

Counselling Priorities in China and the United States: A Cross-Cultural Review of Identity, Stigma, and Help-Seeking

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Abstract

This study critically reviews differences in counselling priorities between China and the United States in relation to broader cultural contexts. It argues that although counselling in both societies ultimately aims to promote psychological well-being, culturally salient counselling concerns differ across settings. In U.S. counselling literature, multicultural competence, intersectionality, cultural humility, race, ethnicity, religion/spirituality, gender, sexuality, and discrimination are frequently foregrounded in relation to therapeutic trust and alliance. In contrast, Chinese counselling literature more commonly emphasises stigma, self-reliance, low mental health literacy, face concerns, family expectations, social pressure, and reluctance to seek professional help. These differences should not be interpreted as rigid national oppositions; rather, the review suggests that both contexts involve issues of identity, stigma, access, and trust, albeit expressed in culturally distinct ways. The paper concludes by arguing that culturally responsive counselling should move beyond essentialised East–West binaries and instead address locally situated experiences of identity, stigma, trust, and social responsibility.

Keywords

counselling, multicultural competence, mental health stigma, help-seeking behaviour

1. Introduction

Counselling is commonly understood as a professional process aimed at alleviating distress, strengthening coping capacities, and promoting psychological well-being. However, counselling is not culturally neutral. Cultural values, social norms, stigma, identity, and institutional accessibility shape the concerns clients bring into therapy, the meanings attributed to emotional distress, willingness to seek help, and expectations of therapists. The World Health Organization notes that poor service quality, low mental health literacy, stigma and discrimination, unaffordability, and limited service availability can all discourage individuals from accessing mental health care [1]. Consequently, counselling priorities must be understood within specific cultural contexts rather than generalised across societies. Although such barriers exist globally, they manifest differently across cultures and therefore generate different counselling priorities. The purpose of this review is not to determine which country possesses a “better” counselling model, but rather to examine how counselling priorities differ between China and the United States in relation to distinct cultural backgrounds, social structures, and expectations surrounding therapy. Counselling literature and professional guidance in the

United States frequently emphasise multicultural competence, multicultural identity, and culturally responsive practice. According to multicultural guidelines published by the American Psychological Association, identity is fluid, complex, intersectional, and shaped by social structures, language, power, privilege, oppression, and institutional barriers [2]. Research on multicultural orientation further indicates that clients who perceive therapists as multiculturally responsive tend to report stronger therapeutic alliances and improved psychological functioning [3]. These findings suggest that race, ethnicity, religion, spirituality, gender, sexuality, discrimination, and trust in the therapeutic relationship are often central concerns in U.S. counselling contexts. In China, however, studies of counselling and mental health service utilisation more frequently focus on stigma, self-reliance, family expectations, face concerns, and social evaluation. Shi et al. [4] report that Chinese adults often encounter barriers to professional help-seeking associated with self-reliance, alternative coping resources, low perceived need, affordability concerns, negative attitudes, stigma, family barriers, limited mental health literacy, and reluctance to disclose psychological difficulties. Ning et al. [5] similarly identify misconceptions about counselling, distrust of campus counselling services, stigma, low mental health literacy, and access barriers as significant obstacles among Chinese university students. This review therefore argues that while counselling in both societies seeks to promote mental health, the therapeutic concerns considered most salient differ across cultural contexts. The paper first outlines the theoretical background before reviewing literature concerning multicultural counselling in the United States, stigma and help-seeking in China, family and social pressures, and the implications for culturally responsive counselling practice.

2. Theoretical Background

This review is informed by four interrelated concepts: multicultural competence, stigma and help-seeking, collectivist family norms, and culturally responsive counselling. Together, these concepts help explain why different counselling priorities emerge across societies while preserving the shared purpose of counselling. First, multicultural competence refers to a therapist's ability to work effectively with clients whose cultural identities, values, and social experiences differ from their own. Sue et al. [6] conceptualise multicultural competence as comprising three major domains: counsellor awareness of personal assumptions, knowledge of culturally diverse clients, and culturally appropriate intervention skills. This framework is particularly relevant in the United States, where counselling frequently involves issues relating to race/ethnicity, religion, gender, sexuality, and other identity dimensions. Multicultural competence therefore extends beyond simply "knowing" about cultural groups; it also involves recognising how social location shapes distress, trust, and therapeutic communication. Second, stigma and help-seeking theory help explain why individuals may avoid professional counselling despite experiencing psychological distress. Stigma may operate socially, publicly, or internally through shame and self-blame. This is especially relevant in China, where help-seeking may be constrained by concerns about disclosure, social evaluation, and being perceived as weak or mentally unstable. Shi et al. [4] identify self-reliance, low perceived need, negative attitudes, stigma, family opposition, and unwillingness to disclose mental illness as significant barriers among Chinese adults. Similarly, Yin et al. [7] found that higher levels of public stigma were associated with lower mental health literacy in Chinese community samples. Third, collectivist family norms are important because decisions regarding counselling are often relational rather than purely individual. In collectivist settings, emotional distress may be interpreted through the lens of family responsibility, social harmony, and relational obligations. Kuo [8] argues that many Asian clients may find Western individualistic counselling models unfamiliar because these models prioritise autonomy and emotional self-expression over interdependence and relational problem-solving. Yu et al. [9] further demonstrate that stigma and family pressure can significantly influence treatment-seeking behaviour for depression in China. Finally, culturally responsive counselling involves adapting therapeutic approaches to clients' cultural and social realities. The multicultural orientation framework emphasises cultural humility, cultural comfort, and responsiveness to cultural opportunities within therapy [10]. This perspective provides a useful framework for comparing counselling priorities in China and the United States because it does not assume that all clients share identical concerns; rather, it examines which concerns are most salient within specific cultural environments.

3. Literature Review

3.1 Counselling and Multicultural Identity in the United States

U.S. counselling literature places strong emphasis on the relationship between culture and therapy. Although race and ethnicity remain important considerations, multicultural counselling has expanded to include religion, spirituality, gender, sexuality, social class, language, immigration status, and intersecting systems of power. This emphasis emerged partly from civil rights movements, increasing awareness of mental health disparities among minority populations, and critiques of Eurocentric psychotherapy models. According to multicultural guidelines issued by the American Psychological Association, contemporary multicultural practice should consider culture, language, gender, race, ethnicity, ability, sexual orientation, socioeconomic status, religion, spirituality, immigration, education, and employment as interconnected dimensions of identity [2]. Identity therefore becomes central to many therapeutic interactions. Research further demonstrates the significance of identity-sensitive practice. Cabral and Smith's meta-analysis found that although clients did not overwhelmingly prefer therapists of matching racial or ethnic backgrounds, clients perceived therapists more positively when racial or ethnic identities were shared; however, psychotherapy outcomes remained broadly comparable even without racial matching [11]. This finding suggests that identity matters not simply through demographic similarity, but through therapists' ability to recognise cultural meanings, respond appropriately, and build trust. Meyer and Zane [12] similarly observed that ethnic minority clients considered race and ethnicity more important in treatment than White clients and reported lower satisfaction when these topics were personally salient but not discussed in therapy. In a systematic review of 48 qualitative studies, Sadusky et al. [13] identified practitioner awareness, responsiveness, representation, inclusivity, and reduced discrimination as key factors valued by culturally and racially marginalised clients. Such findings reinforce the argument that cultural competence is not merely an abstract professional ideal but directly affects clients' experiences of safety, respect, and therapeutic alliance. Likewise, cultural humility—defined as an other-oriented stance characterised by openness and non-superiority—has been associated with stronger working alliances and improved therapeutic outcomes [14]. Sexual identity, religion, and spirituality also represent important counselling priorities within the United States. Guidelines from the American Psychological Association concerning sexual minority populations highlight minority stress, intersectionality, stigma, discrimination, victimisation, microaggressions, internalised stigma, and identity concealment [15]. LGBTQ-affirmative psychotherapy emerged partly in response to mental health disparities and social stigma and has demonstrated effectiveness across various populations and therapeutic settings [16]. Pearce et al. [17] additionally argue that spiritual and religious diversity remains insufficiently addressed in graduate mental health training despite its relevance to multicultural counselling practice.

3.2 Stigma and Help-Seeking in the Chinese Context

Shi et al.'s systematic review [4] identifies multiple barriers that discourage Chinese adults from seeking professional mental health services, including preferences for self-reliance, alternative support systems, limited perceived need, restricted accessibility, unwillingness to disclose mental illness, concerns about burdening family members, limited mental health literacy, affordability concerns, negative attitudes, and stigma. These findings suggest that the issue extends beyond mere service availability. Similar patterns appear in university counselling contexts. Ning et al. [5] identified misconceptions about counselling, distrust of campus counselling services, stigma surrounding mental illness, low mental health literacy, and difficulties accessing services as important barriers among Chinese university students. Wang et al. [18] further found that help-seeking intentions among Chinese undergraduates were significantly associated with perceived susceptibility, perceived severity, perceived benefits, perceived barriers, self-efficacy, and external encouragement. These findings imply that psychological distress alone does not necessarily lead students to seek counselling; rather, help-seeking depends upon recognition of the problem, trust in services, accessibility, and social encouragement. Yin et al. [7] found that limited mental health knowledge was associated with greater public stigma within Chinese samples. Similarly, Zhang et al. [19] argue that low mental health literacy may reinforce misconceptions, stigma, and discrimination while simultaneously reducing help-seeking and treatment effectiveness. They also note that much existing Chinese research remains geographically limited and heavily dependent on cross-sectional methodologies. Taken together, these findings suggest that counselling priorities in China often emerge before formal therapeutic engagement itself. Stigma reduction, mental health literacy promotion, institutional trust-building, equitable access to counselling services, professionalisation of

counselling systems, and increasing the social acceptability of counselling all become crucial priorities. These concerns are closely connected to broader cultural issues involving face, disclosure, social evaluation, and the comparatively recent expansion of mental health services.

3.3 Family Expectations and Social Pressure

Counselling priorities in China are also strongly shaped by family expectations and relational obligations. Xu et al. [20] argue that understanding mental health care in China requires attention to family involvement, urbanisation, internal migration, and the influence of traditional Chinese medicine perspectives on mental health. Yu et al. [9] found that stigma and familial obligations significantly affect treatment access among Chinese patients. Some participants hesitated to seek support because mental illness could potentially burden or stigmatise the family itself. Kuo's [8] discussion of collectivist counselling frameworks is relevant here, as he suggests that many Asian clients may perceive Western counselling approaches as unfamiliar because they emphasise autonomy, emotional disclosure, and self-focused change, whereas collectivist approaches prioritise interdependence and relational harmony. Ma et al. [21] similarly found that face concerns among Chinese international students in U.S. universities were associated with greater self-stigma, depression, anxiety, language discrimination, and reduced willingness to seek help. This demonstrates that concerns regarding face, social image, and disclosure can persist across national contexts and continue to shape counselling expectations even outside China.

3.4 Comparing Counselling Priorities Across Contexts

China and the United States should not be viewed as absolute opposites but rather as contexts characterised by differing emphases. Stigma, service barriers, identity considerations, and treatment gaps exist in both settings, although they manifest differently. The World Health Organization identifies stigma, discrimination, low literacy, poor service quality, and limited access as global barriers to mental health care [1]. At the same time, U.S. university counselling systems face substantial demand pressures. The Center for Collegiate Mental Health annual report summarised data from 213 counselling centres, 173,536 students, 4,954 clinicians, and more than 1.2 million appointments during the 2023–2024 academic year [22]. However, counselling discourse in the United States more frequently focuses on how therapists should address identity, discrimination, intersectionality, and culturally specific experiences. In contrast, Chinese counselling literature often centres on why and how individuals access counselling at all, as well as whether counselling services are trustworthy and socially acceptable. The difference therefore lies less in counselling's ultimate goals than in the social and cultural conditions that shape which therapeutic concerns become most urgent.

4. Discussion

The literature suggests that differences between counselling priorities in China and the United States primarily concern relative salience rather than fundamentally different therapeutic aims. In both settings, counselling seeks to reduce distress, strengthen coping capacities, and improve functioning. Nevertheless, therapy is embedded within distinct social realities. In the United States, a recurring concern involves addressing identity, discrimination, and structural inequalities without reducing clients to fixed categories. This partly explains why multicultural competence, cultural humility, and multicultural orientation remain so prominent: they conceptualise therapy not merely as a technical intervention, but as a relational, reflective, and ethically grounded process [6,14]. A major risk within U.S. practice is that failure to engage cultural dimensions may reproduce silence surrounding race, ethnicity, religion, sexuality, gender, or discrimination. In China, by contrast, the literature suggests that many individuals may never reach counselling services in the first place. Stigma, self-reliance, low perceived need, mistrust of services, fear of disclosure, and family pressures may all discourage professional help-seeking [4,5]. This does not imply that Chinese clients lack identity-related concerns, nor that stigma is absent in the United States. Rather, accessibility and social legitimacy often become threshold issues in Chinese counselling contexts. Consequently, psychoeducation, normalisation of emotional distress, confidentiality, trust-building, and culturally sensitive engagement with family expectations and social image become especially important. Importantly, "individual" and "collective" should not be understood as rigid binaries. Contemporary multicultural practice in the United States increasingly addresses social systems, intersectionality, and structural inequality [2]. Likewise, Chinese counselling is not solely concerned with maintaining family conformity; clients may simultaneously

experience family pressures and desire private spaces in which to discuss distress. Although family obligations can provide support, Yu et al. [9] demonstrate that they may also generate burden, affiliate stigma, and reluctance to disclose depression. A major similarity across both contexts is therefore the centrality of trust. U.S. research indicates that culturally responsive practice contributes to stronger therapeutic alliances and greater satisfaction, particularly when cultural concerns are salient for clients [3,12]. Chinese studies similarly suggest that trust depends upon reducing stigma, increasing awareness, improving accessibility, and ensuring that counselling services are socially safe [7,19]. In this respect, the multicultural orientation framework is particularly useful because it emphasises humility, cultural comfort, and sensitivity to cultural opportunities rather than relying upon rigid cultural “checklists” [10]. One limitation of the current literature is that much evidence derives from student samples and cross-sectional designs, often relying upon broad national categories. Future research should therefore examine counselling encounters more directly, include more diverse populations and regions, and avoid simplistic East–West generalisations.

5. Conclusion

This review argues that differences in counselling priorities between China and the United States primarily reflect differing forms of cultural salience rather than fundamentally different therapeutic purposes. In both contexts, counselling seeks to reduce distress, strengthen coping capacities, and promote psychological well-being. Nevertheless, U.S. counselling discourse tends to foreground multicultural identity, discrimination, intersectionality, cultural humility, and therapeutic alliance, whereas Chinese counselling literature more frequently emphasises stigma, low mental health literacy, family obligations, face concerns, self-reliance, and reluctance to seek formal help. These distinctions are significant because counselling that ignores the social meaning of distress and help-seeking is less likely to be effective. In the United States, culturally responsive practice requires therapists to acknowledge the potential influence of race, ethnicity, religion, sexuality, gender, and discrimination on trust and client expectations. In China, counselling may require greater attention to psychoeducation, confidentiality, social judgement, family pressures, and concerns about losing face. Importantly, these priorities are not mutually exclusive. Identity concerns, stigma, family obligations, access barriers, and trust issues exist in both contexts, although they emerge with different levels of prominence. The broader implication is that counsellors should avoid assuming that a single therapeutic model universally fits all clients. Culture should not be reduced to either a checklist or a national stereotype. Instead, culturally responsive counselling should examine which concerns are most salient for particular clients within specific social contexts, including identity, stigma, family, social pressure, access, and trust. Future studies should employ more diverse samples, directly compare counselling experiences across China and the United States, and avoid oversimplified East–West assumptions.

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