1 **Culture and Mental Health Counseling: A Reflective View Based on Observations in China**

2

3

4 Abstract

5

6 Western initiated internationalization of professional psychology has resulted in mental

7 health counseling, a profession indigenous to the Euro-American culture, being transplanted in

8 different parts of the world. Questioning the cultural appropriateness of applying Western

9 theories in non-Western cultures has become more and more imperative and urgent. This article

10 reflects on the cultural context of Western professional counseling and its internationalization

11 and discusses possible harm and problems of practicing Western mental health counseling

12 internationally. Based on observations of counseling development and research in China, the

13 argument is made that lack of attention to the role of culture leads to harm. All professionals who

14 are interested in being part of this internationalization movement need to adopt an international

15 attitude, conduct sharing and learning through a dual-directional collaborative pathway and show

16 a commitment to do courageous work in de-constructing and re-constructing the science and

17 practice of professional psychology for the global community. Only with proper and sufficient

18 culturally informed effort, internationalization of mental health counseling can result in mutual

19 enrichment and benefit all people in all cultures.

20

21 **Keywords**: culture, mental health, counseling, internationalization, China

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23 In the last few decades, one of the significant developments in the field of psychology

24 and mental health has been internationalization of mental health counseling, an indigenous

25 European-American cultural product (Christopher et al, 2014). Increasingly, scholars and

26 practitioners from selected Western countries developed an "on-going commitment to and

27 involvement in the international arena" (Casas, Park, & Cho, 2010, p. 191). This trend is

28 inevitable in the context of modern globalization (Friedman, 2006), and reflects the interest and

29 motivation of the Western professionals to make professional psychology international. While

30 many parts of the world have generally embraced Western psychology and counseling, with or

31 without choice or deliberate intention, there have been reasons and observations that call for

1   responsible and serious reflections about how this internationalization movement has influenced

2   individuals, families and communities around the world. Such reflections may lead to

3   reconsideration of how internationalization should be defined, conducted and promoted so it can

4   reach the desired goal of benefiting but not harming those we intent to help.

5   In this paper, I briefly describe the cultural context of Western mental health counseling

6   and discuss the possible lack of cultural fit when it is practiced in non-Western cultures. Based

7   on my limited understanding and observations, I share what I see as problematic and reflect what

8   is needed to put corrective effort forward and prevent further harm. Internationalization will

9   continue and deliberate efforts are needed to make it a great movement benefiting the entire

10 global village. For the sake of convenience, I used the term West or Western to group the United

11 States and some parts of the Europe where there is a shared history of psychology discipline

12 development.

13   This paper unavoidably contains my personal biases as a China-to-U.S. immigrant whose

14 perspectives have been shaped by life experiences both in China and in the United States. I grew

15 up in China, and have received graduate training, lived and worked in the United States. On a

16 continuous basis, I am engaged in collaboration with Chinese scholars in mental health

17 counseling research and training in China. My general, perhaps biased, conviction is that while

18 the globe is gradually flattening (Friedman, 2006) in economics and other areas, the diversity of

19 culture remains a beauty of the world and mental health a culture-driven phenomenon. Thus, I

20 plea to our academic and professional community that significant attention be given to the role of

21 culture in everything we do to promote mental health, and please recognize that failure of doing

22 so is harm to non-Western individuals and societies that constitute a large part of the world.

23

24 **Cultural Contexts of Mental Health Counseling Development and Internationalization**

25

26   It is probably not accidental that mental health counseling along with its parenting

27 scientific discipline, psychology, started in only a few small areas of the globe (West Europe and

28 North America) and among a small portion of the world population, namely, the Western,

29 Educated, Industrialized, Rich, and Democratic (WEIRD; Henrich, Heine & Norenzayan, 2010).

30 Nor is it arbitrary that the principles and ideologies reflected in the professional counseling, as

31 we know it today, are mostly consistent with those rooted in individualism (Baumerister, 1987)

1   that dominates Euro-American cultures (Hofstede, 2001) and are highly valued among the
2   WEIRD. As these cultures promote individual rights, autonomy and independence, and free
3   choice, mental health counseling logically and conveniently emphasizes self-understanding, self-
4   identity, self-actualization, freedom, individual happiness, and so on. As noted, the development
5   of mental health counseling or psychotherapy has been viewed "a clear American tale of
6   discovery, entrepreneurship, and self-promotion" (Engel, 2008; p. xiv).

7   Culture is the foundation of human behavior and it shapes personalities (Triandis & Suh,
8   2002) and permeates human existence (Geertz, 1973). However, there has been empirical effort
9   made to prove, based on biology or by "cross-cultural" studies that treated culture as a nuisance
10 demographic variable, that there is a universal human nature or certain personality factors are
11 cross culturally valid (e.g., Vogt & Laher, 2009). This is not surprising given "the entrenched
12 parochialism and ethnocentrism" (Christopher et al., 2014; p. 645) of Western psychology and
13 publishable research being known to reflect "psychology that is incomplete and does not
14 adequately represent humanity" (Arnett, 2008). In fact, even the "significant" result supporting
15 universality does not nullify the role of culture in human nature. From a hermeneutic perspective,
16 studying Western personality constructs among individuals in other cultures where "self and
17 culture are inextricably linked" (Christopher et al., 2014; p. 650) would require a lot more than
18 what published studies usually do (examining the individuals without attending to the
19 inseparable part of them: culture). Using Western scientific method studying Western
20 psychological constructs (many of which are meaningless to people outside of Western countries
21 and even not translatable to non-English languages) for understanding people in culture is
22 fundamentally problematic because of its inability of observing "shared meanings and their
23 import for subjectivity and social relations," (p. 653) part of the self of those people.   From
24 another angle, an evolutionary psychological perspective, it is more likely than not that culture
25 selectively activates the complex psychological mechanisms in human mind (Buss, 2001) even if
26 the biology is the same. Moreover, using available empirical evidence to argue for universality is
27 problematic because "most studies have not included emic (culture-specific) traits and have not
28 studied samples that are extremely different in culture from Western samples" (Triandis & Suh,
29 2002, p. 133).

30 It is apparent that the narrow cultural focus of psychology, unrepresentative of the
31 majority of cultures worldwide, led to a culturally exclusive psychological knowledge base that

1 is difficult for international application due to lack of cultural fit. Nonetheless, the past few

2 decades have witnessed mental health counseling in theoretical and practical packages being

3 transported from the West to many parts of the world regardless of local cultures. The privilege

4 of circulating cultural products in a culturally neutral manner certainly belongs to Western

5 professionals and shapes the development of psychology in the international arena.

6 The push from the West to popularize psychology and mental health counseling in China

7 occurred in late 1980s as the world globalization was marked by new progresses (Boughton,

8 2002) and when China embarked on its economic reform following the "Open Door" policy

9 issued in 1978. This Open Door action opened not only China's economic market but also its

10 people's mind toward the West and interest in Western cultural and intellectual products. At the

11 time when mental health counseling as a profession had matured in European and North

12 American countries, the idea of expanding its influence and disseminating its products seemed

13 natural, timely and appealing. Thus, a gradual movement transpired in the West, particularly the

14 United States, to introduce counseling profession to other countries (Gerstein, Heppner,

15 AEgisdottir, Leung, & Norsworthy, 2009).

16 As the result, under the name of "internationalization," and sometimes accompanied by

17 "indigenization," counseling theories and systems entered China from the United States and

18 some European countries, along with devoted scholars and practitioners who generously offered

19 their time and expertise to training Chinese practitioners. Having no non-medical professional

20 mental health care at the time (Qian, Smith, Chen & Xia, 2002), China eagerly accepted the

21 newly imported theories and systems. For instance, psychoanalysis, in its rather traditional form,

22 became a hot and attractive area quickly, and caused high "folk fever" among professionals and

23 the public (Jia, 2016; p, 379). With the persistent effort from several groups of psychoanalysts

24 from Germany, United States and Norway, China let "Freudians put China on the couch"

25 (Tatlow, 2010) just in a few short years. It is quite provocative for us to witness the increasing

26 popularity of Western imported psychoanalysis in China during the time when the medical

27 historian Jonathan Engel (2008) stated "Psychoanalysis has largely died" (p. x) in the United

28 States and the president of American Psychoanalytic Association Dr. Warren Procci

29 acknowledged, in 2010, that "There is an unavoidable message here, much as we do not want to

30 hear it … We are in a decline" (Cited in Evan Osnos, 2011, p. 56). In significant ways,

31 psychoanalysis defined mental health for the Chinese yet-to-be-developed mental health care

system. Its large influence filled the center of the professional space and attention, and entered the public's initial knowing about mental health and counseling. Quickly, the Chinese mental health counseling market became heavily psychoanalytic/psychodynamic, and other therapeutic approaches had a harder time to gain as much public acceptance and recognition.

Addressing the Issue of Cultural Fit: Optional or Imperative?

While such Western enthusiasm and assistance helped jump start professional counseling in China at a time when the globalization and China's opening door to the world unavoidably brought new mental challenges to its citizens, the issue of cultural fit started troubling the academic community and intensified over time. However, due to being largely in a powerless recipient status (without existing counseling professional literature or system) and perceived as suffering from significant increase of mental illness due to the economic reform (Yan, 1998), China was not in a position or had the resource to scrutinize or examine those Western imports for cultural relevance. Therefore, the mental health counseling field took shape and developed with mostly Western features and styles, from its operation to its intervention strategies. Mainly translated textbooks and materials from English were used for teaching and training.

In one area where cultures differ is the degree to which individualism and collectivism predict human behavior and emotions (Hofstede, 2001).   There has been a significant amount of empirical evidence showing that some countries are more or less individualist or collectivist than others, with the United States topping the list of the most individualist countries (http://www.clearlycultural.com/geert-hofstede-cultural-dimensions/individualism/   ). Viewing humans as cultural beings, Triandis (2001) summarized years of research and unambiguously stated "People in collectivist cultures, compared to people in individualist cultures, are likely to define themselves as aspects of groups, to give priority to in-group goals, to focus on context more than the content in making attributions and in communicating, to pay less attention to internal than to external processes as determinants of social behavior, to define most relationships with ingroup members as communal, to make more situational attributions, and tend to be self-effacing" (p. 907). This is a good description of the psyche of people from most non-Western cultures. Thus, questioning the cultural fit of Western theories in these cultures is imperative.

1   There has been research examining mental health related concepts as associated with
2   individualism and collectivism. By comparing mental health stigma among several different
3   ethnic groups in UK, Papadopoulos, Foster and Caldwell (2012) revealed that, "the more
4   stigmatizing a culture's mental illness attitudes are, the more likely collectivism effectively
5   explains these attitudes. . . . the more positive a culture's mental illness attitudes, the more likely
6   individualism effectively explains attitudes" (p. 270). These findings are not surprising
7   considering the nature of individualism and collectivism, but what is interesting and provocative
8   is that such findings are often taken as denoting something negative about collectivism in terms
9   of mental health care. The Westernized thinking is that stigma is an obstacle for promoting
10   interventions and therefore should be reduced or eliminated. Rarely researchers have openly
11   reflected on the possibility that findings like these indicate how mental health is defined, mental
12   illness identified, and mental health care provided are inappropriate in collectivism dominant
13   cultures.

14   Lack of attention to the role of culture is reflected in even social justice-oriented and
15   assistance-focused efforts addressing negative stigma against the mentally ill. Issues of ignorance,
16   prejudice and discrimination embedded in the stigma were brought to the front (Thornicroft,
17   Brohan, Kassam & Holmes, 2008), but questions concerning who are the targets of the stigma
18   and how they became the target were not asked. As expected, existing stigma intervention
19   theories often lack cross-cultural effectiveness (Yang, 2007). Unfortunately, the way in which
20   mental illness is defined and stigma viewed is universally accepted. The scholarship in this area
21   implies that higher stigma is a sign of weakness and more deliberate intervention is needed (Link
22   & Phelan, 2001), and fails to acknowledge cultural biases in the definition of mental illness in
23   the first place.

24   Cultures vary in how they view un-conventional or un-normal behavior. The U.S. based
25   Diagnostic and Statistical Manual of Mental Disorders, a creation of American Psychiatric
26   Association, demonstrated a high tendency to pathologize behaviors. From the first to the fifth
27   edition, it grew from 129 pages containing 106 diagnoses in 1952 to 950 pages with roughly 375
28   diagnoses in 2013. However, when DSM diagnostic criteria consistent behaviors were presented
29   to Chinese, most people would not label them as being symptoms of illness. Rather, they would
30   see the "symptoms" as evidence of "taking things too hard" or "being stuck in thinking" (Li,
31   2014). This phenomenon is conveniently labeled by Western standards as lack of "mental health

1 literacy" (Jorm, 2011), the connotation of which is unmistakable.   Clearly, emphasis on labeling

2 mental illness is culturally determined but the culture neutral stance or cultural inaptness of

3 Western research has portrayed non-Western countries as being lagged behind or under

4 developed in removing stigma toward mental illness, which is culturally insensitive, improper,

5 and possibly damaging.

6 **Mental Health Counseling as an Internationalized Profession**

7 Gradually and surely, mental health counseling has become an international phenomenon.

8 While the Western internationalization has contributed to development of the profession in many

9 parts of the world, a critical view has always existed regarding the one-directional nature of such

10 international effort and its unintended negative consequences (e.g., Duan & Goodyear, 2016).

11 However, this concerning view has not made any wave under the impetus for showing generosity

12 in helping the needed.   In his thought provoking and influential book *Crazy like us: The*

13 *globalization of American Psyche,* Ethan Watters (2010) documented several ways in which the

14 best-intentioned helping efforts by American mental health professionals disseminated the

15 "American brand of hyperintrospection and hyperindividualism" (p. 254) and supported "the

16 grand project of Americanizing the world's understanding of the human mind" (P.1).

17 Using narrated country specific case examinations, Watters detailed how

18 psychopathology or mental illness, defined by the West, was introduced and passed on to

19 different countries. As a result, anorexia nervosa that used to be an exclusive Western eating

20 disorder (Swartz, 1985) became prevalent in Hong Kong through the promotion of Western

21 thinking concerning healthy/unhealthy eating behavior, and by popularizing diagnostic labels,

22 illness-focused prevention and intervention strategies to reinforce the notion of eating disorder.

23 Through a different route, "Americanized version of depression" (p.2), along with corresponding

24 SSRIs (Selective Serotonin Reuptake Inhibitors), was introduced and imposed to Japanese after

25 the targeted "educational" campaign by American drug companies with involvement of credible

26 psychiatry experts. Japanese were educated by Westerners to change their negative attitude

27 toward depression, which marked the beginning of the current state of affair that increasingly

28 more people became depressed and depression was medicalized (Kitanaka, 2006). Packaged with

29 the post-crisis assistance, PTSD (Post Traumatic Stress Disorder), an American socio-political

30 specific label for a particular group of veterans at a particular point in time, was brought to Sri

31 Lanka after 2004 Indian Ocean tsunami by well-intentioned U.S. professionals. Operating out of

1   their own knowledge base, experts introduced PTSD symptoms as must-be-present after natural

2   disasters and taught the locals how to think or feel as victims. The gross cultural

3   inappropriateness was "disappointing and sometimes shocking" (Ganesan, 20016; p. 360) to

4   local professionals and create negative consequences with real people being harmed (Christopher

5   et al., 2014).

6   From one angle, these cases illustrated how one-directional internationalization could

7   result in Westernizing mental illness and its interventions, which has caused harm in various

8   cultures. Undoubtedly, such potential harm was unintentional, but unintentional harm is harm

9   and should not be brushed over. In the counseling profession anywhere nowadays, Western

10   knowledge is clearly privileged and local scholarship and healing practices discouraged or

11   refuted. One major reason is due to the power structure, where scholars from the Western

12   countries run premier scholarly journals and host prestigious academic and professional

13   conferences; Western universities train world's most influential academics and clinicians;

14   Western generous volunteers have the resource to engage in world crisis interventions; Western

15   medical models (often used in counseling) enjoy world-wide recognition and acceptance;

16   Western drug companies spend big money promoting psychotropic medications everywhere; and

17   so on. The values embedded in most currently available counseling systems and assumptions

18   about how human mind works are representative of those by the WEIRD populations rather

19   exclusively. From top or powerful positions, Western professionals can easily apply their

20   knowledge as universally helpful and offer assistance accordingly, which in turn helps maintain

21   the Western position of power.

22

23   **Culture-bound nature of mental Health: A Comparison between U.S. and China**

24

25   Both anecdotal and empirical observations in China support the argument that mental

26   health is a culture-bound concept, and harm is really possible when it is viewed in a cultural

27   vacuum. Facing the reality that Western counseling theories and practices have gained

28   acceptance and popularity among mental health providers, it is time for researchers, practitioners

29   and consumers as well as the governmental agencies to ask serious questions concerning the

30   consequences of such practice. Fortunately, conversations on issues related to cultural fit of

31   imported counseling theories and methods have started (e.g., Jia & Zen, 2014). There have also

1   been empirical studies examining cultural characteristics of Chinese mental health, mental illness,

2   therapeutic interventions and healing arts, which will enrich the understanding of ways to

3   enhance mental health.

4   In the United States, goals of mental health counseling reflect the mega theme of

5   individualism, namely, "helping individuals to overcome obstacles to their personal growth,

6   whereever these may be encountered, and toward achieving optimum development of their

7   personal resources" (American Psychological Association, 1956, p. 283). The markers of mental

8   health include adequate self-understanding or insight, self-identity, self-realization, autonomy,

9   freedom, choice, independence, individual happiness, no negative emotions, etc. The focus on

10   the individual and individual rights and interest is in the center of these definitions. The

11   existential theorist Rollo May reflected toward the end of his life:

12   ". . . we in America have become a society devoted to the individual self. The danger is

13   that psychotherapy becomes a self-concern, fitting what has recently been called a new

14   kind of client, the narcissistic personality. . . . we have made of therapy a new cult, a

15   method in which we hire someone to act as a guide to our success and happiness. Rarely

16   does one speak of duty to one's society – almost everyone undergoing therapy is

17   concerned with individual gain, and the psychotherapist is hired to assist in this

18   endeavor" (Rollo May，1992：p. xxv）

19   In sharp contrast, China defines the goals of mental health services as "to improve public

20   mental health, promote social stability and interpersonal harmony, and enhance public well-

21   being, … and to cultivate good morality, promote coordinated economic and social development,

22   nurture and exercise socialist values and principles" (Committee of National Health and Family

23   Planning, 2016, p.1). The central focus is on stability, harmony, public well-being, and morality

24   to ensure economic and social development. These goals differ from those cherished by most

25   mental health counseling theories in 1) emphasizing public health, 2) promoting harmony, which

26   has to involve others or society, and 3) stressing morality and social responsibility.

27   The different views of mental health reflect different cultural values, particularly those

28   values concerning the individual and self. There have been theories differentiating individual,

29   collective and relational self (Sedikides & Brewer, 2001) and independent and dependent self

30   (Markus & Kitayama, 1991). Theorists tend to view these various selves co-existing in

31   individuals, but recognize the patterns of experienced self in cultures (Oyserman, & Lee, 2008;

1 Sedikides, Gaertner & O'Mara, 2011). It is not hard to derive the general understanding from a
2 myriad of theories and research findings that the independent self and individual self are more
3 salient than relational, collective, or dependent self for individuals from the West (more
4 individualist than collectivist culture) and the vice versa for those from the East (more
5 collectivist than individualist culture).

6   Having different types of self is no small matter in terms of how mental health should be
7 understood and cared for. The China's definition of mental health does reflect collectivist nature
8 of the culture, where "we" or "our" mentality (collective, dependent and relational self) is much
9 more prominent than "I" or "my" focus (individual and independent self). For instance, people
10 are much more like to use "our" than "my" in daily language, such as "our country" (vs. "my
11 country)." Interestingly, "country" in Chinese is 国家 containing both "state" (国，guo)
12 and "home" (家, jia). In the traditional view, Chinese value "One should be the first to worry
13 for the future of the state and the last to claim his share of happiness" (先天下之忧而忧, 后天下
14 之乐而乐） (From Poem by 范仲淹 Song Dynasty; Retrieved from
15 https://zhidao.baidu.com/question/490725319040991852.html). Researchers have described
16 basic Chinese values in modern time as respect for age, group orientation, concept of face, and
17 importance of relationships (Lockett, 1988), or that for family or kinship, elders, obligations
18 toward friends and relatives, and harmony and face (Tan, 1990).

19   Arguably, Chinese culture has been changing and adjusting in the context of being a
20 member of the globalized world (Liu, 2012), but distinct cultural characteristics remain. A study
21 of mental health values among college students revealed several traditional cultural tenets in how
22 mental health is viewed (Lei, 2016). After running several focus groups, interviews, and a survey
23 of a large number of students, Lei found six themes of their mental health values: functionality in
24 contexts, family, relationship, character and attitude, purpose and meaning, achievement and
25 communication. These themes contrast those used to measure mental health values in the United
26 States: self-acceptance, negative traits, achievement, affective control, good interpersonal
27 relations, untrustworthiness, religious commitment and receptivity to unconventional experiences
28 (Tyler et al., 1983). Chinese students' values seem to be more collectivist than individualist and
29 more other-focused than self-focused. In her report, Lei particularly emphasized that throughout
30 her research process, family and relationship arose as top considerations among the participants
31 whenever they thought about mental health.

1   There have also been limited discussions and empirical explorations on cultural

2   variations regarding mental illness and its diagnosis, which demonstrates researchers' attention

3   to the importance of culture. Nonetheless, DSM still becomes a widely used diagnostic bible all

4   over the world and mental illness is talked about linguistically as a universal concept. Notably, a

5   recent study in China produced evidence to question this practice. Using a large sample drawn

6   from multiple provinces and representative of a wide range of age and educational levels, Li

7   (2015) examined the public's view of mental illness. The result showed that Chinese public

8   lacked a clear concept of mental illness/disorder (not seeing certain DSM symptoms as

9   expression of mental illness), focused on consequence/impact when led to think about mental

10   illness, emphasized multi-factors if asked to make attributions, and recognized both the role of

11   individual subjective willpower and that of social/family support when talking about healing

12   from mental illness. In contrast, studies in the United States had demonstrated a strong public

13   concept of mental illness, high stigma toward those who are mentally ill in society; strong focus

14   on causes and biomedical interpretations in discussing mental illness; and enthusiasm advocating

15   for professional care (Martin, Pescosolido, Olafsdottir, & McLeod, 2007). Evidently, Westerners

16   endorsed more of a medical view and made stronger call for professional interventions than

17   Chinese, and Chinese were less likely to see atypical behaviors as expression of illness and more

18   concerned with consequences of those behaviors than Westerners.

19   Observable in clinical settings, Western beliefs about psychological trauma (how it

20   occurs and recovers), necessity of venting emotions for recovery (seen as healthier than stoic

21   silence), humans fragility and mental illness, biomedical approach to understanding and treating

22   mental illness have shaped treatment of mental illness all over the world. In my many

23   conversations with and supervision of Chinese counselors, I have observed that they tried very

24   hard to do use the "right" intervention, even if they feel it being counterintuitive and lacking

25   cultural fit. For instance, once in a supervision group when one relatively unexperienced member

26   reported that her male college student client, who came to counseling for lack of motivation to

27   study, reported feeling better after two "supportive" sessions, several more experienced

28   counselors in the group expressed doubt about the progress and deemed the client being in denial.

29   They believed that he couldn't have really felt better because he had not developed deep

30   understanding of the trauma his strict mother (Client said that his mother was strict and would

31   ban him from playing when he received bad grade) had caused him, got in touch with and

1 express his inner anger toward mother, and experienced transference with the counselor to fully
2 express his anger toward mother in session. I was in absolute disbelief, seeing the degree to
3 which the Western psychoanalytic thinking compromises local clinician's sense of cultural
4 reality. It is alarming knowing that prior to counseling being internationalized, "Nowhere else in
5 the world do people explore their deepest and most intimate secrets with total strangers with such
6 alacrity and enthusiasm" (Engle, 2008; p. xiv).

7 Culture shapes mental health, mental illness, its diagnosis and its treatment (Watters,
8 2010), it would be irresponsible and unethical if we do not ask serious questions concerning
9 efficacy or harm of existing mental health practice. Equally important that local cultural practice
10 be revealed and understood. In this spirit, a series of counseling process and outcome studies in
11 China were conducted and demonstrated that Chinese clients' help seeking behavior (e.g., Xia,
12 Jiang & Duan, 2015), counseling expectations (e.g., Duan, Duan, Zhang, & Xie, 2011), preferred
13 interventions (e.g., Duan, et al., 2018), as well as coping and change processes (e.g., Lei & Duan,
14 2015) were often different from those commonly believed and observed in the Western countries.
15 For example, Xia, Jiang and Duan found that one of the most important determinants of
16 professional help seeking among college students was client self-efficacy of being a good client.
17 Students would not seek help if they do not believe they can be good clients, which hasn't been
18 much of a topic in Western literature.

19 The research on use and effect of counselor directives (Duan et al., 2012; Duan et al,
20 2014; Jiang, Lin & Duan, 2017) showed that both counselors and clients expect counselor
21 directives (counselor telling client what to do) as it is culturally appropriate for a hierarchical
22 relationship like that between counselor and client. Counselors do in fact often use directives but
23 a) want to hide the fact that they used them, knowing they "shouldn't" based on their training, b)
24 want to deliver the directives indirectly, so clients won't lose face, c) evaluate non-directive
25 counselor behavior higher than that of directive counselors, knowing that is what theories say,
26 and d) prefer directives that "plant a seed" or are "encouraging" than those that give solutions.
27 On the other hand, clients reported wanting to have counselor directives, receiving more
28 directives than their counselors said they had given (deriving them from counselor comments),
29 feeling better (more hopeful, thoughtful, and relieved) after receiving directives (before or
30 without implementation) and only intending to implement the directives if they are beneficial

1 and doable. These results make sense in the context of Chinese culture, but are not typical from

2 the perspective of established theories.

3 **Reflective comments:**

4   Internationalization of mental health counseling should and will continue. With proper

5 culturally informed effort it will benefit all people in all cultures. There are significant challenges,

6 however. First, although the existence of cultural diversity has been generally acknowledged, the

7 danger of its absence in mental health counseling has not generated due attention. Sufficient

8 awareness is yet to be achieved that psychology and established mental health counseling are

9 indigenous to the Euro-American culture, and without proper de-constriction and re-construction,

10 transplanting it to other cultures runs the risk of being culturally colonizing (Adams, Kurtiş,

11 Salter, & Anderson 2012), homogenizing (Melluish, 2014), and even exploitation (Jagger, 2002).

12 Further, the one-directional internationalization from the West to developing countries or the

13 "global south" during the time of their economic and social vulnerability has created large

14 markets for Western imported counseling systems and inadvertently marginalized local

15 professionals and local folk psychologies. American "definitions and treatments" of mental

16 illness "have become the international standards" (Watters, 2010; p. 2), which gives more power

17 to Western exporters and more urgency to locals to import what is offered by the West. The

18 language barrier also contributes to the existing power structure by using English in the world's

19 understanding of mental health. While students of psychology in many non-English speaking

20 countries have full access to English literature, most English-only speaking scholars may have

21 limited knowledge the countries where they are offering help. Much of the research outcome

22 from non-English speaking countries has not been integrated in the knowledge of the profession.

23   Actively pursuing an international agenda is on the right side of history, but making this

24 course mutually beneficial requires deliberate, intentional and well-thought equal-power

25 collaborations among all who are involved. There are proposed models and methods such as

26 emic-and-etic integrative approach (Cheung, van de Vijver, & Leong, 2011) or cultural lens

27 approach (Hardin, et al., 2014) that are appropriate for international work, but acquiring

28 international and multicultural competence should the preamble. Individuals who are to conduct

29 international work need to position themselves with an appropriate attitude and clear direction as

30 well as a commitment to doing the necessary learning before embarking on the task..

31

1   **An International Attitude**

2

3   An international attitude involves a new worldview that acknowledges the uneven

4   distribution of power, a new understanding of how this power structure shapes human experience

5   in international communities, and a new commitment to dismantling this power structure for the

6   sake of being truly humanitarian and generating mutual benefit. Further this attitude contains a

7   view seeing all international work as a mutual learning process, because there are no experts

8   when the knowledge changes cultural settings. It falls on the shoulders of the powerful to be

9   willing to share power, adopt a learning mindset, and respect equal partnership. The less

10   powerful should recognize their power on other scales such as the knowledge of local culture,

11   being in a relatively more relational context, and having access to local resources. Each side has

12   advantages and disadvantages and has the responsibility to share with and learn from the other.

13   This has to be a deliberate and intentional process in which both offerors and receivers cultivate

14   a critical cultural awareness and initiate examinations of cultural fit for everything that is

15   transported.

16   In clinical settings, an international attitude allows us to see that culture defines mental

17   health and constructs clinical reality (Kleinman, Eisenberg & Good, 2006), and any ethnocentric

18   view of mental health is harmful to others in different cultural reality (Comas-Diaz, 2011). It is a

19   sobering fact that the current body of psychological knowledge is largely grounded in mono-

20   cultural perspectives that promote Euro-American ethnocentrism, because it was "created by the

21   mainstream to serve the mainstream… has failed marginalized people in fundamental ways"

22   (McLellan, 1999, p. 325).

23   Internationalization should not be "the 'Americanization' or 'Westernization' wrapped

24   around on the outside by a nice wrapping paper with an 'international' label" (Leung, et al., 2009;

25   p. 113), and instead, should be "an ongoing process of integrating knowledge from research and

26   practice derived from different cultures and applying this knowledge to solve problems in local

27   and global communities" (p. 112) and involves "collaborations and equal partnerships in which

28   cultural sensitivity and respect are required for success" (p. 115). An ethnocentric view would

29   make Western professionals of mental health counseling feel being in an "advanced" position

30   and having little to learn from other countries. An international attitude, however, would enable

31   them to see the actual reality that Western professionals do not know as much as those from

1   other countries about folk psychologies, different worldviews and diverse moral visions

2   (Christopher et al, 2014), the very foundations of mental health. As pointed out by Moghaddam

3   et al. (2007), alternative psychologies by the third world countries have more advanced abilities

4   to generate locally relevant knowledge and "achieve greater contextual sensitivity to address the

5   diverse needs of continually changing societies" (p. 181).   Moreover, there has been cultural

6   wisdom around the world that U.S. or other Western countries could benefit from. For instance,

7   understanding meaning of suffering, mindfulness practice, or lighting a lamp for someone else as

8   means to brighten one's own path, to name a few, from Eastern cultural or Buddhism traditions

9   can potentially help even the WEIRD at times.

10

11   **A dual-directional communicative path**

12

13   Building two-way streets in all international work is necessary and constructive, and

14   learning and sharing should always go hand in hand for all who are involved. Quite often

15   professionals from the West are automatically seen as teachers or experts when working in these

16   countries, which could make it difficult for them to engage in knowing and learning what they

17   lack while sharing what they know. Scholars have pointed out that Western professionals may

18   not be aware of the weakness in their knowledge and skills when cross-cultural work is

19   attempted. These areas include insufficient understanding of the "cultural grounding of human

20   experience and social relation" (Christopher et al., 2014; p. 652), weak tools and skills to

21   "discern folk psychologies and moral visions that differ from their own" (p. 652), and others. A

22   deliberately designed two-way street with collaborative partnerships will allow necessary mutual

23   learning to avoid harm inherit in one-directional sharing and maximize the benefit of dual

24   directional assistance and enrichment.

25   There are wisdom to be gained and lessons to be learned in both directions. It has been

26   well recognized that the mental health counseling profession in the West has a lot to be

27   internationalized, and the rest of the world has been trying to "catch up" by learning as much as

28   possible from the West. Little effort has been made to bring awareness that many non-Western

29   countries have a lot offer as well, in areas such as understanding folk psychologies, healing

30   people in relationships, holistic philosophy in health care, prevention via prioritizing public

31   health, Eastern religious teachings related to psychological peace and harmony, and so on.

1   Further, there are also various cultural practices around the world that are effective in non-
2   professional interventions aiming at coping, relaxation, and maintaining well-being. A good
3   example is that mindfulness and meditation from the Eastern tradition have been widely accepted
4   and proved to be efficacious in psychological healing and well-being for people cross country
5   and culture boundaries. Lack of intentional learning from other cultures is failure to use resource,
6   which hinders progress and development of a healthy discipline or profession.

7

8   **An agenda of courageous effort**

9

10 It takes courage to do the needed self-work before, during and after reaching out
11 internationally for Western professionals, because this work involves recognizing serious
12 limitations and blind spots, as well as the ethnocentrism embedded, in the knowledge that was
13 generated mainly by and for the WEIRD populations. Willingness to see the possible harm of
14 directly applying this knowledge in different cultures is necessary. Specifically, answering the
15 call for decolonizing psychological science (Adams, et al, 2012) and critically examining the
16 knowledge that is being disseminated require courage to challenge, to self-exam and to adopt
17 different perspectives. Liberation Psychology that addresses privilege-power dynamic and
18 Cultural Psychology that emphasizes the interplay of culture and mind (Shweder, 1990) are good
19 resources for learning. Getting out of the comfort zone and seriously considering de-
20 construction and re-construction of what has been established are necessary to meet the
21 challenge of the 21st century (Marsella, 1998). Further, it is important that one takes an *emic*
22 perspective in understanding any culture, and prioritizes achieving cultural fit. Being fluent in a
23 specific foreign culture is challenging but necessary, and it is impossible for anyone to be an
24 "expert" without being fluent in the culture and understanding the construction of the cultural
25 reality.

26 On the side of the professionals from non-Western cultures, it also takes courage to show
27 responsibility learning what is being offered, asking serious questions concerning its cultural fit,
28 and offering local cultural understanding to assist the necessary deconstruction and
29 reconstruction processes. It is always challenging to speak up to the powerful when being on the
30 bottom of the power totem. What may be helpful is the knowledge that no one knows particular
31 cultural contexts better than those who live in the culture. The similar logic applies that mental

health professionals within the culture have the unremitting responsibility to prevent harmful imports that lack cultural fit. In fact, Western professionals are generally interested in learning new cultures and respect those who can think critically and challenge existing knowledge, which is a practice Western scientific community values. They need assistance from the local professionals to pursue an international agenda!

Summary

Culture is the foundation of mental health and of everything we do in professional counseling. In the 21st century, we face the challenge of deconstructing the science and practice of psychology that are indigenous to the Euro-American culture, and re-construct theories of mental health and counseling to serve the diverse cultural communities in the global world. For the common goal of promoting mental health worldwide and advancing the psychological science, international collaborative efforts are needed and professionals in the different corners of the world should share the responsibility. Equal power international collaborations have to prevail the past one-directional international export/import to avoid harm and to achieve mutual benefit.

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