

Meeting the Unique Needs of Asian Americans and Pacific Islanders with Disabilities: A Challenge to Rehabilitation Counselors in the 21st Century

Nan Zhang Hampton

Abstract - This article focuses on the unique rehabilitation needs of Asian Americans and Pacific Islanders (AAPIs) with disabilities. The prevalence of disabilities among AAPIs is reviewed based on the available data in the literature. Cultures of AAPIs and barriers preventing AAPIs with disabilities from seeking or receiving vocational rehabilitation services are discussed. Recommendations are presented on how to improve vocational rehabilitation counseling services in the 21st century for this underserved population.

Asian Americans and Pacific Islanders (AAPIs) are one of the fastest growing minorities in the U.S. From 1990 to 1999, the population of AAPIs has increased by 57%, proportionally more than any other minority group in the U.S. (U.S. Bureau of the Census, 1999). In some states and metropolitan cities (California, Hawaii, New York, etc.), AAPIs constitute a considerable proportion of the total population. It is projected that, by the year 2050, the total number of AAPIs will reach 34 million which is 9% of the total population (U.S. Bureau of the Census, 1999).

The term AAPIs represents a heterogeneous group. It comprises people from many cultures (e.g., Chinese, Filipino, Hawaiians, Indian, Japanese, Vietnamese, etc.), several religious groups (e.g., Buddhists, Catholics, Hinduists, Protestants, Taoists, etc.), and various socioeconomic levels, with different levels of English proficiency and acculturation (Leung & Sakata, 1988). The immigration patterns of AAPIs in the U.S. also vary widely. For instance, Hawaiians are native to this land. The Chinese, mainly male peasants, were brought to the U.S. as labors in the mines and railroads at least 150 years ago and their families were not allowed to immigrate with them for a long time because of the Chinese Exclusion Act (the law was abolished in 1965). The majority of Cambodians, Laotians, and Vietnamese came to this country in the 1970s as refugees of the Vietnam war (Inouye, 1999).

In contrast to the fast-growing rate of AAPIs, very little research has been conducted on the prevalence of disabilities among AAPIs and the rehabilitation needs of this population. A decade ago, Leung and Sakata (1988) described the discrimination against AAPIs in American society and discussed the cultural differences within AAPIs and between AAPIs and Whites. They called for recognition of the problems facing AAPIs with disabilities. Since then, we have seen some positive changes in the society's attitude towards AAPI and resultant improvement in providing social services to this population. However, many problems discussed by Leung and Sakata (1988) remain unsolved. For instance, AAPI were excluded from the Current Population Reports - Americans with Disabilities: 1994-1995 (McNeil, 1999) published by the U.S. Bureau of the Census. This report summarized differences in the prevalence of disabilities among Whites, African Americans, and Hispanic Americans, but failed to report the prevalence of disabilities among AAPIs and Native Americans.

Although rehabilitation agencies in major metropolitan cities such as Boston, Honolulu, Los Angeles, and New York have adopted specific outreach methods to reach AAPIs consumers and some have hired bilingual counselors

who speak one of the Asian languages (Walker, Saravanabhavan, Williams, Brown, & West, 1996), it is difficult to determine the magnitude of the success of these agencies in providing services to AAPIs with disabilities. This difficulty derives from the lack of the information regarding the number of AAPIs with

disabilities served by the state-federal rehabilitation system and the percentage of successful closure among these clients. Like other researchers (e.g., Walker et al, 1996), the author of this article had approached state departments of vocational rehabilitation and the Rehabilitation Services Administration in Washington, DC for data in this regard, but was unable to obtain a positive response.

Based on what we know in the current literature, it appears that AAPIs with disabilities have been underserved by the state-federal rehabilitation system. For example, a qualitative study on 43 Chinese Americans with disabilities

indicated that Chinese Americans with disabilities wanted to work but they did not know where they could get help (Hampton & Chang, 1999). Although state rehabilitation agencies have provided services to AAPIs with disabilities, the numbers of AAPIs with disabilities being served by the state-federal vocational rehabilitation system are not in proportion to the population (Woo, 1991). For instance, in one state AAPIs constitute 8% of the state's population, but only 3% of the total clients served by the state rehabilitation agencies (Woo, 1991).

As we enter the 21st century, we need to develop vigorous strategies to address the underserved problems. The vocational rehabilitation system should take more effective actions to meet the rehabilitation needs of AAPIs with disabilities. The purpose of this article is to examine the prevalence of disabilities among AAPIs, to discuss cultures of AAPIs and barriers preventing AAPIs with disabilities from seeking or receiving vocational rehabilitation services, and to make recommendations on how to improve vocational rehabilitation counseling services for this population.

The Prevalence of Disabilities Among AAPIs

According to the U.S. Bureau of the Census (1990), about 10% of AAPIs had a disability in the 16 to 64 year old age group. Of them, 43% had a work disability (including those with a mobility limitation) and 62% had mobility or self-care limitations. However, the information on the causes of disabilities (e.g., health risks, chronic diseases, impairment, and morbidity patterns) among AAPIs is scarce (Wright & Leung, 1993). Myers, Kagawa-Singer, Kumanyisa and Lex (1995) reviewed the evidence on five health-related risk behaviors: cigarette smoking, dietary intake, being overweight, limited exercise, and alcohol consumption among African Americans, AAPIs, Latinos, and Native Americans. They found limited information on AAPIs. The researchers suggested that the limited information on AAPIs indicated the lack of awareness of health-related problems of this population among policymakers and health care professionals.

Few available data indicated that AAPIs had high incidents of a variety of diseases that may cause disabilities. For instance, the infection rate of Hepatitis B, which may lead to several disabling conditions (e.g., liver cancer and cirrhosis), is much higher in AAPIs (15%) than in the general population (1%; Gall & Gall, 1993; Tong, 1996). Tuberculosis is growing among AAPIs at a rate of five times that of the general population (Walker et al, 1996). The incident of malaria is 11.81 per 1,000 among AAPIs compared with, 15 per 1,000 in the general population (Walker et al., 1996).

The stomach cancer rate is five times higher among Korean American men than the general population (Koh & Koh, 1993). Japanese Americans have twice the rate of diabetes (Type II) as Whites (Myers et al., 1995).

In addition, cigarette smoking is a potential problem among Asian Americans. For instance, three surveys conducted by the Centers for Disease Control and Prevention (1992a, 1992b, 1997) in California indicated that Chinese, Korean, and Vietnamese American men were more likely to be current smokers than were men of other races (28% vs. 21%; 39% vs. 19%, and 38% vs. 22%; respectively), although women in these three ethnic groups showed lower smoking prevalence than did women of other races (1% vs. 18%; 6% vs. 16%, and 1% vs. 19%; respectively). *Further*, several researchers reported that the smoking rate was rising among Asian American youths (Chen, Unger, Cruz, & Johnson, 1999; Zane & Huh-Kim, 1998). Because many disabling conditions (e.g., heart disease and lung cancer) are associated with cigarette smoking, if we do not intervene, the prevalence of smoking-related disabilities among AAPIs may be on the increase in the 21st century.

With respect to psychiatric disorders among AAPIs, the rehabilitation and mental health literatures have not kept pace with this fast growing population. Basic research is lacking on the prevalence of general mental disorders among AAPIs. A few studies indicated that mental disorders among AAPIs are on the rise (Iwamasa & Hilliard, 1999; Roberts, Roberts, & Chen, 1997). For instance, the incidence rate of posttraumatic stress disorder is high among Cambodian and Vietnamese Americans (Calson & Rosser-Hogan, 1993; Kinzie, Bochnlein, Leung, Moore, Riley, & Smith, 1990). Kuo (1984) surveyed 499 Asian Americans in Seattle, Washington and found that the participants had higher scores on the Center for Epidemiologic Studies Depression Scale (CESD) than their White counterparts. Similarly, Tabora and Flaskerud (1994) reviewed the literature on depression among Chinese Americans. They found that a large number of Chinese Americans had increased depressive symptoms measured by the CESD due to the immigration and acculturation processes. Furthermore, the U.S. Department of Health and Human Services (1999) reported that the death rate caused by suicide was 8.1 per 100,000

among AAPI women aged 65 and over, compared with 2.0 to 2.5 among African American women, 2.4 among Hispanic women, and 5.6 among White women.

Although AAPIs were reported having a low rate of substance abuse (Johnson & Nagoshi, 1990; McLaughlin, Raymond, Murakami, & Goebert, 1987), the existing literature is for the most part not an epidemiological one. It is very difficult to rely on the existing literature to attain any picture of the prevalence of substance abuse among AAPIs (Varma & Siris, 1996). Zane and Kim (1995) reported that Japanese and Filipino American men have a high alcohol abuse rate. Harley (1995) indicated that recently immigrated Asian Americans used alcohol and other drugs more than those who had lived in the U.S. for a longer period. Without intervention, the substance abuse rate among AAPIs will increase in the 21st century, given the fact that a considerable proportion of AAPIs is new immigrants from Asia.

Barriers to Rehabilitation and Employment

Leung and Sakata (1988) pointed out that the discrimination against Asian Americans in American society was one of the major problems preventing AAPIs from receiving social services. Eleven years have passed since the publication of Leung and Sakata's article, but the discrimination against AAPIs still exists. The difference between then and now is that the discrimination is often more subtle than overt. In the political arena, the participation of Asian Americans has been hindered by the negative portrayal of Asian Americans in the mainstream media. In the workplace, AAPIs have experienced discrimination more than their Caucasian counterparts (Bell, Harrison, & McLaughlin, 1997). Many employers are reluctant to hire persons with disabilities who have limited English-speaking skills (Woo, 1991). AAPIs with disabilities have reported experiencing racial discrimination in the workplace with respect to work assignments, salary levels, and promotions (Hampton & Chang, 1999).

The second barrier is the myth of "model minority" (Leung & Sakata, 1988). AAPIs tend to struggle with their problems themselves and often do not seek help from the society at large, therefore, they have been given the title of "model minority". Consequently, they are perceived as having overcome social barriers, thus, do not require special attention and aid. In other words, AAPIs are invisible when it comes to social services and other federal or state-funded programs, including vocational rehabilitation services. Have AAPIs really made it? The reality is that a larger proportion (11%) of Asian American compared to 8% of White families were below the poverty line and many AAPIs with disabilities belong to this low-income group (the U.S. Bureau of the Census, 1990). In addition, educational level and poverty status of several subgroups among AAPIs (e. g., Cambodian, Pacific Islanders, and Vietnamese) are the lowest nationally (Bennett, 1992). Without interventions, the high rate of poverty will continue preventing AAPIs with disabilities from full participation in society.

The third barrier is the shortage of trained professional rehabilitation counselors who understand the cultural uniqueness of AAPIs and have the knowledge and skills to work with AAPI clients effectively. It should be noted that increasing attention has been given to multicultural awareness in the rehabilitation counseling field over the past 20 years (Harley, Feist-Price, & Alston, 1996). Multicultural rehabilitation counseling continuing education workshops have been conducted (Rubin, Davis, Noe, & Turner, 1996) and multicultural counseling skill training has been incorporated into the curricula of rehabilitation counselor education programs (Davis & Rubin, 1996). Furthermore, the knowledge and skills of multicultural counseling have been added to the standards of rehabilitation counseling accreditation and certification (Linkowski, Thoreson, Diamond, & Leahy, 1993). However, little is known about the level of multicultural counseling competencies among rehabilitation counselors. Few studies on counselors' multicultural counseling competencies indicated that Asian American and Hispanic counselors reported more multicultural counseling knowledge than did White counselors and that African American, Asian American, and Hispanic counselors reported more multicultural counseling awareness and relationships than did White counselors (Granello & Wheaton, 1998; PopeDavis & Ottavi, 1994; Sadowsky, Kuo-Jackson, Richardson, & Carey, 1996). Further, research indicated that approximately 50% of AAPI clients in counseling were terminated prematurely (Chan, Lam, Wong, Leung, & Fang, 1988; Leung & Sakata, 1988; Marshall, Wilson, & Leung, 1983) and that some AAPI clients were not satisfied with vocational rehabilitation services provided by the state rehabilitation agencies (Anderson, Wang, & Houser, 1993). Given the fact that non-bilingual White counselors constitute a dominant proportion of rehabilitation counselors (e. g., 80% in the state-federal system, Kundu, Dutta, & Walker, 1997) and that a considerable proportion of AAPIs with disabilities does not have English proficiency (Chan et al, 1988; Woo, 1991), it seems

warranted that rehabilitation counselors may have insufficient knowledge and skills to provide effective services to AAPIs with disabilities.

The fourth barrier is the lack of English proficiency among AAPIs. This problem not only prevents AAPIs from understanding the disability-related laws and the service system in the U.S., but also impedes their abilities to develop meaningful relationships or receive support from those outside their ethnic groups. As we know, most support groups or independent living centers use English as the mean of communication. AAPIs with disabilities who do not speak English well may be unable to participate in any activities of these groups. Further, because of the language problem, AAPIs with disabilities may only find jobs in Chinatown, Filipino-town, Japanese-town, or Korean-town where an ethnic language is spoken (Hampton & Chang, 1999; Woo, 1991). Consequently, the opportunity for those people to obtain appropriate employment is limited.

Finally, the lack of knowledge of their civil rights among AAPIs with disabilities is another barrier that blocks the way to success for this population. For instance, Hampton and Chang (1999) interviewed 43 Chinese Americans with disabilities. They found that 77% of the interviewees had never heard of the Americans with Disabilities Act. Of all the interviews, 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. Without knowing their rights and available rehabilitation services, AAPIs with disabilities are unable to protect what they are entitled to and to request needed rehabilitation services.

Cultural Uniqueness

As mentioned earlier in this article, AAPI is not a culturally homogenous group. Each ethnic group has its own unique culture. Even within a single ethnic group, such as Chinese Americans, there are cultural differences due to geographic variations. It is not within the scope of this article to outline every single culture among AAPIs. As an alternative, the author will illustrate the values commonly held by AAPIs across ethnic groups, to delineate the major religions among AAPIs, and to discuss influences of these values and religious beliefs on the process and outcome of rehabilitation among AAPI with disabilities.

It should be noted that the influences of Asian cultures vary significantly in accordance with their rates of acculturation (Chan et al, 1988). Also, every single person in the AAPI group has his or her unique socialization experience which makes him or her a distinctive individual. The response of an AAPI with a disability to the rehabilitation process is strongly affected by the person's degree of acculturation and personality characteristics.

Nonetheless, the most obvious commonality among AAPIs is that they all suffer from racism and other disadvantages of being a minority. Although AAPIs have been migrating to the U.S. for more than 150 years (Leung & Sakata, 1988) and have contributed to the development of this country in many ways, American society did not accepted AAPIs for many years. Whenever the country's economy declines or there is a political dispute, AAPIs are often the scapegoats. Living in such an environment, AAPIs have learned not to trust the authority. The consequence of this distrust reflected on help-seeking behavior is that AAPIs tend not to seek assistance from the authority establishments (e.g., state vocational rehabilitation agencies). They may not even try to advocate for themselves because of the fear of being punished by the authority. "Silence is golden" is a principle that guides the behavior of many AAPIs. When it comes to governmental organized activities, such as the national population census, AAPIs tend not to participate. This may be one of the reasons for the lack of the disability-related information on AAPIs.

In the domain of disability-related beliefs, the cultural uniqueness among AAPIs derives from the philosophy of life and religious beliefs. In contrast to the individualistic orientation of the mainstream culture in the U.S., AAPIs tend to have a collectivistic orientation. They tend to place great emphasis on *filial piety* (meaning loyalty, respect, and devotion to parents), family, and responsibility to the group (Chan et al, 1988; Thompson, 1997). The ability and worth of an individual among AAPIs tends to be determined by his or her contribution to the in-group. Decisions, whatever they concern at the time, tend to be made based on what is best for the in-group, not an individual.

For many AAPIs, having a disability is not just a personal problem. An AAPI with a disability is not only concerned about his or her problems as the consequence of having a disability, but also the impact of the disability on his or her family, that is, whether the disability will affect him or her in the performance of family duties. The person also worries if he or she will become a burden to others and if his or her disability will bring shame to the family. On the other hand, maintaining inner strength under all the circumstances is considered by many AAPIs as an expression of dignity (Lam, 1992). As a result, AAPIs with disabilities tend to rely on their family members or relatives for support before seeking professional help (Lam, 1992). They may also have a stronger sense of involving family members in their rehabilitation plans. However, due to the concept of sacrificing the individual needs for the good of the group, AAPI clients may place the interests of their families above their own interests when they consider possible benefits and barriers of such a plan.

With respect to religious beliefs, three religions have strong influences on AAPIs. The first one is Buddhism which was established by Siddhartha Gautama about 2,500 years ago in India and later spread thought northeastern and southeastern Asia. In the U. S., Buddhism is worshiped by several of the largest Asian American groups (e.g., Cambodian, Chinese, Japanese, Korean, Laotian, Thai, and Vietnamese Americans). Buddhism is concerned exclusively with the human situation and with the sufferings and frustrations of human beings. For example, Buddhists believe in the Four Noble Truths which include: (a) all life is suffering, (b) suffering comes from desires, (c) the cure for suffering is the extinction of desire, and (d) the extinction of desire can be obtained by following a path of right. Because of such beliefs, Buddhists may not give the same weight to some life goals (e.g., financial achievement, business success, and life satisfaction) held highly by American society. On the other hand, Buddhists believe in the doctrine of *Karma*, that is, performing good deeds will earn positive consequences and doing bad deeds will result in negative consequences. From this perspective, having a disability may be perceived as the destiny or a punishment for one's wrong doing in the past.

The second belief is Confucianism which was founded by Confucius who lived in China from 551 to 479 B.C. As a mode of thinking and a way of life, Confucian tradition still provides a standard of inspiration for many Chinese, Japanese, and Korean Americans. Confucian philosophy emphasizes harmony in society. It holds that harmony may only survive in a form of structured hierarchical relationships with the senior member always controlling a wide range of powers and authority with respect to the junior (Chan et al., 1988). Harmony will be achieved when each member of the unit is conscientious in following the requirements of his or her role (Chan et al., 1988). Thus, knowing one's duty as a member under the hierarchical system, being able to eat "bitterness", and sacrificing individual needs for the common good of the group are regarded as the good virtues. Putting one's interest first and complaining about one's situation is considered selfish and childish. The positive influence of this philosophy is that individuals have very strong work ethics that make them very loyal and dependable employees. Yet, Confucian philosophy also has a negative impact on people. Guided by this belief, people often rely on the kindness or mercy of others, particularly those who have powers. They will not even try to advocate for their own rights and benefits. Furthermore, Confucian philosophy emphasizes perfection. Believers of such a concept are usually ashamed of their family members who have disabilities. Parents with such a belief may not record the birth of a child with a disability in family records (Woo, 1991).

The third religion is Taoism which was founded by a Chinese philosopher - Lao Tzu (571 to 471 B.C.). Taoism has a strong influence on Chinese Americans, the largest ethnic group among AAPIs. Taoism emphasizes harmony between human beings and the natural world. The ultimate goal of human endeavor is to maintain the harmony. The universe is perceived as a whole. However, within nature itself there is a gradation of power. The concept of Tao (the rule of the universe) is subdivided into the Tao of Heaven (Yang), the Tao of Earth (Yin), and the Tao of Man (the creature of Yin and Yang). Each of the three parts fits into the other as an indivisible entity (Veith, 1966). Neither of the components ever exist in an absolute state. Within Yang there is contained Yin and within Yin there is contained Yang.

Derived from the concept of Tao, the traditional Chinese medicine considers the mind and body as a whole. It also holds that human beings are composed of both Yin and Yang. In a normal situation Yin and Yang within the body keep a relative balance. This means that the body is free from any *Xieqi* (unhealthy environmental influences) that may cause disharmony. When an imbalance between Yin and Yang occurs, the body is easily affected by unhealthy environmental influence, resulting in people suffering from diseases. From this perspective, a disability resulting from a disease or impairment is viewed as a pattern of disharmony that describes situations of distress or imbalance in a person's body. Healing, therefore, is a process of bringing the configuration into balance so to restore harmony to the individual.

The mental health and rehabilitation literatures indicate that Chinese Americans have a tendency of somatizing mental health problems (Chan et al, 1988; Sue & Kirk, 1973). Investigators suggested that the feelings of denial and shame might be responsible for this tendency (Chan et al, 1988; Sue & Kirk, 1973). However, in two independent studies, one conducted in San Francisco's Chinatown (Loo, Tong, & True, 1989) and another in Shanghai, China (Altshuler, Wang, Qi, Hua, Wang, & Xia, 1988), researchers found that both Chinese Americans in San Francisco and Chinese in Shanghai tended to consider mental problems as organic diseases, meaning attributing the problems to physical dysfunctions. Research findings also indicated that the traditional Chinese health concepts of "wholeness" and balance between "Yin" and "Yang" were the major reason preventing Chinese Americans from seeking Western style of medical and mental health care (Woo, 1991). Thus, an alternative explanation for this somatization tendency is that it may be a reflection of the Chinese beliefs of the wholeness of the mind and body.

Implications for Policymakers

From an ecological perspective, the problem of AAPIs being underserved should be addressed systemically. Policymakers at the federal and state levels should consider making multicultural

research a priority and provide funding for research projects that focus on empowering ethnic minority rehabilitation consumers including AAPIs with disabilities. Policies that encourage state rehabilitation agencies to hire more minority counselors may also be established. For example, the proportion of minority counselors in a state agency and the quality of the agency's minority outreach programs may be used as one of the criteria for service evaluations. Also, the public should have the access to the evaluation results. In the area that AAPIs constitute a considerable proportion of the local population, hiring bilingual counselors should be one of the priorities of the local rehabilitation agency. Also, multicultural counseling competencies may be added onto the criteria for promotions or salary raises of rehabilitation counselors.

Implications for Rehabilitation Researchers

Given the fact that only few empirical data on AAPIs with disabilities are available in the literature, researchers in the rehabilitation field are encouraged to pay more attention to this population. As we know, many policies were made based on research findings. Without research data, we would have difficulty convincing policymakers about the needs of AAPIs with disabilities. Rehabilitation researchers may develop culturally valid assessment tools and conduct studies on the prevalence of disabilities among AAPIs. They may investigate the quality of rehabilitation services perceived by AAPI clients. They may also study environmental and personal factors that affect the success of rehabilitation among AAPIs.

Implications for Rehabilitation Counselors

Rehabilitation counselors play an essential role in meeting the needs of people with disabilities. However, effective services for AAPIs with disabilities need to be designed in ways that match the specific cultural, religious, linguistic, and psychosocial characteristics of these people. First of all, rehabilitation counselors should empower AAPIs with disabilities by providing training or education workshops regarding the Americans with Disabilities Act (ADA) and the rights of people with disabilities in the U.S. They may also help AAPIs with disabilities establish self-help groups and encourage them to self-advocate for their needs and rights. Because many AAPIs with disabilities can only find employment in businesses owned by AAPIs due to the lack of English proficiency, rehabilitation counselors need to reach out to the AAPI business community and provide them with training on the ADA. On the other hand, rehabilitation counselors have to work with mainstream employers to make the work place more inviting to AAPIs with disabilities (Woo, 1991).

Second, in order to work with AAPI clients and their family, rehabilitation counselors need to understand the client's views of life and self. They may need to see their clients' family and assess the dynamics before focusing exclusively on the individual. For example, less acculturated AAPIs may not view themselves as isolated or even isolatable individuals. Rather, self is understood in relationships with others, particularly one's family members. When working with such a client, the participation of family members in developing a rehabilitation plan is not only desirable but absolutely necessary.

Third, many rehabilitation counselors may not know much about Buddhism and the helping role that these temples play among AAPIs. It is suggested that rehabilitation counselors with an AAPI caseload pay a visit to the temples in their communities in order to get first hand experience. They may also establish active interaction with Buddhist associations. A cooperative and respectful relationship between rehabilitation counselors and Buddhist organizations may lead to mutual enrichment which, in turn, will benefit the clients served by both parties.

Finally, Chinese Americans appeared to have difficulty separating mental problems from physical problems. The somatization of mental problems among Chinese is often considered as a denial, which may be true for some clients. However, for others, the belief of "wholeness of the mind and body" may be responsible for such behaviors; therefore, rehabilitation counselors need to be sensitive to these issues and develop appropriate counseling plans accordingly.

Conclusion

The prevalence of disabilities among AAPIs is not fully understood. The lack of data in this area indicates a unique need for further investigations. Nevertheless, AAPIs with disabilities appears to be underserved in the rehabilitation system. It is essential that the rehabilitation system makes changes in order to accommodate this fast growing population in the U.S. The 21st century is full of challenges and opportunities. Let us work together to create an enriched environment in which the needs of all people (including AAPIs) with disabilities will be met.

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Nan Zhang Hampton, Ph.D., CRC is an assistant professor in the Department of Counseling and School Psychology at University of Massachusetts-Boston.