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

Abstract

Western initiated internationalization of professional psychology has resulted in mental health counseling, a profession indigenous to the Euro-American culture, being transplanted in different parts of the world. Questioning the cultural appropriateness of applying Western theories in non-Western cultures has become more and more imperative and urgent. This article reflects on the cultural context of Western professional counseling and its internationalization and discusses possible harm and problems of practicing Western mental health counseling internationally. Based on observations of counseling development and research in China, the argument is made that lack of attention to the role of culture leads to harm. All professionals who are interested in being part of this internationalization movement need to adopt an international attitude, conduct sharing and learning through a dual-directional collaborative pathway and show a commitment to do courageous work in de-constructing and re-constructing the science and practice of professional psychology for the global community. Only with proper and sufficient culturally informed effort, internationalization of mental health counseling can result in mutual enrichment and benefit all people in all cultures.

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

In the last few decades, one of the significant developments in the field of psychology and mental health has been internationalization of mental health counseling, an indigenous European-American cultural product (Christopher et al, 2014). Increasingly, scholars and practitioners from selected Western countries developed an “on-going commitment to and involvement in the international arena” (Casas, Park, & Cho, 2010, p. 191). This trend is inevitable in the context of modern globalization (Friedman, 2006), and reflects the interest and motivation of the Western professionals to make professional psychology international. While many parts of the world have generally embraced Western psychology and counseling, with or without choice or deliberate intention, there have been reasons and observations that call for
responsible and serious reflections about how this internationalization movement has influenced individuals, families and communities around the world. Such reflections may lead to reconsideration of how internationalization should be defined, conducted and promoted so it can reach the desired goal of benefiting but not harming those we intent to help.

In this paper, I briefly describe the cultural context of Western mental health counseling and discuss the possible lack of cultural fit when it is practiced in non-Western cultures. Based on my limited understanding and observations, I share what I see as problematic and reflect what is needed to put corrective effort forward and prevent further harm. Internationalization will continue and deliberate efforts are needed to make it a great movement benefiting the entire global village. For the sake of convenience, I used the term West or Western to group the United States and some parts of the Europe where there is a shared history of psychology discipline development.

This paper unavoidably contains my personal biases as a China-to-U.S. immigrant whose perspectives have been shaped by life experiences both in China and in the United States. I grew up in China, and have received graduate training, lived and worked in the United States. On a continuous basis, I am engaged in collaboration with Chinese scholars in mental health counseling research and training in China. My general, perhaps biased, conviction is that while the globe is gradually flattening (Friedman, 2006) in economics and other areas, the diversity of culture remains a beauty of the world and mental health a culture-driven phenomenon. Thus, I plea to our academic and professional community that significant attention be given to the role of culture in everything we do to promote mental health, and please recognize that failure of doing so is harm to non-Western individuals and societies that constitute a large part of the world.

Cultural Contexts of Mental Health Counseling Development and Internationalization

It is probably not accidental that mental health counseling along with its parenting scientific discipline, psychology, started in only a few small areas of the globe (West Europe and North America) and among a small portion of the world population, namely, the Western, Educated, Industrialized, Rich, and Democratic (WEIRD; Henrich, Heine & Norenzayan, 2010). Nor is it arbitrary that the principles and ideologies reflected in the professional counseling, as we know it today, are mostly consistent with those rooted in individualism (Baumerister, 1987)
that dominates Euro-American cultures (Hofstede, 2001) and are highly valued among the WEIRD. As these cultures promote individual rights, autonomy and independence, and free choice, mental health counseling logically and conveniently emphasizes self-understanding, self-identity, self-actualization, freedom, individual happiness, and so on. As noted, the development of mental health counseling or psychotherapy has been viewed “a clear American tale of discovery, entrepreneurship, and self-promotion” (Engel, 2008; p. xiv).

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

It is apparent that the narrow cultural focus of psychology, unrepresentative of the majority of cultures worldwide, led to a culturally exclusive psychological knowledge base that
is difficult for international application due to lack of cultural fit. Nonetheless, the past few decades have witnessed mental health counseling in theoretical and practical packages being transported from the West to many parts of the world regardless of local cultures. The privilege of circulating cultural products in a culturally neutral manner certainly belongs to Western professionals and shapes the development of psychology in the international arena.

The push from the West to popularize psychology and mental health counseling in China occurred in late 1980s as the world globalization was marked by new progresses (Boughton, 2002) and when China embarked on its economic reform following the “Open Door” policy issued in 1978. This Open Door action opened not only China’s economic market but also its people’s mind toward the West and interest in Western cultural and intellectual products. At the time when mental health counseling as a profession had matured in European and North American countries, the idea of expanding its influence and disseminating its products seemed natural, timely and appealing. Thus, a gradual movement transpired in the West, particularly the United States, to introduce counseling profession to other countries (Gerstein, Heppner, AEgisdottir, Leung, & Norsworthy, 2009).

As the result, under the name of “internationalization,” and sometimes accompanied by “indigenization,” counseling theories and systems entered China from the United States and some European countries, along with devoted scholars and practitioners who generously offered their time and expertise to training Chinese practitioners. Having no non-medical professional mental health care at the time (Qian, Smith, Chen & Xia, 2002), China eagerly accepted the newly imported theories and systems. For instance, psychoanalysis, in its rather traditional form, became a hot and attractive area quickly, and caused high “folk fever” among professionals and the public (Jia, 2016; p, 379). With the persistent effort from several groups of psychoanalysts from Germany, United States and Norway, China let “Freudians put China on the couch” (Tatlow, 2010) just in a few short years. It is quite provocative for us to witness the increasing popularity of Western imported psychoanalysis in China during the time when the medical historian Jonathan Engel (2008) stated “Psychoanalysis has largely died” (p. x) in the United States and the president of American Psychoanalytic Association Dr. Warren Procki acknowledged, in 2010, that “There is an unavoidable message here, much as we do not want to hear it … We are in a decline” (Cited in Evan Osnos, 2011, p. 56). In significant ways, 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
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.
There has been research examining mental health related concepts as associated with individualism and collectivism. By comparing mental health stigma among several different ethnic groups in UK, Papadopoulos, Foster and Caldwell (2012) revealed that, “the more stigmatizing a culture's mental illness attitudes are, the more likely collectivism effectively explains these attitudes. . . . the more positive a culture's mental illness attitudes, the more likely individualism effectively explains attitudes” (p. 270). These findings are not surprising considering the nature of individualism and collectivism, but what is interesting and provocative is that such findings are often taken as denoting something negative about collectivism in terms of mental health care. The Westernized thinking is that stigma is an obstacle for promoting interventions and therefore should be reduced or eliminated. Rarely researchers have openly reflected on the possibility that findings like these indicate how mental health is defined, mental illness identified, and mental health care provided are inappropriate in collectivism dominant cultures.

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

Cultures vary in how they view un-conventional or un-normal behavior. The U.S. based Diagnostic and Statistical Manual of Mental Disorders, a creation of American Psychiatric Association, demonstrated a high tendency to pathologize behaviors. From the first to the fifth edition, it grew from 129 pages containing 106 diagnoses in 1952 to 950 pages with roughly 375 diagnoses in 2013. However, when DSM diagnostic criteria consistent behaviors were presented to Chinese, most people would not label them as being symptoms of illness. Rather, they would see the “symptoms” as evidence of “taking things too hard” or “being stuck in thinking” (Li, 2014). This phenomenon is conveniently labeled by Western standards as lack of “mental health
literacy” (Jorm, 2011), the connotation of which is unmistakable. Clearly, emphasis on labeling mental illness is culturally determined but the culture neutral stance or cultural inaptness of Western research has portrayed non-Western countries as being lagged behind or underdeveloped in removing stigma toward mental illness, which is culturally insensitive, improper, and possibly damaging.

Mental Health Counseling as an Internationalized Profession

Gradually and surely, mental health counseling has become an international phenomenon. While the Western internationalization has contributed to development of the profession in many parts of the world, a critical view has always existed regarding the one-directional nature of such international effort and its unintended negative consequences (e.g., Duan & Goodyear, 2016). However, this concerning view has not made any wave under the impetus for showing generosity in helping the needed. In his thought provoking and influential book *Crazy like us: The globalization of American Psyche*, Ethan Watters (2010) documented several ways in which the best-intentioned helping efforts by American mental health professionals disseminated the “American brand of hyperintrospection and hyperindividualism” (p. 254) and supported “the grand project of Americanizing the world’s understanding of the human mind” (P.1).

Using narrated country specific case examinations, Watters detailed how psychopathology or mental illness, defined by the West, was introduced and passed on to different countries. As a result, anorexia nervosa that used to be an exclusive Western eating disorder (Swartz, 1985) became prevalent in Hong Kong through the promotion of Western thinking concerning healthy/unhealthy eating behavior, and by popularizing diagnostic labels, illness-focused prevention and intervention strategies to reinforce the notion of eating disorder. Through a different route, “Americanized version of depression” (p.2), along with corresponding SSRIs (Selective Serotonin Reuptake Inhibitors), was introduced and imposed to Japanese after the targeted “educational” campaign by American drug companies with involvement of credible psychiatry experts. Japanese were educated by Westerners to change their negative attitude toward depression, which marked the beginning of the current state of affair that increasingly more people became depressed and depression was medicalized (Kitanaka, 2006). Packaged with the post-crisis assistance, PTSD (Post Traumatic Stress Disorder), an American socio-political specific label for a particular group of veterans at a particular point in time, was brought to Sri Lanka after 2004 Indian Ocean tsunami by well-intentioned U.S. professionals. Operating out of
their own knowledge base, experts introduced PTSD symptoms as must-be-present after natural disasters and taught the locals how to think or feel as victims. The gross cultural inappropriateness was “disappointing and sometimes shocking” (Ganesan, 20016; p. 360) to local professionals and create negative consequences with real people being harmed (Christopher et al., 2014).

From one angle, these cases illustrated how one-directional internationalization could result in Westernizing mental illness and its interventions, which has caused harm in various cultures. Undoubtedly, such potential harm was unintentional, but unintentional harm is harm and should not be brushed over. In the counseling profession anywhere nowadays, Western knowledge is clearly privileged and local scholarship and healing practices discouraged or refuted. One major reason is due to the power structure, where scholars from the Western countries run premier scholarly journals and host prestigious academic and professional conferences; Western universities train world’s most influential academics and clinicians; Western generous volunteers have the resource to engage in world crisis interventions; Western medical models (often used in counseling) enjoy world-wide recognition and acceptance; Western drug companies spend big money promoting psychotropic medications everywhere; and so on. The values embedded in most currently available counseling systems and assumptions about how human mind works are representative of those by the WEIRD populations rather exclusively. From top or powerful positions, Western professionals can easily apply their knowledge as universally helpful and offer assistance accordingly, which in turn helps maintain the Western position of power.

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

Both anecdotal and empirical observations in China support the argument that mental health is a culture-bound concept, and harm is really possible when it is viewed in a cultural vacuum. Facing the reality that Western counseling theories and practices have gained acceptance and popularity among mental health providers, it is time for researchers, practitioners and consumers as well as the governmental agencies to ask serious questions concerning the consequences of such practice. Fortunately, conversations on issues related to cultural fit of imported counseling theories and methods have started (e.g., Jia & Zen, 2014). There have also
been empirical studies examining cultural characteristics of Chinese mental health, mental illness, therapeutic interventions and healing arts, which will enrich the understanding of ways to enhance mental health.

In the United States, goals of mental health counseling reflect the mega theme of individualism, namely, “helping individuals to overcome obstacles to their personal growth, wherever these may be encountered, and toward achieving optimum development of their personal resources” (American Psychological Association, 1956, p. 283). The markers of mental health include adequate self-understanding or insight, self-identity, self-realization, autonomy, freedom, choice, independence, individual happiness, no negative emotions, etc. The focus on the individual and individual rights and interest is in the center of these definitions. The existential theorist Rollo May reflected toward the end of his life:

“... we in America have become a society devoted to the individual self. The danger is that psychotherapy becomes a self-concern, fitting what has recently been called a new kind of client, the narcissistic personality. ... we have made of therapy a new cult, a method in which we hire someone to act as a guide to our success and happiness. Rarely does one speak of duty to one’s society – almost everyone undergoing therapy is concerned with individual gain, and the psychotherapist is hired to assist in this endeavor” (Rollo May, 1992: p. xxv)

In sharp contrast, China defines the goals of mental health services as “to improve public mental health, promote social stability and interpersonal harmony, and enhance public well-being, ... and to cultivate good morality, promote coordinated economic and social development, nurture and exercise socialist values and principles” (Committee of National Health and Family Planning, 2016, p.1). The central focus is on stability, harmony, public well-being, and morality to ensure economic and social development. These goals differ from those cherished by most mental health counseling theories in 1) emphasizing public health, 2) promoting harmony, which has to involve others or society, and 3) stressing morality and social responsibility.

The different views of mental health reflect different cultural values, particularly those values concerning the individual and self. There have been theories differentiating individual, collective and relational self (Sedikides & Brewer, 2001) and independent and dependent self (Markus & Kitayama, 1991). Theorists tend to view these various selves co-existing in individuals, but recognize the patterns of experienced self in cultures (Oyserman, & Lee, 2008;
Sedikides, Gaertner & O’Mara, 2011). It is not hard to derive the general understanding from a myriad of theories and research findings that the independent self and individual self are more salient than relational, collective, or dependent self for individuals from the West (more individualist than collectivist culture) and the vice versa for those from the East (more collectivist than individualist culture).

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

Arguably, Chinese culture has been changing and adjusting in the context of being a member of the globalized world (Liu, 2012), but distinct cultural characteristics remain. A study of mental health values among college students revealed several traditional cultural tenets in how mental health is viewed (Lei, 2016). After running several focus groups, interviews, and a survey of a large number of students, Lei found six themes of their mental health values: functionality in contexts, family, relationship, character and attitude, purpose and meaning, achievement and communication. These themes contrast those used to measure mental health values in the United States: self-acceptance, negative traits, achievement, affective control, good interpersonal relations, untrustworthiness, religious commitment and receptivity to unconventional experiences (Tyler et al., 1983). Chinese students’ values seem to be more collectivist than individualist and more other-focused than self-focused. In her report, Lei particularly emphasized that throughout her research process, family and relationship arose as top considerations among the participants whenever they thought about mental health.
There have also been limited discussions and empirical explorations on cultural variations regarding mental illness and its diagnosis, which demonstrates researchers’ attention to the importance of culture. Nonetheless, DSM still becomes a widely used diagnostic bible all over the world and mental illness is talked about linguistically as a universal concept. Notably, a recent study in China produced evidence to question this practice. Using a large sample drawn from multiple provinces and representative of a wide range of age and educational levels, Li (2015) examined the public’s view of mental illness. The result showed that Chinese public lacked a clear concept of mental illness/disorder (not seeing certain DSM symptoms as expression of mental illness), focused on consequence/impact when led to think about mental illness, emphasized multi-factors if asked to make attributions, and recognized both the role of individual subjective willpower and that of social/family support when talking about healing from mental illness. In contrast, studies in the United States had demonstrated a strong public concept of mental illness, high stigma toward those who are mentally ill in society; strong focus on causes and biomedical interpretations in discussing mental illness; and enthusiasm advocating for professional care (Martin, Pescosolido, Olafsdottir, & McLeod, 2007). Evidently, Westerners endorsed more of a medical view and made stronger call for professional interventions than Chinese, and Chinese were less likely to see atypical behaviors as expression of illness and more concerned with consequences of those behaviors than Westerners.

Observable in clinical settings, Western beliefs about psychological trauma (how it occurs and recovers), necessity of venting emotions for recovery (seen as healthier than stoic silence), humans fragility and mental illness, biomedical approach to understanding and treating mental illness have shaped treatment of mental illness all over the world. In my many conversations with and supervision of Chinese counselors, I have observed that they tried very hard to do use the “right” intervention, even if they feel it being counterintuitive and lacking cultural fit. For instance, once in a supervision group when one relatively unexperienced member reported that her male college student client, who came to counseling for lack of motivation to study, reported feeling better after two “supportive” sessions, several more experienced counselors in the group expressed doubt about the progress and deemed the client being in denial. They believed that he couldn’t have really felt better because he had not developed deep understanding of the trauma his strict mother (Client said that his mother was strict and would ban him from playing when he received bad grade) had caused him, got in touch with and
express his inner anger toward mother, and experienced transference with the counselor to fully
express his anger toward mother in session. I was in absolute disbelief, seeing the degree to
which the Western psychoanalytic thinking compromises local clinician’s sense of cultural
reality. It is alarming knowing that prior to counseling being internationalized, “Nowhere else in
the world do people explore their deepest and most intimate secrets with total strangers with such
alacrity and enthusiasm” (Engle, 2008; p. xiv).

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

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

**Reflective comments:**

Internationalization of mental health counseling should and will continue. With proper culturally informed effort it will benefit all people in all cultures. There are significant challenges, however. First, although the existence of cultural diversity has been generally acknowledged, the danger of its absence in mental health counseling has not generated due attention. Sufficient awareness is yet to be achieved that psychology and established mental health counseling are indigenous to the Euro-American culture, and without proper de-constriction and re-construction, transplanting it to other cultures runs the risk of being culturally colonizing (Adams, Kurtiș, Salter, & Anderson 2012), homogenizing (Melluish, 2014), and even exploitation (Jagger, 2002). Further, the one-directional internationalization from the West to developing countries or the “global south” during the time of their economic and social vulnerability has created large markets for Western imported counseling systems and inadvertently marginalized local professionals and local folk psychologies. American “definitions and treatments” of mental illness “have become the international standards” (Watters, 2010; p. 2), which gives more power to Western exporters and more urgency to locals to import what is offered by the West. The language barrier also contributes to the existing power structure by using English in the world’s understanding of mental health. While students of psychology in many non-English speaking countries have full access to English literature, most English-only speaking scholars may have limited knowledge the countries where they are offering help. Much of the research outcome from non-English speaking countries has not been integrated in the knowledge of the profession.

Actively pursuing an international agenda is on the right side of history, but making this course mutually beneficial requires deliberate, intentional and well-thought equal-power collaborations among all who are involved. There are proposed models and methods such as emic-and-etic integrative approach (Cheung, van de Vijver, & Leong, 2011) or cultural lens approach (Hardin, et al., 2014) that are appropriate for international work, but acquiring international and multicultural competence should the preamble. Individuals who are to conduct international work need to position themselves with an appropriate attitude and clear direction as well as a commitment to doing the necessary learning before embarking on the task.
An International Attitude

An international attitude involves a new worldview that acknowledges the uneven distribution of power, a new understanding of how this power structure shapes human experience in international communities, and a new commitment to dismantling this power structure for the sake of being truly humanitarian and generating mutual benefit. Further this attitude contains a view seeing all international work as a mutual learning process, because there are no experts when the knowledge changes cultural settings. It falls on the shoulders of the powerful to be willing to share power, adopt a learning mindset, and respect equal partnership. The less powerful should recognize their power on other scales such as the knowledge of local culture, being in a relatively more relational context, and having access to local resources. Each side has advantages and disadvantages and has the responsibility to share with and learn from the other. This has to be a deliberate and intentional process in which both offerors and receivers cultivate a critical cultural awareness and initiate examinations of cultural fit for everything that is transported.

In clinical settings, an international attitude allows us to see that culture defines mental health and constructs clinical reality (Kleinman, Eisenberg & Good, 2006), and any ethnocentric view of mental health is harmful to others in different cultural reality (Comas-Diaz, 2011). It is a sobering fact that the current body of psychological knowledge is largely grounded in monocultural perspectives that promote Euro-American ethnocentrism, because it was “created by the mainstream to serve the mainstream… has failed marginalized people in fundamental ways” (McLellan, 1999, p. 325).

Internationalization should not be “the ‘Americanization’ or ‘Westernization’ wrapped around on the outside by a nice wrapping paper with an ‘international’ label” (Leung, et al., 2009; p. 113), and instead, should be “an ongoing process of integrating knowledge from research and practice derived from different cultures and applying this knowledge to solve problems in local and global communities” (p. 112) and involves “collaborations and equal partnerships in which cultural sensitivity and respect are required for success” (p. 115). An ethnocentric view would make Western professionals of mental health counseling feel being in an “advanced” position and having little to learn from other countries. An international attitude, however, would enable them to see the actual reality that Western professionals do not know as much as those from
other countries about folk psychologies, different worldviews and diverse moral visions
(Christopher et al, 2014), the very foundations of mental health. As pointed out by Moghaddam
et al. (2007), alternative psychologies by the third world countries have more advanced abilities
to generate locally relevant knowledge and “achieve greater contextual sensitivity to address the
diverse needs of continually changing societies” (p. 181). Moreover, there has been cultural
wisdom around the world that U.S. or other Western countries could benefit from. For instance,
understanding meaning of suffering, mindfulness practice, or lighting a lamp for someone else as
means to brighten one’s own path, to name a few, from Eastern cultural or Buddhism traditions
can potentially help even the WEIRD at times.

A dual-directional communicative path

Building two-way streets in all international work is necessary and constructive, and
learning and sharing should always go hand in hand for all who are involved. Quite often
professionals from the West are automatically seen as teachers or experts when working in these
countries, which could make it difficult for them to engage in knowing and learning what they
lack while sharing what they know. Scholars have pointed out that Western professionals may
not be aware of the weakness in their knowledge and skills when cross-cultural work is
attempted. These areas include insufficient understanding of the “cultural grounding of human
experience and social relation” (Christopher et al., 2014; p. 652), weak tools and skills to
“discern folk psychologies and moral visions that differ from their own” (p. 652), and others. A
deliberately designed two-way street with collaborative partnerships will allow necessary mutual
learning to avoid harm inherit in one-directional sharing and maximize the benefit of dual
directional assistance and enrichment.

There are wisdom to be gained and lessons to be learned in both directions. It has been
well recognized that the mental health counseling profession in the West has a lot to be
internationalized, and the rest of the world has been trying to “catch up” by learning as much as
possible from the West. Little effort has been made to bring awareness that many non-Western
countries have a lot offer as well, in areas such as understanding folk psychologies, healing
people in relationships, holistic philosophy in health care, prevention via prioritizing public
health, Eastern religious teachings related to psychological peace and harmony, and so on.
Further, there are also various cultural practices around the world that are effective in non-professional interventions aiming at coping, relaxation, and maintaining well-being. A good example is that mindfulness and meditation from the Eastern tradition have been widely accepted and proved to be efficacious in psychological healing and well-being for people cross country and culture boundaries. Lack of intentional learning from other cultures is failure to use resource, which hinders progress and development of a healthy discipline or profession.

An agenda of courageous effort

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

On the side of the professionals from non-Western cultures, it also takes courage to show responsibility learning what is being offered, asking serious questions concerning its cultural fit, and offering local cultural understanding to assist the necessary deconstruction and reconstruction processes. It is always challenging to speak up to the powerful when being on the bottom of the power totem. What may be helpful is the knowledge that no one knows particular 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.


