially before its trickle-down effects begin to spread and with a

delay in the improvements in particular social services, despite the increased spending for them. It mainly affects the wellbeing of the people with disabilities in two ways: the delay makes the available services far short of satisfying the needs of the disabled and deprives the disabled and their families of the motivation and opportunities to test the efficacy of their actions aimed at improving their wellbeing.

In 2010, Vietnam *Law on Persons with Disabilities* was introduced. The Law addressed the needs of the disabled in a comprehensive framework. It aims to promote the health and wellbeing of persons with disabilities in the areas of healthcare, education, employment, and a barrier environment for this disadvantaged group, in addition to money provisions to those with severe disabilities^[1] and also their caregivers. However, the reality for the disabled has fallen far short of Vietnam's ambitions, at both the national level and local level.

At the national level, the value of social assistance transfers in Vietnam remains small (only 6.7% of GDP per capita compared to 15% in other developing countries) with only limited impact on the wellbeing of the beneficiaries (Kidd et al. 2016, 51-52). As of April 2019, 1.5 million persons with severe disabilities and *exceptionally severe disabilities*² are provided with disability certificates, among whom 1,012,923 persons are provided with a health insurance card (VJSI 2019). Nonetheless, the increase in health insurance holders has only a limited effect on their *use* of public health services, e.g., only 2.3% of the children with disabilities make use of rehabilitation (GSO 2016, 17). A couple of reasons include the bureaucratic system of health insurance, the quality of public health services, and the competition of private health services.

Regarding education for children with disabilities, Education Law (2005, Vietnam) states that “the State shall give priority in enabling children of ethnic minorities, children of families in the areas with special socio-economic difficulties, targeted groups of socially prioritized policies, disabled and handicapped persons and beneficiaries of other social policies to realize their learning rights and obligations” (Education Law. Article 10). The message is unequivocal that health and other conditions of the concerned children are not the basis of their exclusion. The impact was immediate. The number of children with disabilities who began formal education jumped. 107,500 (at regular and special schools) at the school year 2003-2004 increased four times in 2008-2009 school year to 397,500 (390,000 at regular schools and 7,500 at specialized training facilities.) (DSA 2013). The most updated data from the Survey on Persons with Disabilities shows that the enrolment rate at the primary school is 88.7% (GSO, 19).

However, these enrollment figures conceal another significant indicator of the reality of inclusive education. The dropout rate among students with disabilities is alarmingly high at the primary and secondary levels, more than 30% (Tuoi tre 2015). This poor performance at school prevents them from benefiting from an important utility of education: employment. 61% of the disabled Vietnamese people are in the working-age, but only 40% of them can work and, of them, only 30% work (MOLISA 2016).

Locally, as of December 2017, 31,311 people are recognized and provided with disability certificates (excluding the mild cases, approximately 3000, 11 % of the total) in the Province of Binh Dinh, wherein Phu Cat is the District that has the highest number of people with disabilities – 4, 298 persons (who are recognized as such and receiving disability certificates). Most of the cases we visited have disability certificates, health insurance cards and monthly allowance ranging from 405,000 đồng (roughly \$20) to 675,000 đồng (\$32), depending on the severity of the disability. The process of determining the severity of disability³ does not necessarily correspond to the actual severity of disability of the person, nor the income level of the families. The intricate processes dictating the determination involve political, social, and even personal considerations.

² A Disability Degree Determination Council at local level (as regulated by Law on Persons with Disabilities in 2010 in its Article 16, Clause 2) includes only one medical specialist from Commune-level health station, one from commune-level People's Committee; a Commune official in charge of Labor, War Invalids and Social Affairs, head or deputy head at the commune-level of Vietnam Fatherland Front Committee, Women's Union, Youth Union and War Veterans' Associations, and the head of the Commune-level organization of persons with disabilities in the locality in which such an organization operates.

Regardless, the way the families utilize medical services has not seen any significant change over many years. No families have reported a regular clinic visit for the physical or mental deficiencies of their children. There is a pattern across these families: they spent much money (for transportation and medical fees) soon after they found out their children had some severe health issues. A few of them trekked the upward path of medical examination, from a nearby Commune Clinic to the District Health Center (3~10km away), to the Provincial hospital in Qui Nhon (30~40km away), and finally to Ho Chi Minh (650km away). At every step, the family has to hold back hope for a medical solution until they reach higher institutions. Their hope stops altogether after they are told: “there is nothing we can do.” The upward movement along the hierarchy of medical establishment usually comes with a greater disappointment for the disabled children’s parents.

The use of educational services fares no better. The families of disabled children and even local medical staff have difficulty seeing the point of investing time and resources for the future of the children with disabilities. During the first round of our research in 2004 and 2005, one repeated scene caught our attention: among all of the families we visited, none of the children went to school, even though some of them exhibited signs of learning ability. All of them stayed at home, doing nothing but hanging around with neighbourhood children, if the latter were home. Within the past five years, however, we noticed that there were more children with disabilities who had been to regular schools. In our weekend class project for the disabled,⁴ there are currently 71 students, of whom 25 have gone to regular schools, but only 4 are still going. Of the 21 who dropped out, 1 stayed on until ninth grade before dropping out, 6 quit soon after finishing first grade, 4 quit after fourth or fifth grade, 10 do not remember when they quit. The cost of sending the children may not have been high. However, if that choice produces no gain, the cost is still the cost. Many parents also do not hang much hope on the possibility that their children can receive any form of support to remedy even a fraction of their physical or mental deficiencies at regular school. Schools are disabled children’s local “hangout” in much the same way as their neighbourhood yards and alleys.

Regarding vocational training, none of these disabled children we met go to vocational school for the apparent reason: there is no such school in the area and anywhere near it. Nearly all of the disabled children stay home and grow up under the care of their parents and family members. If not bed-ridden and mentally sick, girls help mothers making straw hats at home, and boys help fathers with cow herding. The families just let the children do things “for fun.”

Having no means to overcome the problem, the children with disabilities in this District become complete dependents on their families. Poverty at the households that we visited is often times an attribute to their difficult situations. However, it is the poverty of choices (for this particular group) that put hopes of their families in desperation for not seeing the future in their child. The poverty of choices in this case is an illustration of the statement made by former British Secretary of State for Health, Alan Johnson: “the causes of poor health are not so much about the choices people make but the choices that they are able to make” (Quoted in Upton & Thirlaway 2010, 356).

As a consequence, the parents see their children with disabilities no other than an object of care, a loss for which other healthy siblings compensate. They have no choice but rely on their own family for the responsibility of taking care of the disabled child, and pass down that responsibility to other siblings of the disabled child. However, many of their (healthy) children have left the main house for other cities, either to get married or to work. “Who will take care of my child when we are gone?” This is the nagging concern that continues to gnaw at many of these parents. What is left for them is to rely on the Narrating Self for “illusions” of this harsh reality to make it easier to live with the consuming responsibility while no social and/or medical solution is within their reach.

6. Conclusions

Our Dual Self Model is still at its early stage. Our ambition is to develop it into a tool for field research in order to understand how people deliver their everyday life given a particular problem, and how their living environment influences, for better or worse, influences their living. An inquiry into

⁴ See fn.2 above

why they tell us the way they do would help researchers overcome biases against what people tell them even when it seems absurd and irrational. *Why they tell us the way they do* needs to be analyzed at the three world evolving people's everyday life: the social world, the cultural world, and the idiosyncratic world. The social world is the world of choices- what is (not) there for them to fall back on when they run into a problem, the constraints in this world feed the need for Narrating Self to take action. The cultural world is the world of “canonical norms” (Bruner 1998, 52) that offers “tool kits” (Bruner 1998, 12), or scripts for the Narrating self, but at the same time the norms in this world also limits the freedom to tell its own story of the Narrating self. Lastly, the idiosyncratic world is the world of individual intentions (beliefs, desires, wants, needs, goals) (Bruner 1998, 52). The three worlds interact with each other, conflicting each other, shaping each other, and together they create a narrative identity for the person. The analysis of people's living at the three levels is believed to provide essential feedback for policy-making schemes.

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