Chapter 3
A Rare Professor: Processing Social Location as a Taiwanese American Male in Academia and Clinical Training

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With feelings of relief, accomplishment, and some exhaustion, I look upon the audience of smiling faces; some words of appreciation, some audience members applauding, and others with inquisitive looks probably momentarily coming to the podium with questions or comments. I have just completed another workshop presentation on cultural humility, a topic I have presented on since the beginning of my academic career. While I know I will present on topics of diversity, multiculturalism, and its subtexts again, I cannot help but think whether this topic picked me or I actively decided to present on such a safe topic. Cultural diversity, multiculturalism, and cultural humility are current and discussion worthy topics in the field of Marriage and Family Therapy. It often brings heated discussion for political correctness and demonstrates our mental health value for inclusivity and equity. As I connect with supportive and enthusiastic colleagues at this national conference, I can't help but feel torn between my passions for this topic of discussion and wonder if being Taiwanese American both privileges me to this research but also limits me to it.

Throughout the history of Asian Americans, there have been many themes of Asian American men being emasculated from a social context perspective (Chan, 1991; Takaki, 1998). The cultural perspective associated with Asian American manliness has been associated with only achievement and financial success. Although mental health professionals have advocated for concepts such as empathy, vulnerability, and emotional connection, little literature focuses on these concepts with Asian American men. Furthermore, one would be hard-pressed to find literature on how to navigate the field of MFT as an Asian American male therapist, partly because Asian American men represent one of the lowest percentages of therapists today (Data USA, 2017). While several publications have focused on working with Asian American individuals (Leong & Kalibatseva, 2011; Shibusawa & Chung,

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2009; Wang & Kim, 2010) and families (Atwood & Conway, 2004; Lim & Nakamoto, 2008; Pandya & Herlihy, 2009), few researchers have concentrated on Asian American men therapist development. Quek and Chen's (2017) qualitative study looked at Chinese therapists (including five males) in training, but from the context of China rather than Western culture. In this chapter, I perceive my role in academia as a program and clinical director for Alliant International University's Couple and Family Therapy program through the lens of intersectionality (Case, Iuzzini, & Hopkins, 2012; Chenfeng, Kim, Wu, & K-M, 2017) between my Taiwanese American culture, gender identity, and social location. The social location under examination consists of structural power stemming from my academic position and of my residential geographic location of Sacramento, California. Through this perspective, I hope to convey an understanding of social location and delineate how I navigate my function and role in academia as a Taiwanese American man.

Emigration Toward Achievement

My mother emigrated to the USA from Taiwan in the late 1970s and then met and married my father in Hawaii. There they started a family and soon moved to Texas for more opportunities. I grew up in a suburban area of Dallas, Texas, with some diversity but like most suburbs of Dallas at the time, dominated by White culture. Contrary to what many thought of our family at the time, we did not have "family jewels that we carried over from China." Wealth was not something my family had. Instead, welfare, food stamps, and public transportation were commonplace in my early childhood. My mother valiantly tried her best to shield me and my sister from the feelings of living without. Actually, it was not until much later that I realized in fact we were rather poor. As early as I could remember, my mother showed us the concept of hard work, frugality, and most importantly, doing well in school. Eventually, my family worked into a middle-class income family and much later even into upper middle-class. Although our family did not have a specific religious or spiritual value, many of our Taiwanese values mirrored more Buddhist teachings: wisdom, kindness, patience, generosity, and compassion (Kibra, 2002). Above all, the value of education reigns supreme, as the main purpose for my mom's original immigration was to provide her future children a better opportunity for education.

The question "What do you want to be when you grow up?" always circulates in my mind whenever I reflect upon my career in academia as a professor, clinical director, and program director for an MFT program. For most of my childhood and early adulthood life, the answer to that question was consistently "a medical doctor, of course." More specifically, it was a cardiothoracic surgeon. The idea was one passed down and drilled in by my mother. Back in her time and into the early 2000s, Taiwan had a very challenging college application process. While many high school students desired to enter the prestigious Taiwan universities, high achieving students saturated entrance exams, coupled with limited prestigious university admis-

sions, lead to a low percentage of success. The United States had a much different process which gave more opportunities. That was my family's American dream: the opportunity to enter a prestigious college, to seek a medical degree, and to establish a legacy on family, success, and generosity. While many Asian American families saw the big four occupations—medical doctor, engineer, lawyer, and pharmacist (Takaki, 1998)—as the only acceptable college degrees, my mom limited us to just a medical doctor. My parental expectations were very narrow, and ultimately, my career choice deviated heavily from cultural and familial expectations. Not only did my career choice not fall within cultural expectations, but the decision also deviated from normal cultural patterns of filial piety. Ironically, my decision to pursue a career in marriage and family therapy was supplanted by Taiwanese values; the belief that the family system mattered and was worth talking about. I gravitated toward MFT because of how important I see relationshipss and how much we can achieve through healthy relationships.

Unfortunately, navigating through this field as a Taiwanese American man lacked role models and contained many foreign concepts, such as differentiation, the family circumplex model, and self-care, which are unique to Western cultures, but contradicted Asian values such as: collectivism, family enmeshment, and being self-sacrificing (Hynes, 2019). The esteemed Insoo Berg Kim was one of few major role models who confirmed the possibility that Asian Americans can contribute to a mostly Westernized social science. Understanding my family's emigration story paves my perspective on my identity as a clinical director and program director. As I conceptualize my social location, I will be speaking on two fronts: the microlevel perspective within Sacramento (a Northern California diverse urban community) and the macrolevel of a Taiwanese American male in the field of marriage and family therapy education. Both the micro and macrolevel assessment contributes to my continuous internal dialogue.

My Social Location

For this chapter, I will be addressing social location in accordance to two administrative roles I hold in my profession. The context of these roles will be evaluated based on my current residence of Sacramento, but I must also acknowledge that my social location has changed, given my pursuit in my academic career as I will discuss later. My role as program director for an MFT program reveals areas of privilege and systemic power that I must navigate throughout my role with students. As my program's clinical director, I must also be mindful of how my cultural values, expectations, and identity interact with my work with the local Sacramento community, a diverse population with mental health access and funding difficulties. At the microlevel, my social location revolves around the physical setting of Sacramento, California, one of the most diverse cities in the United States, capital to one of the most influential states with a high concentration of MFTs, and a city that, like many, struggles to find value in mental health, which is reflected in limited

grant funding and political support. On the macrolevel, I consider the values of the MFT field and context of MFT training. I utilize an intersectional model (Chenfeng et al., 2017; Mahalingam, 2007) lens specific to my identity as a Taiwanese American man interacting with my social location and perceive how they influence my academia position and internal processing.

The Asian American Cultural Bubble

Often times, the Asian American community talks about the Asian American bubble both in positive and negative ways. Let me start by saying that, to me, the Asian American bubble comes from a place of privilege because in my life, it mostly has been a social choice to stay in the bubble rather than one which is forced like gentrification. The Asian American bubble may start with social interactions early in teenage and young adult years and be perpetuated by one's family involvement within the Asian American community, and then grows into social and residential segregation in adulthood. In my early teenage and college years, I was in the Asian American bubble. I socialized exclusively with Asian Americans (mostly Chinese, Taiwanese, Korean, and Japanese Americans), only had Asian American roommates, predominately ate Asian cuisine, studied with an all-Asian American study group, and often times only had to speak Mandarin, if I chose to. When non-Asian individuals entered our social bubble, it was looked upon with suspicion and concern. Looking back, it was not a proud moment for me, but it did breed levels of comfort, safety, and a strong sense of belonging; all things I was searching for early on. This concept has become more difficult for me to grasp now because of my strong belief in promoting diversity, multiculturalism, and inclusivity to facilitate difficult dialogues and improve mental health throughout our communities. Change happened as I got older and experienced ever-changing social locations.

Even as I began my MFT education, there was a social bubble I meant to impact. I wanted to pursue a career in MFT to connect with Asian American individuals, couples, and families. I wanted to break down why Asian Americans were the least likely to utilize mental health services (Kim, 2007; Kim, Ng, & Ahn, 2005; US Department of Health and Human Services, 2001), end the stigma in Asian culture that seeking mental health services is a sign of weakness, and help Asian couples find higher levels of marital satisfaction. The course of my education took me to two predominantly White homogeneous cities (Abilene, Texas and Provo, Utah) largely absent of the Asian American bubble. At first, I was very resistant to change, and it brought me little joy. Finally, my academic position placed me in one of the most diverse cities in the nation. At that point, I had to make a difficult decision for myself: either reestablish the Asian American bubble or utilize the diverse location and not only make an impact in Asian American mental health, but an impact to promote diversity within mental health and decrease stigma of mental health across race and ethnicities.

Although it may seem like an easy decision to make, it was difficult for me because for the first time, my position of power as a faculty member with PhD status allowed for more action and change to occur, and that seemed terrifying in a community I was not accustomed to. In addition, it somehow felt like a betrayal to my Asian American community. It was not comfortable. One occurrence especially comes to mind—when I entered a Black community panel discussion involving social injustice, police brutality, and how mental health agencies can be more effective with the black community. I was an outsider going into a community that has been suffering and hurting. The community was angry, frustrated, outraged, and wanted change. When I was first introduced, I perceived a deep sense of judgment and disconnection from that community. Although my first instinct was to build credibility with my research, accolades, university position, and education level, a part of me knew that would create more disconnection and potentially even disdain. So, I took a page out of the Sue and Sue's (2016) research I so held dearly and asked for the opportunity to listen to the community. I listened, and listened, and continued to listen as individuals and families talked about the generations and multiple instances of how the various mental health systems have failed them. My panelist role inverted to being a member of the audience, and I loved it!

Throughout the discussion, I had to follow multicultural practice (Sue & Sue, 2016) and check my privilege repeatedly. My Taiwanese culture wanted to say "you see the problem, don't just complain about it, pull yourself up by your bootstraps and do something about it. Better yourself, and if you can't, that is your own fault." As more stories were shared, I began to resent this part of me more. How could a part of me lack so much empathy? I quickly differentiated that this part of me has always been present, and it was an important part of who I am and how I got to where I am today. Although I would never say my academic position is something to brag about (Taiwanese humility), it was a goal I had, and obtaining my academic position was an achievement. Internally, I had to process and check this privileged part of me, stemming from my cultural upbringing, at the door when I came back for round two of a similar discussion. Only through this struggle and first seeing my privilege could I better empathize with my community and begin working with the community's many struggles, which I may not be directly impacted by but frequently am a part of based on my geographic location alone.

This experience marked a tremendous epiphany for me because for the first time, I was able to step out of my created Asian American bubble and see my privilege and use that privilege to work with a marginalized community in desperate need of mental health reform. I would not say we made tremendous changes, but I believe the discussions were rich and fueled community action to build connections around mental health and the Black community. I believe that, although my cultural bubble bred safety, comfort, and familiarity, my education and training begged me to participate with my community rather than continue to seclude. As I articulate this belief, I realize even that choice was one of privilege. My social location coupled with the privilege of my educational training propelled me to learn and do better.

It is with this perspective that I keep engaging with my community and my role as a clinical director. This role serves as a connection between the mental health

agencies, communities accessing mental health services, my university, and our program's students. It is within my job description to develop community agency sites where our students can gain clinical practicum experience. I believe this is a pivotal role in any MFT program because students' first experience as an MFT therapist relies on the populations that their community mental health agencies serve. That experience can vary from more homogeneous client populations like a private practice from a high-SES community setting to a very diverse population such as a transitional homeless community shelter.

My role as a clinical director bestows a great deal of power. What I choose with that power may dictate accessibility of mental health services albeit on a small scale. My experience interacting with my community has taught me that although my students may not always feel the most comfortable in gaining experience in these communities of need, it is certainly my obligatory duty bestowed by my social location to connect my students, my program, and at times supervision, research, and consultation to mental health agencies focused on serving marginalized populations. Just like that, my Asian American cultural bubble not only burst, but from it paved way for a new and more inclusive bubble. Fortunately, this new bubble resonated more with my newly learned core beliefs and resonates better with MFT's core values.

My Three Ps: Problems, Power, and Privilege

It would be an oversight to discuss social location without examining power and privilege. Ironically, I have considered many Asian American stereotypes from a perspective of privilege. The major one being the model minority concept originating from William Peterson, a sociologist who writes for *The New York Times Magazine* in the mid-1960s (Chan, 1991; Takaki, 1998). What followed was a series of success stories published by various newspapers and magazines, detailing the various challenges, persistence, and achievement of predominantly Asian Americans. The concept is now associated with high socioeconomic success, lower rates of criminality, and high familial stability. The dark side of the model minority stereotype alludes to suggestions that as a whole, the Asian American population should not receive governmental assistance or programs, and further breeds divide between minority groups. In addition, individual Asian Americans who do not achieve to the expectations of the model minority status tend to be ostracized. While those constant expectations and achievement levels have plagued my adolescent and young adult life, my social location perspective has provided some levels of privilege.

The model minority stereotypes cast the shadow of family and marital stability upon me. Although also a stereotype, being a marriage and family therapist clinician, teaching for an MFT program and obtaining my PhD in Marriage and Family Therapy already projects such traits. It is natural, albeit flawed, to believe that such an individual would have family and marital stability; just like it would be to expect a medical doctor to always have good healthy habits, a personal trainer to be in

immaculate physical shape, or a pastor to be spiritually grounded. Based on this stereotype, I believe it has granted me a privilege because of the alignment between MFT's focus on family systems and the model minority assumptions.

It has felt that I have found my place in my community of mental health focused on generating healthy, stable, safety, and secure relationships between partners and family members. It becomes easy and almost natural to advocate for my students to conduct family therapy and couple therapy because of this stereotype. Often when I am creating agency partnerships for students' practicum, systemic therapy is not always a method agencies are familiar with or can necessarily implement. Many past MFT researchers have found support that systemic therapy is actually effective and often more cost-effective than individualized treatment (Crane & Christenson, 2014; Goorden et al., 2016), but agencies still sometimes need convincing. I believe this is one area which my model minority privilege, based on the stereotypes of achievement, success, and strong family values, opens the conversation with partnered agencies to allow my students to conduct systemic family therapy. This trend tends to happen effortlessly, which I credit to the intersection of the model minority stereotypes and my credential as an MFT professor. Considering how mental health funding seem to be decreasing year after year, especially in a city like Sacramento, where advocacy and lobbying for other issues are just as rampant, consistently finding a place for systemic therapy in the community is not guaranteed, but a focus on therapeutic achievement and success seems to resonate with many community mental health agencies. This privilege has given our program an abundance of practicum partnerships, essential for student training success.

What about the problems of the "model minority" stereotype? Here, I would like to take a look at the interaction between Taiwanese American culture as the model minority and culture of academia. Specifically, I want to highlight the academic culture of working endless hours producing research, improving program success data (i.e., graduation rates, student attrition, student job placement rate, etc.), and impacting your community. The interaction between these two cultural traits breeds opportunity to overwork endlessly and tirelessly.

The Unsuspecting MFT Program Director

The percentage of Asians as marriage and family therapists has and still lags far behind White Americans, Hispanic/Latino Americans, and Black/African Americans (Data USA, 2017). Within the Asian American group, males are even less represented as MFTs compared to females. It is relatively rare to see an Asian American male therapist, and even rarer to have one part of an MFT program. Asian Americans have the tendency and stereotype to not express vulnerable emotions (Chan, 1991; Takaki, 1998), something that is frequently discussed in the field of psychotherapy, but absolutely crucial as a marriage and family therapist.

I remember a distinct moment in my early childhood. I must have been maybe 10 or 11 years of age. I was in Taiwan on summer vacation, where my sister and I fre-

quently went to stay with my aunt and grandmother. I can't quite remember what I did, but I was being strongly scolded by one of my uncles. I do remember that I then began to cry, which quickly spurred my uncle to raise his voice and say in Mandarin "不能哭，男子漢 大丈夫眼淚比血更珍貴" (stop crying, a man's tears are more precious than blood). From that moment, I learned to not show emotions, hold my vulnerabilities close to my heart, and not let others see it. Of course, I now recognize that this perspective is erroneous and potentially destructive because it minimizes the importance of emotions and how emotions are a basic part of human interactions and mental health. Nearly every MFT theory emphasizes the importance of emotions, needing to recognize and validate emotions, and being able to effectively express them. It took many years, some therapy, countless hours of self-reflection, and journey through both a Master's and PhD marriage and family therapy program to overcome this aspect of my Taiwanese male stereotype.

Naturally, it would have been difficult to hold onto this stereotype and teach in an MFT program that preaches empathy, vulnerability, talking about emotions, and compassion. It would be nearly impossible, and highly hypocritical, if I held onto my uncle's words and taught or modeled entirely different therapeutic concepts to my students. As a program director, often I meet with students who are struggling with the curriculum, clinical practice, or program in general. Often times, their struggles are not because of the lack of comprehension but rather life's circumstances (i.e., working two jobs and not having time to complete homework assignments, grieving loss, natural disasters, or mental health struggles). Internally, I recognize that throughout my life, I have had to push aside disappointment, shame, heartbreak, and rejection to focus on a job, assignment, exam, or responsibilities. It never entered my mind to ever ask an employer, professor, or supervisor for accommodations because of life's circumstances. Doing so would only bring upon more shame (Hampton & Sharp, 2014) and be a sign of weakness.

In my journey in academia, many of my mentors showed me compassion and empathy rather than shaming my lack of achievement whenever I fell short. Through this model, it has propelled me to want to achieve more and not disappoint them. I believe this resonates with a more strength-based model which is prevalent in our field (Nichols & Davis, 2015). As a program director, I have to demonstrate empathy and compassion to my students, understanding that it takes more courage to talk with an authority figure and express struggles and vulnerability. While my uncle responded to my vulnerability with anger and discipline, I chose to take a different path: one of empathy and encouragement.

This foundation lends an opportunity to build a stronger connection with students and opens the door toward support and conversation, where intimidation and fear may have previously resided. Of course, I have to validate my part that does still value achievement and task completion by following up with students with "how can I support you to encourage your best work moving forward?" or "what can we do to get your best work?" I believe this method resonates with the MFT systemic model because it places a student's success in our program not squarely on the student's shoulders, but allows the burden to be supported by the program as well. This systemic perspective to promote student success also resonates with Asian collectiv-

istic principles (Takaki, 1998). Specifically, when there is collective responsibility and cooperation to bring about student success, it also leads to program success. This deviates from individualistic perspectives, which may put the responsibility solely on the student to achieve, which strongly deviates from systems thinking, the foundation of any MFT program. There must be shared responsibilities toward the path of student training successful as a prosperous marriage and family therapist. Balance has been a strong cultural identity I have taken from my Taiwanese American heritage and incorporated into all aspects of my career in academia.

Topic of Balance

As the late Pat Morita said while playing the role of Mr. Miyagi "The lesson is not just for karate only. The lesson is for the whole life. If your whole life has balance, everything will be better." Culturally, balance is at the key center of Confucianism and Taoism, and very much rooted in Taiwanese culture (Chan, 1991; Takaki, 1998). The concept of Yin and Yang applies to all aspect of life, including health, nature, and character. Only when there is balance, does one gain the most clear perspective and is able to maximize achievement. Although I do not identify with the religious label of Buddhism, the cultural principle of balance has centered my perspective in my academic position. In addition, balance interacts with my cultural identity on achievement.

What is the balance between the rigors of my academic position and my social location? In many ways, the balance is grounded in how I can maximize and be most efficient in the work that I do. The outcome matters. Maybe that is a Taiwanese cultural bias, but success is extremely important to my identity and perception of my academic role. I also definitely understand that success for my MFT program, the students, and my mental health professional community takes a great deal of balance. The drive to push these three levels toward success is grounded in my cultural identity. As a result, I think my social location provides the perfect opportunity to achieve this success. As a program director, it allows me to make influential decisions that directly impact the success of our program and students. My role as a clinical director not only carries a responsibility for my students' success, but also the continued growth and visibility of MFT mental health. Being at the capital of California gives me opportunity for great visibility on state policies in a state, which the rest of the country often looks for leadership in mental health policies.

But what happens when we lose balance and disruptions occur? Often this can happen when social injustice reigns. I perceive this on both the internal and external fronts. Internally, what am I doing to counter these social problems? Externally, what change is happening to promote social justice? This all becomes central issues that from my position of power I feel the need to address. I am fortunate enough to be employed by an institution that values inclusivity. Specifically, my university is "committed to inclusive, excellence; [they] value, include and engage the rich diversity of the [university's] community." This synergy between my values and my uni-

versity's values allows for opportunity for action to be taken to seek internal balance in hopes of external change leading to more balance.

The actions I have taken from a position of power as an MFT program director and clinical director include: supporting disadvantaged students, working with and empowering marginalized communities, and advocating for social justice. These actions bring me internal balance because social justice work is being done. The external balance is perceived when students from historically marginalized communities graduate and then inspires and gives back to their underserved communities, and also, when advocacy for social justice contributes to appropriate policy changes. Balance in my academic role is then achieved by being allowed and encouraged to incorporate topics of social justice, diversity, inclusion, and multiculturalism into program curriculum, practicum site development, course content, and program-community engagement. Our program engages and promotes collaboration with community mental health agencies centered on inclusivity. Finally, within the university, a culture of difficult dialogues, social justice and diversity education, and multicultural practice are a commonplace occurrence. This results in moments of my internal harmony even while external factors may be chaotic, disruptive, and experiencing social unrest. The balance becomes the final string that ties my Taiwanese American male identity and my social location together.

Conclusion

My journey is not done, nor do I want it to be. In my ever-changing social location, it would be extremely remise if I found comfort in where I reside today and impede my growth. When power is bestowed based on aspects of social location, leaders of our community get the opportunity to decide how that privilege is utilized. I hope that I will continue to grow and challenge my comfort level. I hope that I continue to better understand my position of privilege and use that privilege to both support and advance marginalized communities. The interaction between my cultural and gender values, my academic roles, and place of residency brings about a unique social location that can in turn change the landscape of mental health, bit by bit.

As I sit at the airport after giving my last talk on cultural humility, I recall answering questions, exchanging contact information, and discussing potential future collaboration and connections. I now sit here pondering how social location has shaped not only who I am in academia, but how I conduct myself from an administrative perspective and represent both my program and students. Fortunately, I feel empowered and privileged that my social location also allows me to affect my community both on a micro and macrolevel. So, as I board my flight home, I reflect on a sense of optimism, challenge, and career goals of bringing these experiences and knowledge gained to the MFT field and my current and future students. This purpose shall never tire me.

Acknowledgment I have to start by thanking God for blessing me with the many opportunities in my career. I want to acknowledge my loving wife, Lindsay, without her encouragement and support none of this would be possible. I also want to acknowledge my mother and sister who always push me to be my absolute best. Thanks also to all the many mentors along my academic journey who have challenged me and pushed me out of my comfort zone. Finally, thanks to all my supportive faculty and colleagues at my university who always offer tremendous support and collegiality.

References

Atwood, J. D., & Conway, B. Y. M. (2004). Therapy with Chinese American families: A social constructionist perspective. *The American Journal of Family Therapy, 32*, 155–172.

Case, K. A., Iuzzini, J., & Hopkins, M. (2012). Systems of privilege: Intersections, awareness, and applications. *Journal of Social Issues, 68*, 1–10.

Chan, S. (1991). *Asian Americans: An interpretive history*. New York, NY: Twayne Publishers.

Chenfeng, J., Kim, L., Wu, Y., & K-M, C. (2017). Addressing culture, gender, and power with Asian American couples: Application of socio-emotional relationship therapy. *Family Process, 56*(3), 558–573.

Crane, D. R., & Christenson, J. (2014). A summary report of cost-effectiveness: Recognizing the value of family therapy in healthcare. In J. Hodgson, A. Lamson, T. Mendenhall, & D. R. Crane (Eds.), *Medical family therapy: Advanced applications* (pp. 419–436). Cham, Switzerland: Springer International Publishing.

Data USA. (2017). *Marriage & family therapy*. https://datausa.io/profile/cip/marriage-family-therapy#employment.

Goorden, M., Schawo, S. J., Bouwmans-Frijters, C. A. M., van der Schee, E., Hendriks, V. M., & Roijen, L. H. (2016). The cost-effectiveness of family/family-based therapy for treatment of externalizing disorders, substance use disorders and delinquency: A systematic review. *BMS Psychiatry, 16*, 237.

Hampton, N. Z., & Sharp, S. E. (2014). Shame-focused attitudes toward mental health problems: The role of gender and culture. *Rehabilitation Counseling Bulletin, 57*(3), 170–181.

Hynes, K. C. (2019). Cultural values matter: The therapeutic alliance and East Asian Americans. *Contemporary Family Therapy, 41*, 392–400.

Kibra, N. (2002). *Becoming Asian American: Second-generation Chinese and Korean American identities*. Baltimore: The John Hopkins University Press.

Kim, B. S. K. (2007). Adherence to Asian and European American cultural values and attitudes toward seeking professional psychological help among Asian American college students. *Journal of Counseling Psychology, 54*, 474–480.

Kim, B. S. K., Ng, G. F., & Ahn, A. J. (2005). Effects of client expectation for counseling success, client-counselor worldview match, and client adherence to Asian and European American cultural values on counseling process with Asian Americans. *Journal of Counseling Psychology, 52*, 67–76.

Leong, F. T. L., & Kalibatseva, Z. (2011). Effective psychotherapy for Asian Americas: From cultural accommodation to cultural congruence. *Clinical Psychology: Science and Practice, 18*, 242–245.

Lim, S.-L., & Nakamoto, T. (2008). Genograms: Use in therapy with Asian families with diverse cultural heritages. *Contemporary Family Therapy, 30*, 199–219.

Mahalingam, R. (2007). Essentialism and cultural narratives: A social-marginality perspective. In A. J. Fuligni (Ed.), *Contesting stereotypes and creating identities: Social categories, social identities, and educational participation* (pp. 42–65). New York, NY: Russell Sage Foundation.

Nichols, M. P., & Davis, S. D. (2015). *Family therapy: Concepts and methods* (11th ed.). Upper Saddle River, NJ: Pearson Education.

Pandya, K., & Herlihy, J. (2009). An exploratory study into how a sample of a British South Asian population perceive the therapeutic alliance in family therapy. *The Association for Family Therapy and Systemic Practice, 31*, 384–404.

Quek, K. M.-T., & Chen, H.-M. (2017). Family therapy in Chinese culture and context: Lessons from supervising therapists-in-training in China. *Contemporary Family Therapy, 39*, 12–20.

Shibusawa, T., & Chung, I. W. (2009). Wrapping and unwrapping emotions: Clinical practice with East Asian immigrant elders. *Clinical Social Work Journal, 37*, 312–319.

Sue, D. W., & Sue, D. (2016). *Counseling the culturally diverse: Theory and practice*. Hoboken, NJ: Wiley.

Takaki, R. (1998). *Strangers from a different shore: A history of Asian Americans*. Boston, MA: Back Bay Books.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, ethnicity—A supplement to mental health: A report of the surgeon general*. Rockville, MD: Author.

Wang, S., & Kim, B. S. K. (2010). Therapist multicultural competence, Asian American participants' cultural values, and counseling process. *Journal of Counseling Psychology, 57*(4), 394–401.