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JAMES COOK UNIVERSITY AUSTRALIA

Cultural Negotiations in Transnational Knowledge: Cases of Clinical Psychology from the Malay Archipelago and Beyond

Thesis submitted for Master of Philosophy in Interdisciplinary Studies

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Declaration of Ethics

This research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct in Human Research (2007). The proposed research study received human research ethics approval from the JCU Human Research Ethics Committee Approval Number H5302.

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Statement of the Contribution of Others

In addition to the important contributions of members of the Advisory Panel, the research and thesis benefitted from the following contributions of others.

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Contribution	Name	Affiliation
Pilot interview	Dr Nenna Ndukwe	California Counseling
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Abstract

This interdisciplinary thesis in Anthropology and Psychology seeks to understand how transnational knowledges can be culturally negotiated and how cultural imperialism in higher education can be countered. Cultural imperialism is a central challenge in transnational higher education as it intersects with the globalisation of knowledges. In the Malay Archipelago – a region between Southeast Asia and the Pacific with interweaving cultural, linguistic and trade histories – the expansion of transnational education is critiqued for supporting a neo-colonial incorporation of knowledge from the west. This situation demonstrates the critical need to understand how students and academics in this region engage with transnational knowledge and through this engagement negotiate knowledge.

Cultural negotiations in transnational knowledge are explored through a case study of clinical psychology, an academic discipline taught in postgraduate programs and practiced in mental health care settings. A mapping of exchanges in clinical psychology in the Malay Archipelago shows that the discipline continues to be influenced by one-way flows of knowledge from Europe, and more recently from Australia to the region. Therefore, this thesis also looks beyond the archipelago to explore the important contexts of transnational education and (post)colonialism through cases from Australia and the Netherlands (representing Europe).

This interdisciplinary thesis analyses case studies of clinical psychology from a social science perspective, using theories from cultural anthropology and psychology. From an anthropological perspective based on interdisciplinary theories of globalisation, deterritorialisation, and power/knowledge, academic disciplines are analysed as territories of change. Territories consist of non-hierarchical networks of

knowledges that are constantly changing as they are reinterpreted – clinical psychology is constantly mapping its own terrains. This notion creates an analytical space for the study of cultural influences on clinical psychology knowledge through a focus on application in training and practice. From a psychological perspective, cultural re-interpretations of American research are studied in Singapore, Australia and the Netherlands through the theory of multicultural counselling competency (MCC). The cross-cultural applicability of MCC in the case studies is analysed through the hypothesis that satisfaction with cultural training, cross-cultural clinical psychology practice experience and identification as a cultural minority are associated with MCC – in line with American research.

Data collection for this thesis took place in two universities in Singapore, two in Australia and two in the Netherlands. Insights into clinical psychology training and practice were acquired through statistical analysis of a survey of MCC, interpretative phenomenological analysis (IPA) of interviews regarding experiences of training and practice, and through phenomenological analysis of ethnographic data. Two years of ethnographic fieldwork was conducted in a clinical psychology training clinic of a university in Singapore, and several intervals of multi-sited fieldwork were conducted at clinical psychology departments at the other case universities in Singapore, Australia and the Netherlands. The main sources of ethnographic insights are based on informal conversations and discussions, observations, university and teaching resources, and analysis of information recorded in a reflective fieldwork journal.

The integrated quantitative and qualitative results from this research demonstrate that there are attempts to standardise 'western' knowledge as universally applicable, such as through MCC. However, transnational knowledge in clinical psychology is subject to cultural negotiation during training and practice. These

negotiations are related to specific perceptions of the territory of clinical psychology, the cultural context of training and practice, and take place during daily applications of the discipline's knowledge and practices. Taken together, these insights highlight the importance of cultural negotiations as sites of resistance towards cultural imperialism in clinical psychology.

Based on these case studies of clinical psychology, this thesis argues that transnational knowledge forms a territory that is culturally negotiated from 'above' (professional organisations, education institutions) as well as from 'below' (students, academics, practitioners). Knowledges are actively constructed as universal and therefore considered transnational, but they are also appropriated and changed. Risks of cultural imperialism in higher education are exacerbated by (post)colonial hierarchies in knowledge production and valuation, discourses of science, and ideas of globalisation of education. However, this thesis shows that knowledges are never separate from culture, and that transnational knowledges are always subject to cultural negotiations from the ground.

Table of Contents

List of Tables

List of Figures

List of Acronyms

APA	American Psychological Association
APAC	Australian Psychological Accreditation Council
ANOVA	Analysis of Variance
APS	Australian Psychological Society
DSM	Diagnostic and Statistical Manual of Mental Disorders
HIMPSI	Association of Indonesian Psychologists (*Himpunan Psikologi Indonesia*)
IPA	Interpretative Phenomenological Analysis
MAKSS	Multicultural Awareness, Knowledge, and Skills Survey
MANOVA	Multivariate Analysis of Variance
MCC	Multicultural Counselling Competency
MCSDS-SF	Marlowe-Crowne Social Desirability Scale – Short Form
MSCP	Malaysian Society of Clinical Psychology
NIP	Netherlands Institute of Psychologist (*Nederlands Instituut van Psychologen*)
SPS	Singapore Psychological Society

1. Introduction: Exploring Cultural Negotiations in Transnational Knowledge in the Malay Archipelago and Beyond

Globalisation of higher education invites a focus on transnational knowledge and practice. In the past two decades the higher education sector has seen massive growth across national borders (Knight, 2011; Yang, 2002). Universities have opened campuses abroad, have increased international collaboration and are dedicated to having a global impact. For example, the National University of Singapore promotes itself as *"a leading global university centred in Asia,"* while Australia's James Cook University has an explicit mandate of *"creating a brighter future for life in the tropics world-wide through graduates and discoveries that make a difference"* (Harding, 2011; James Cook University, 2015; National University of Singapore, 2015; Xavier & Alsagoff, 2013). In this international context, academics and students are expected to have a global, cross-cultural outlook and capabilities (Matthews & Sidhu, 2005). The focus on global practice supports the transnational export of knowledges that are deemed universally applicable.

Cross-border expansion of the higher education sector demands better understanding of the cultural effects of globalisation of knowledge, especially in relation to cultural imperialism. The notion of cultural imperialism refers to the imposition and dominance of one set of cultural values, ideas and knowledges over others. This is highly relevant to education: higher education programs have always been instruments for establishing 'truths' and impressing cultural values (Bourn, 2011). Under conditions of globalisation, the cultural impacts of academic programs are more

extensive than ever. Globalised education produces effects of epistemic hegemonies across countries and cultures (Rizvi, 2007) while influencing our imaginaries of the world, and shaping our alliances and relationships to it. Although theoretically internationalisation of academic disciplines could provide space for cultural negotiation; at the same time disciplines can become vehicles for cultural imperialism (Yang, 2013). This may be the case where Anglo-American academic traditions take a leading role in defining knowledge and research practices (Yang, 2006). Cultural imperialism represents a central challenge in today's globalised higher education landscape. There is a critical need to understand how transnational knowledges are culturally negotiated.

This thesis seeks to understand how transnational knowledges are culturally negotiated in the Malay Archipelago and beyond. This region, between Southeast Asia and the Pacific, has interweaving cultural, linguistic and trade histories. The Malay Archipelago includes Malaysia, Singapore, Indonesia and the Philippines – countries that are partially characterised by their colonial pasts. The critical study of transnational knowledge is pertinent in this region as the expansion of transnational education is critiqued for supporting a neo-colonial incorporation of knowledges and academic paradigms from the global 'west' (Chan & Lo, 2008; Ng, 2012b). 'Western' knowledge is considered universally applicable, which de-emphasises its cultural origins and potentially leads to 'western' cultural influences through education. This thesis analyses how a specific academic discipline – clinical psychology – is culturally negotiated in the Malay Archipelago. The analysis also expands its focus beyond the archipelago to highlight the important contexts of transnational education and (post)colonialism through case studies from Australia and the Netherlands (representing Europe).

Clinical psychology – the example of transnational knowledge in this thesis – is the field of psychology focusing on the prevention, diagnosis and treatment of mental illness (American Psychological Association; APA, 2013). This discipline is largely based on contributions from Caucasian American researchers, leading Guthrie (1976) to wryly conclude that "even the rat was white" in psychology research. Critiques of the American-centricity of clinical psychology continue in contemporary debates (Arnett, 2008; Henrich, Heine, & Norenzayan, 2010) and have been extended to clinical psychology's therapies and practices (Fernando, 2003; Gerstein, 2009) and to diagnostic methods (Thakker & Ward, 1998). In addition, postgraduate education in clinical psychology is often standardised according to American-designed training models (Donn, Routh, & Lunt, 2000) with little consideration given to the suitability of these models in non-American settings. Clinical psychology is thus an especially relevant case study of transnational knowledge that potentially illustrates how foreign influence through knowledge is negotiated in the Malay Archipelago and beyond.

Research Approach

This thesis investigates the cultural negotiations in transnational knowledge through cross-disciplinary case studies of clinical psychology in Singapore (as one specific example from the Malay Archipelago), Australia and the Netherlands. This inquiry requires a perspective that incorporates dimensions of psychology and culture, and scrutiny of contexts of training and practice. Therefore, this research compares and combines theories and methods from both psychology and cultural anthropology. Psychology provides an evidence base regarding cultural practice of clinical psychology, illustrating cultural negotiations within the discipline. An alternative perspective is provided by cultural anthropology, the subfield of anthropology that

studies social patterns and practices across cultures (American Anthropological Assocation, 2015). Cultural anthropology conceptualises and theorises how people can exert cultural influences on flows of knowledge, and is used here to examine how clinical psychology knowledge is negotiated during experiences of training and practice.

The incorporation of these different disciplinary perspectives provides important insights into the research topic, but also into the disciplinary hurdles intrinsic to interdisciplinary research. The experiences of conducting interdisciplinary research in psychology and cultural anthropology are therefore discussed in Chapter 2. This chapter demonstrates that the disciplines rely on different epistemologies and philosophies of science – speaking different disciplinary languages and viewing the research focus and the world through different lenses. Recurrent structural issues arose when conducting research into and through these two different epistemologies. Therefore, Chapter 2 provides a necessary introduction to the interdisciplinary approach upon which this thesis depends. These insights are important for readers to understand how this research was developed, how it was conducted, and how it resulted in this thesis.

Following the discussion of interdisciplinarity, Chapter 3 outlines knowledge flows in clinical psychology in five case study countries: Singapore, Malaysia and Indonesia (representing the Malay Archipelago), the Netherlands (an example from Europe), and Australia. This chapter demonstrates that clinical psychology was introduced into the Malay Archipelago and Australia by colonial European scholars. The academic programs and clinics developed by these scholars often depended upon foreign expertise until at least a few decades after independence. Thus early clinical psychology in the Malay Archipelago and Australia represents a neo-colonial

continuation of the incorporation of foreign knowledge into these regions. These one-way flows of knowledge continue to the present day, although the configuration of actors has changed. Transnational education stimulates the import of standardised American models for clinical psychology worldwide, and Australian practices of clinical psychology to the Malay Archipelago. This one-way flow requires a nuanced mapping of cultural negotiations and impacts on flows of knowledge in clinical psychology.

The mapping of cultural negotiations outlined in this thesis is supported by a review of theories from cultural anthropology and psychology, outlined in Chapters 4 and 5. Chapter 4 provides an anthropological review of theories that lead to a more nuanced understanding of cultural influences on flows of knowledge. Informed by exemplary interdisciplinary theories of globalisation (Appadurai, 1996), deterritorialisation (Deleuze & Guattari, 1988), and power/knowledge (Foucault, 1994), academic disciplines are argued to be territories of change. Territories consist of non-hierarchical networks of knowledges that are constantly changing as they are reinterpreted – clinical psychology continually maps its own terrains. This notion creates an analytical space for the study of cultural influences on clinical psychology knowledge through a focus on application in training and practice.

Another perspective is provided in Chapter 5, which investigates cultural influences on clinical psychology through notions of culture utilised in psychological research. It reviews the theory of multicultural counselling competency (MCC; Sue et al., 1982), an American-designed psychological model aiming to help understand multicultural practice. The chapter provides a framework for testing the cross-applicability of transnational knowledge in psychology. If the American MCC model is applicable, then results of the survey data collected in Singapore, Australia and the

Netherlands would be in line with American findings. MCC would be associated with cross-cultural practice experience, satisfaction with cultural training, and with identification as a personal minority.

In-depth investigation of case studies of clinical psychology training and practice are described from a psychological perspective in Chapters 6 – 8, and re-analysed together from an anthropological angle in Chapters 9 and 10. Data described in these chapters were collected through clinical psychology programs at two universities in Singapore, two in Australia and two in the Netherlands. Insights into cultural negotiations of transnational knowledge were acquired through statistical analysis of a survey of MCC, interpretative phenomenological analysis (IPA) of interviews about experiences of training and practice, and through phenomenological ethnography. Two years of ethnographic fieldwork were conducted in a clinical psychology training clinic at a university in Singapore, and several intervals of up to one month of multi-sited fieldwork were conducted in clinical psychology departments at the other case universities in Singapore, Australia and the Netherlands. The main sources of data derived from ethnography are informal conversations and discussions, observations, university and teaching resources, and analysis of information recorded in a reflective fieldwork journal.

Chapter 11 concludes this thesis by returning to the problematic risk of cultural imperialism in transnational higher education. Several conclusions are made on how (post)colonial flows of knowledge are negotiated. The thesis ends with theoretical implications relevant to the study of transnational knowledge.

2. On Interdisciplinarity in Cultural Anthropology and Psychology – An Exploration of Epistemologies

> *This chapter provides an outline of the interdisciplinary research approach in cultural anthropology and psychology upon which this thesis depends. It is written as a reflective narrative of the experiences of the disciplinary hurdles related to the epistemologies of the two disciplines – hurdles that characterise this thesis. These insights may help readers understand how this research was developed, how it was conducted, and how it resulted in this thesis.*

Interdisciplinary research integrates ideas, data, and methods from at least two disciplines in order to develop a common research framework (Rigg et al., 2012). Such approaches are believed to invite better understandings and provide more robust solutions for the multidimensional challenges that societies face today (Jacobs & Frickel, 2009). In addition, interdisciplinary researchers may advance academia by pushing the boundaries of research with critical and cutting-edge discoveries (Lyall, Bruce, Tait, & Meagher, 2011; Moore, 2011). It has become "a mantra for change" (Klein, 2009, p. 1), and is widely promoted in governments, businesses and universities (e.g. Australian Council of Learned Academic Communities, 2012; Prime Minister's Office Singapore, 2014). The positive appraisals of interdisciplinarity made it interesting and timely to explore how the two disciplines which I have previously studied – cultural anthropology and psychology – would contribute to this thesis.

The attempt to integrate disciplinary perspectives provided important insights into the research topic, but also into the multifaceted and novel challenges of interdisciplinary research. Cultural anthropology provided insights into how cultural influences were experienced by people engaged in training and practice of clinical

psychology, while psychology perspectives provided insights in how the discipline regards cultural influences. However, these two disciplines rely on different epistemologies and philosophies of science – they speak different disciplinary languages and view the research issue and the world through different lenses.

This chapter addresses recurrent structural issues that arose when conducting research in two different epistemologies. These insights provide insights into how this research was developed, how it was conducted, and how it resulted in this thesis. In order to understand the unique contributions of the two disciplines without generalising them, this chapter is written as a reflective narrative of experiences of conducting this research. This writing style is commonly used in cultural anthropology, as personal reflections are considered empirical evidence that can inform research results under specific circumstances. In other words, the disciplinary interpretations described in this chapter are based on my experiences of cultural anthropology and psychology in this research project, which may not generalise to other research projects. An aim is to help readers navigate the different epistemological underpinnings of the chapters that follow.

Clashing epistemologies provide valuable insights into how academic disciplines influence the way we conduct research. Inspired by Rigg et al.'s (2012) analysis of their project, which was conducted in different fields, this chapter outlines three epistemological clashes that are relevant to this thesis. These clashes emerged during consultations with my anthropologist and psychologist supervisors, during conversations with research collaborators, and were structural issues that I experienced as an interdisciplinary researcher. The first epistemological clash includes the approach to data collection, management and analysis. The second clash relates to the role of theory in guiding the research, and the role of the researcher in the creation of scientific

knowledge. This leads to a third epistemological clash, namely the conceptualisation and assessment of culture. These three clashes are discussed in the sections below.

When Epistemologies Clash

Defining, analysing and collecting scientific 'evidence'

During research consultations, recurring discussions were related to the different ways in which scientific evidence is defined by cultural anthropologists and psychologists. This included what was considered data and how it should be assessed methodologically.

This thesis includes methods from cultural anthropology and psychology. Cultural anthropology's hallmark research method is ethnography, which is based on extended fieldwork involving participation in daily life in the study field as well as simultaneous observation and self-reflection (Robben & Sluka, 2012). In this study, ethnographic fieldwork took place during part-time work in a psychology training clinic in Singapore, and during visits to clinical psychology departments at other universities. I kept a reflective fieldwork journal on my experiences as someone from the Netherlands conducting this research at an Australian university located in Singapore. Other anthropological methods include free-listing tasks which help understand how participants experienced culture and clinical psychology. Psychological methods include a survey of multicultural counselling competency (MCC). Questionnaire research is a commonly used and well-respected research method in psychology, so by using this method the research results are made comparable to previous psychological studies. Finally, semi-structured interviews, included in this study, are commonly used in psychology and cultural anthropology research.

The use of different methods for data collection in cultural anthropology and psychology reveal the different epistemologies of the disciplines. During the discussion phase of the research proposal, my anthropologist supervisor stressed the importance of open-ended interviews and to maintain a reflexive research journal during data collection, as such qualitative and explorative data would allow for interesting insights to emerge. Therefore, she felt it would be suitable to start by exploring the issues at stake for students, academics and alumni of clinical psychology, through conversations and discussions with them. In contrast, my psychologist supervisor emphasised the need to collect quantifiable and reliable data linked to a theory-based working hypothesis. From her perspective, a survey with a standardised questionnaire would make the study replicable and thus credible, so I should start focusing on preparing the survey and on the recruitment of an adequate sample of participants. I solved these contrasting visions on methodological preparations by making arrangements for both types of data collection simultaneously.

The different preferences for particular types of data and methods in cultural anthropology and psychology result from their divergent scientific orientations. Cultural anthropology can be located at the intersection of social sciences, arts and humanities while clinical psychology is influenced by biology and ethology, placing the discipline in between the social and natural sciences. Psychology is increasingly leaning towards the natural sciences, exemplified by the recent restructure of the Psychology Department at James Cook University from the Faculty of Arts and Social Sciences to the College of Health Sciences. Natural sciences rely upon controlling the research environment and gathering objective evidence through standardised procedures to minimise potential for researcher's bias (Richards, 2010). Psychologists preferably conduct experiments and survey large representative samples of populations

using protocols and standardised questionnaires in order to get quantifiable, numerical data. In contrast, current cultural anthropologists generally rely on research methods that are, arguably, less intrusive and both more participatory and observational, as they allow for more culturally and contextually specific information. The detailed data acquired through anthropological methods contrast with the numerical data attained through most psychological methods. Although qualitative research has made a resurgence in psychology, such qualitative data is nevertheless handled differently by psychologists and anthropologists.

In cultural anthropology, the 'field' of research is the topic or issue for which data are collected. It defines the sites and types of data. Anthropology does not a-priori delineate the field. So when I conducted anthropological fieldwork I collected different types of ethnographic evidence, such as casual conversations with students, academics and practitioners of clinical psychology, observations made during fieldwork, brochures from psychology clinics, and my own reflections on experiences of culture and notes on the information various people in clinical psychology sites shared. These multiple sources of data provided important insights into how clinical psychology training and practice are culturally negotiated. Such varied and rich data were valued by my anthropologist supervisor, but considered 'unscientific' by my psychologist supervisor. Psychology relies upon the standardised collection of empirical evidence, the various types of evidence collected during fieldwork were not considered systematic and from a psychology perspective may be considered biased. Consequently, psychological and anthropological data collection and analysis took place concurrently but separately, and multiple types of data, both quantitative and qualitative, were analysed independently. An exception was the interview data, this was considered a valid method for data collection from both psychological and anthropological perspectives.

Using theory and creating knowledge

Disciplinary logics influence how data relates to theory. Anthropological methods generally do not require a priori specification of theory-based hypotheses, but are based on exploring the 'field' as it presents itself to the researcher (Robben & Sluka, 2012). From an anthropological point of view, the fieldwork data, including views from participants, inform the consideration of theory. My anthropologist supervisor encouraged me to maintain an awareness of how the data itself could guide me to particular theories. In contrast, theory takes an a-priori place in guiding psychological research: it defines the focus, methods and application of research (Bem & Looren de Jong, 2013). My initial review of psychological literature focused on identifying potentially useful theory, such as MCC, and deriving theory-based hypotheses on MCC and on instructions for conducting the survey. The survey of cultural competency was based on hypotheses and the observed data was used to support or challenge the theory. While there are many exceptions, generally, cultural anthropology relies on data to induce new theory, while psychology mainly uses data to help deduce conclusions from existing theory. The logics of induction and deduction contrasted sharply. Again, the interview data do not fit this dichotomy and were analysed from psychological and anthropological perspectives simultaneously.

Cultural anthropology's and psychology's different use of theory became apparent in interview analyses. I analysed the interviews through an Interpretative Phenomenological Analysis (IPA), a psychological framework (Smith, Flowers, & Larkin, 2009), partly because I assumed that psychology's IPA and anthropology's shared basis in phenomenology would unite the disciplinary interpretations of the data. It was also the most appropriate technique as it allowed a focus on the experiences and practices of clinical psychologists. I reviewed anthropological and psychological

interpretations of phenomenological philosophy which was developed by, among others, Merleau-Ponty (1962) and Heidegger (1973). However, disciplinary interpretations of this theory differed considerably. Anthropological phenomenology aims to understand people's life-worlds, their ontologies and experiences which precede expression in language (Jackson, 1996). Therefore, cultural anthropologists are encouraged to write ethnographies based on experiences of ontologies arising from the experience of the field instead of based on external theory. Surprisingly, this approach contrasts with psychology's phenomenological method of IPA, which requires researchers to deduct abstract themes that "invoke psychological terminology" (Smith, 2008, p. 68). However, from an anthropological perspective, interpreting data based on existing theory is a devaluation of participants' experiences while invoking a "cultural privilege" for familiar theory (Jackson, 1996, p. 1). Anthropological literature thus discourages researchers to actively frame data through existing theory, while IPA encourages the researcher to do so. In addition, IPA focuses exclusively on the transcripts of interviews, while anthropological phenomenologists also value non-verbal, sentient data. The different data and use of theory complicated the integration of insights gained from IPA with anthropological phenomenological understandings of the data.

The different roles of theory also influenced how culture was identified and studied. A research collaborator at one university engaged in this study suggested that I should define 'culture' in the survey. From her psychological perspective, participants should understand what kind of experiences they should think of when the survey enquired about culture, which could be achieved by defining the concept. However, from an anthropological perspective that would invoke a cultural privilege, it would be ethnocentric to use my own framework of culture to define cultural experiences for the

participants (Clifford & Marcus, 1986). I put forward an argument to the research collaborator that my framework of culture is influenced by my own background and experiences, and may be inadequate to describe the experiences of the participants, and therefore it would be more interesting and objective to hear from participants how they experienced or theorised culture. Free-listing items were included in the questionnaire for this reason. This addition to the survey allowed theory on culture to arise from the information provided by participants. The research collaborator understood the rationale. Such negotiations between disciplinary perspectives on culture constantly took place during the research.

The epistemological differences between the disciplines also underlie the opposing perspectives on the relation between theory and data. Anthropological research is generally based on an understanding of the role of the researcher in the construction of knowledge. The literary turn in anthropology, also known as the reflexive turn, drew self-critique and attention to the subjective role of the researcher in writing and representing people and data (Behar & Gordon, 1996; Clifford & Marcus, 1986). This led to insights into how researchers co-construct data and influence analyses. Objectivity in science thus cannot be ensured and knowledge cannot be value-free. On a personal note, I first realised that knowledge may be culturally relative when I started studying cultural anthropology alongside a psychology undergraduate degree. Understanding that knowledge is culture-specific and not necessarily cross-culturally applicable was such an epiphany that I still remember the exact place and time I came to this realisation. I had previously regarded psychological facts as established truths. Some psychological literature indeed argues for an understanding of psychological theories as the products of specific cultural contexts, times and settings (Richards, 2010), however, a relativist stance in science was not presented in my undergraduate

psychology training at the time. Contemporary clinical psychology's increasing attention on neurobiological malfunctioning in mental illness suggests an increasing orientation towards objective evidence and universally applicable science, which makes a relativist perspective on science less likely. The contrasting epistemologies between clinical psychology and cultural anthropology greatly impacted on the ability to integrate disciplinary perspectives in this research.

Thus, constructing conclusions beyond disciplinary confines and based on combined data was difficult for the following reasons. Different ideas of what constitutes 'good' data complicated integration of methods in a coherent manner; epistemological differences regarding the objectivity of science impaired the creation of an overarching theoretical framework; and most academic journals, university structures and conferences are resolutely disciplinary, which discourages writing papers drawing out interdisciplinary perspectives (Oliver, 2013).

Once I discovered cultural relativism it seemed impossible to go back to an absolutist stance in science, so I often used anthropological literature to critique clinical psychology's reliance on a presumed universality. This chapter could be considered an example of this approach.

Defining and assessing culture

Conceptualising and operationalising culture as a measurable construct gave rise to the third and final epistemological clash in this research. It was difficult, if not impossible, to construct interdisciplinary definitions of culture because cultural anthropology and clinical psychology have different objects of study based on different notions of the subject. Psychological theories tend to focus on the "workings of the individual mind" (Norenzayan & Heine, 2005, p. 766), while anthropological theories

usually describe persons in relations with their social, cultural, material, political and other contexts (Moore, 2007).

Psychologists usually regard culture as ethnicity – a given, stable, characteristic of a person – and use it as a categorical variable in research. Psychological studies have commonly defined people's culture as arising from their race, ethnicity or country of origin (Matsumoto, 2000). This invokes a notion of culture as static, factual information on individuals. Reasons for including culture as a variable in clinical psychology research are, among others, that culture influences subjective experience (Laungani, 2004; Matsumoto, 2000), personal identity (Gómez-Estern & de la Mata Benítez, 2013; König, 2009), interpersonal behaviour (Schröder, Netzel, Schermuly, & Scholl, 2013), meaning-making (Alarcón, 2009), norms for psychological test scores (Arnett, 2008; Henrich et al., 2010), and mental health (Draguns & Tanaka-Matsumi, 2003; Hwang, Myers, Abe-Kim, & Ting, 2008; Thakker, Ward, & Strongman, 1999; Tseng, Min, Nakamura, & Katsuragawa, 2012).The categorical notion of culture has provided a range of useful knowledge for psychologists.

In contrast, anthropological understandings of culture can be characterised as anti-essentialist. As an anthropologist researcher I tried to refrain from using all-encompassing descriptions such as 'Asian' or 'western' culture as they unrealistically summarise different identities and histories of peoples in 'Asia' or 'the west' into homogenous categories (Spivak, 2008). Similarly, the container identities 'Caucasian Australian' or 'Indigenous Australian' cultures, which were used in the survey, may provide little insight into people's actual cultural heritage, identities and experiences, as these groups are diverse and people's identities may overlap. Contemporary cultural anthropologists regard cultural histories as interwoven and cultural identities as changeable and fluid (Bhabha, 2012). Consequently, instead of defining and delineating

culture, anthropologists usually analyse cultural experiences and expressions in their variety of forms and complexity (Moore, 2007).

At times this research had to adopt the epistemological logic of either psychology or cultural anthropology according to what problematic was under analysis. Thus this research used a psychological notion of culture in the survey. Previous research reported that participants' ethnicity was associated with their cultural competency scores (Pope-Davis, Reynolds, Dings, & Nielson, 1995). That research study defined ethnicity in terms of cultural groups in the United States, such as African-American or Asian-American. Similarly, the survey in this research asked participants to pick the cultural group with which they identified most, such as Indigenous Australian, Caucasian Australian, Chinese Singaporean, Malay Singaporean. This practical approach to culture enabled a comparison of questionnaire scores and characteristics of different cultural groups. However, from an anthropological perspective this measure of culture may not offer depth of insight, and may be considered problematic.

Multicultural counselling competency (MCC) provided another, albeit indirect, psychological definition of culture. This standardised model for cultural competency aims to assist clinical and counselling psychologists in the United States in cross-cultural practice (Sue et al., 1982). According to the tripartite model, psychologists need to develop multicultural awareness, knowledge, and skills, in order to be able to practice cross-culturally (Sue, Arredondo, & McDavis, 1992; Sue et al., 1982). It is believed that the MCC model may help psychologists to provide services for diverse clientele in today's multicultural societies (Ridley & Kleiner, 2003), and MCC is being incorporated into education programs and professional diversity policies (APA, 2003). As is argued in Chapter 5, the expansion of the psychological study of MCC in

different cultural contexts is required to assess MCC's cross-cultural applicability. Therefore, a study of MCC in line with psychological parameters of 'good science' was included in the research.

From an anthropological perspective, the theory of MCC may problematically suggest that cultures are homogenous and static. Cultural competency reduces culture to a technical skill that can be mastered by psychology practitioners, which implies that "a series of do's and don'ts" for treating clients of particular ethnic backgrounds define culturally sensitive practice (Kleinman & Benson, 2006, p. 1673). Such cultural stereotyping may hinder rather than help psychology practitioners' understanding of their culturally different clients, as stereotypical assumptions may lead practitioners away from enquiring about their clients' personal perspectives and experiences. In addition, anthropologists regard culture to be inseparable from economic, religious, political, psychological and biological domains (Moore, 2007). From an anthropological perspective, focusing only on culture as ethnicity, as the MCC model does, may at best lead to incomplete understandings of people's culture. Worse, it can lead to misunderstandings of clients' situations or even to racism.

Anthropological theories are influenced by interdisciplinary engagement and for this thesis these theories provided different perspectives on culture. Scholarship of the cultural effects of globalisation (Appadurai, 1996), deterritorialisation (Deleuze & Guattari, 1988), and the interrelations of knowledge and power (Foucault, 1994) was used to theorise the context in which clinical psychology is taught and practiced cross-culturally. As will be argued in Chapter 4, these anti-essentialist and anti-imperialist theories advanced this study of culture by locating cultural negotiations in daily encounters of teaching, studying and practicing clinical psychology. Data collection

and fieldwork were aimed at understanding how imperialist tendencies of clinical psychology were experienced and contested.

This 'Interdisciplinary' Thesis

Crossing disciplinary boundaries

This research made me appreciate the kind of challenges interdisciplinary research entails. Although most research is simply called 'interdisciplinary' without further investigation of the level of integration (Jacobs & Frickel, 2009), Table 1 summarises types of collaborative research with different levels of autonomy and integration between disciplines. Interdisciplinary research fully integrates epistemologies of two or more disciplines; it is the most integrated type of research. Cross-disciplinary research is less integrated: it depends on an interpenetration of epistemologies. Multidisciplinary research combines disciplinary approaches, which remain autonomous in their conceptual framings and methods (see Table 1). In this thesis, the stark epistemological contrasts between cultural anthropology and clinical psychology made complete integration of the disciplines impossible. For this reason, the present MPhil thesis could perhaps better be classified as multidisciplinary – bordering cross-disciplinarity – rather than interdisciplinary.

This thesis could be regarded as a mapping of disciplinary approaches to the research topic. While there were numerous attempts to create shared or overarching theoretical frameworks between cultural anthropology and psychology, most chapters are based on theories and epistemologies from an anthropological or psychological disciplinary perspective (indicating multidisciplinarity), except for Chapter 3. That chapter relies on anthropological and psychological theory, with the anthropological

perspective involving the interdisciplinary method of mapping used in social sciences and humanities. Chapter 4 provides an interdisciplinary social science perspective based on an anthropological interpretation of theory from philosophy and cultural studies, while Chapter 5 relies on psychological theory. The interdisciplinary character of Chapter 4 demonstrates that anthropological theory is perhaps more easily integrated with sociological, philosophical and educational theory than with psychology. Psychological theory is perhaps more easily integrated with disciplines that relate to the natural sciences. In the end, the epistemological and ontological differences between cultural anthropology and clinical psychology were too wide to be bridged, and methodologies could not be fully integrated.

Table 1. *Disciplinary Border Crossings*

Boundary crossing		Characteristics
Disciplinary	Increasing integration and holistic approach	Research undertaken within the intellectual and methodological boundaries of a single discipline
Multi-disciplinary		Research undertaken when disciplines work together on a problem or real world issue but maintain their autonomy in terms of methods, conceptual framings and theoretical structures. Such an approach juxtaposes rather than combines disciplines, and therefore does not transcend disciplinary boundaries.
Cross-disciplinary		Research based on a common theoretical understanding and accompanied by a mutual interpenetration of disciplinary epistemologies.
Interdisciplinary		Research which involves cooperation and the combination or integration of ideas, data, techniques, concepts and methods across at least two disciplines so as to develop a common approach and framework of research.

Derived from Rigg, Law, Tan-Mullins, Grundy-Wari, and Horton (2012)

Reading this thesis

Interdisciplinary research theses need to illustrate a researcher's understanding of disciplinary canons and rules, and introduce interdisciplinary understandings and present results in ways that are insightful to audiences who come into from different

disciplinary angles (National Academy of Engineering, National Academy of Sciences, Committee on Science Engineering and Public Policy, National Academies Committee on Facilitating Interdisciplinary, & Research Institute of Medicine, 2005). To enhance readability of this thesis for cultural anthropologists and clinical psychologists, and specialists in the globalisation of education, ideas and concepts had to be carefully negotiated and words carefully chosen. Concepts from anthropology had to be explained for psychologists and vice versa, as did concepts in global education theory.

The writing process was shaped by the different communication styles mainly in anthropology and psychology. Psychological reports are often written in a highly factual style, distanced and objective (Bem & Looren de Jong, 2013). Anthropological writing, on the other hand, has become more liberal and poetic, sometimes with a narrative presence of the researcher in the text (Behar & Gordon, 1996; Clifford & Marcus, 1986). Furthermore, anthropological texts are often written in the present tense, 'the anthropological present', in order to create a sense of 'being there' at the fieldwork sites, while psychological texts are usually written in the past tense in order to create and maintain a sense of objectivity. Although I greatly enjoy reading the often lively and engaging accounts of anthropologists, this style of writing would not suit a psychologist audience. Anthropologists, however, are familiar with the more objective writing styles in most other disciplines. Therefore, with the exception of this more reflective first chapter, and the ethnographic Chapters 9 and 10, this thesis is written in the past tense and with minimal use of the subjective term 'I' in order to create the sense of the researcher being an objective observer outside the text.

Interdisciplinary or multidisciplinary theses, such as this one, place not only extra work on the higher degree by research candidate and the supervisors, but also on the readers. Readers who come in from disciplinary perspectives may encounter new

concepts, methods and ideas introduced in interdisciplinary theses. Therefore, cultivating an interdisciplinary or cross-disciplinary outlook is important in reading such theses.

Conclusion

Compared to disciplinary research, interdisciplinary research requires enhanced critical thinking and planning at all levels. While interdisciplinary research is promoted in governments, businesses and universities for its innovative and robust approaches, many researchers have struggled to establish greater integration between disciplines (Oliver, 2013; Rigg et al., 2012; Strober, 2010). Interdisciplinarity research is often less recognised and appreciated by academics than disciplinary work, which may harm a graduate student's career (National Academy of Engineering et al., 2005). It is paradoxical. As interdisciplinary research is considered the future of science (Klein, 2009), and as intensified collaborations across disciplines, universities, research institutes and countries are promoted, still, those who explore interdisciplinary research face epistemological and institutional barriers (Lyall et al., 2011). This research was no exception. It was certainly challenging but it was also informing and inspiring. I hope readers will find the epistemological negotiations underlying this thesis as insightful as I did.

3. Mapping Cultural Influences on Clinical Psychology[1]

This chapter explores cultural negotiations of transnational knowledge by mapping knowledge flows in clinical psychology in the Malay Archipelago and beyond. It explores the premise that clinical psychology knowledge is American biased. A cross-cultural comparison of the developments of clinical psychology in the countries in the Malay Archipelago, Australia and the Netherlands shows the extent to which clinical psychology has diversified in different cultural contexts.

Clinical psychology, the academic discipline and profession through which transnational knowledge is analysed in this thesis, is the subfield of psychology that focuses on the prevention, assessment and treatment of mental illness (APA, 2013). The discipline originated in the United States in 1896 when Lightner Witmer, a psychologist at the University of Pennsylvania, introduced a practical component of child guidance in the university's psychology training program (Donn et al., 2000). He called this

[1] An adaptation of this chapter was published as:
Geerlings, L.R.C., Thompson, C.L., & Lundberg, A. (2014). Psychology and culture: Exploring clinical psychology in Australia and the Malay Archipelago. *Journal of Tropical Psychology,* 4(e4), 1–12. doiI:10.1017/jtp.2014.4

The publication was a sequel to earlier work, which was published as:
Geerlings, L.R.C., Lundberg, A., & Thompson, C. (2013). Transnational psychology: A case study of South East Asia. In P. Mandal (Ed.), *Proceedings of the International Conference on Managing the Asian Century* (pp. 73-79). Singapore: Springer. doi:10.1007/978-981-4560-61-0_9

Geerlings, L.R.C., Thompson, C., & Lundberg, A. (2013). Borderless psychology in South East Asia: History, current state and future directions. In P. Mandal (Ed.), *Proceedings of the International Conference on Managing the Asian Century* (pp. 353-362). Singapore: Springer. doi:10.1007/978-981-4560-61-0_40

applied psychology 'clinical psychology'. Clinical psychology activities were extended to adults when the federal government stimulated expansion of the number of training opportunities during the Second World War (Kazarian & Evans, 1998; Sarason, 2002). After the war, American universities adopted standardised empirical scientific based models of clinical psychology such as the scientist-practitioner (Boulder) model in 1949, and the practitioner-scholar (Vail) model in 1973 (Donn et al., 2000). Presently, these American models for clinical psychology are increasingly embedded outside the United States.

As was outlined in the introduction, clinical psychology is critiqued for relying on knowledge from the United States (Arnett, 2008; Fernando, 2003; Gerstein, 2009; Henrich et al., 2010; Thakker & Ward, 1998), and for spreading this culturally biased knowledge across the world through American-designed training models (Donn et al., 2000). In addition, apart from a few notable exceptions (e.g. Blowers & Turtle, 1987; Taft, 1982), historical analysis of clinical psychology has mainly been an American endeavour (Kazarian & Evans, 1998). As a consequence, little is known about the expansion and diversification of clinical psychology in culturally different regions such as the Malay Archipelago, and in countries as culturally diverse as Australia and those of Europe. This situation indicates a logical starting point for the study of cultural negotiation: by mapping flows of knowledge in clinical psychology in the Malay Archipelago and beyond, this chapter analyses to what extent the discipline has been culturally appropriated and diversified in different cultural contexts.

Histories of Clinical Psychology

A comparison of histories of clinical psychology in different countries reveals how countries have variously appropriated initially foreign clinical psychological

knowledge. The histories of clinical psychology were explored by reviewing online and in-print resources from scientific databases, psychological organisations, universities and libraries. A list of dates discussed in this chapter can be found in Table 2.

Two structural issues are relevant. Firstly, as early developments of clinical psychology are intertwined with advances of psychology – of which clinical psychology is a sub-discipline – this chapter discusses developments in clinical psychology together with advances in psychology. Secondly, the countries are discussed in an order that best illustrates the chronology of flows of clinical psychology knowledge: the Netherlands, Australia, Indonesia, Singapore and Malaysia.

The Netherlands

The history of clinical psychology in the Netherlands illustrates increasing American influence in clinical psychology in Europe. In 1892, about the same time that Lightner Witmer developed clinical psychology in the United States, Gerard Heymans founded the first psychological laboratory in the Netherlands, hallmarking the birth of psychology in the country. Developments of the discipline, however, were slow, and psychology was introduced in universities as a branch of philosophy in the 1920s (Van Drunen & Van Strien, 1999). In 1921 psychology was first introduced as a service to the public, when psychologists started to provide testing and assessment services (Dehue, 1991). These early applied psychologists developed their own tests based on an interpretative method, which differed considerably from the American standardised approach (Dehue, 1991). Early applied psychology was characterised by a hermeneutic approach linked to psychoanalysis.

Table 2. *Timeline of Clinical Psychology in the Netherlands, Australia and the Malay Archipelago*

Year	Landmark
1841	Mental asylums in Singapore established by British colonialists
1890s	Psychological laboratory in Netherlands; Mental philosophy in Australia
1913	First psychology lecturer in Australia
1914	First psychology course in Singapore
1920s	Psychology first applied outside universities in the Netherlands and Australia
	Psychology introduced in universities in the Netherlands
1930	First undergraduate psychology program in Australia
1938	Netherlands Institute for Psychologists (NIP) established
1941	Psychology clinics in Indonesia established by Dutch colonialists
1942	First clinical psychologist appointed in the Netherlands
1952	Beryl Wright teaches psychology in Singapore
1953	First psychology graduate program in Indonesia
1956	First clinical psychology graduate program in Australia
1959	Association of Indonesian Psychologists established
1960s	Rapid expansion of psychology and clinical psychology in the Netherlands
1961	First Faculty of Psychology in Indonesia
1966	First clinical psychology graduate program in Australia
	Australian Psychological Society (APS) established
1970s	Health care restructuring impacts on clinical psychology in the Netherlands
1974	Regulation of clinical psychology education in Indonesia
	Wan Rafei and Abdul Halim Othman teach psychology in Malaysia
1979	Singapore Psychological Society (SPS) established
	First Department of Psychology in Malaysia
1986	First psychology program in Singapore
1989	Ratification of requirements for clinical psychology education in the Netherlands
1990s	First clinical psychology doctoral program in Australia
	Ratification of requirements for clinical psychology education in Indonesia
	First Islamist-inspired Department of Psychology in Malaysia
1998	First clinical psychology graduate program in Singapore
2003	Australian university teaches psychology in Singapore
2008	Australian Psychological Accreditation Council accredits psychology degrees
	Private university teaches clinical psychology in Malaysia
2009	National University of Singapore starts joint degree with University of Melbourne
	Malaysian Society of Clinical Psychology (MSCP) established

Clinical psychology first appeared before the Second World War but developed more rapidly in the Netherlands in the 1960s. Before the war, in 1938, the Dutch Institute of Practicing Psychologists (now: Netherlands Institute of Psychologists, *Nederlands Instituut van Psychologen,* NIP) was established. It is now the largest professional psychology organisation in the country (NIP, 2015). The first clinical psychologist was appointed in 1942, with his tasks limited to diagnostics (Emmelkamp

& Scholing, 2001). Only when clinical psychology expanded in the 1960s did clinical psychologists start offering therapy for mental distress and disorders (Emmelkamp & Scholing, 2001).

Due to increasing demand and health care restructuring the hermeneutic and psychoanalytic orientation that characterised early clinical psychology was replaced by an American-influenced empirical-analytical approach in the 1970s (Dehue, 1991; Stufkens, 2006). The Netherlands Institute of Psychologists established training requirements for registered clinical psychologists, including postgraduate training, in 1989 (Hutschemaekers & Oosterhuis, 2004). These programs adhered to a scientist-practitioner model. By the turn of the 20th century clinical psychology was the most popular specialisation, attracting over a quarter of graduates in psychology (Emmelkamp & Scholing, 2001). Today postgraduate clinical psychology is offered in eight out of fourteen public universities (see Table 3). Standardised American models for clinical psychology training and practice are mainstreamed in the Netherlands.

The increasing demand for clinical psychology was accompanied by further standardisation of the profession. Graduates of clinical psychology postgraduate programs are required to register with the government as a 'basic psychologist' and are supervised by an experienced clinical psychologist. Two additional training years at a tertiary institute are required in order to practice clinical psychology independently (Rino Groep, 2015). Only a few of these postgraduate training places are available each year. Furthermore, the professional organisation states the need to address cultural diversity in training and practice (NIP, 2007), however, an examination of available online data of two universities chosen for deeper analysis as case studies in this thesis

shows that this is not always translated to clinical psychology curricula.[2] Thus, cultural considerations have yet to be standardised in clinical psychology in the Netherlands.

Table 3. *Psychology Education in the Netherlands (in alphabetical order)*

University name (est.)	Type	Undergraduate	Graduate
Erasmus Universiteit Rotterdam (1913)	Public	BSc	MCP; MP
Open Universiteit (1984)	Public	BSc	MCP; MP
Radboud Universiteit Nijmegen (1923)	Public	BSc	MCP; MP
Rijksuniversiteit Groningen (1614)	Public	BSc	MCP; R
Universiteit Leiden (1575)	Public	BSc	MCP; MP; R
Universiteit Tilburg (1927)	Public	BSc	MCP; MP
Universiteit Twente (1961)	Public	BSc	MP
Universiteit Utrecht (1636)	Public	BSc	MCP; MP; R
Universiteit van Amsterdam (1632)	Public	BSc	MP; R
Universiteit van Maastricht (1976)	Public	BSc	MP; R
Vrije Universiteit van Amsterdam (1880)	Public	BSc	MCP; MP
Webster University (1983)	Private	BA	

Australia

Psychology in Australia is as old as in the Netherlands. It developed from the academic subject called 'mental philosophy' introduced in the 1890s by British scholars to universities in Australia (Taft, 1982; Taft & Day, 1988). In 1913 the first specialist lecturer in psychology was appointed at the University of Western Australia, followed, in 1930, by an undergraduate program in psychology (Australian Psychogical Society; APS, 2014; Taft, 1982; Taft & Day, 1988). Such early Australian psychology programs depended heavily on ideas from the northern hemisphere. For example, psychology lecturers were exclusively trained in the United Kingdom, Germany or the United States (Taft, 1982). Thus, early clinical psychology in Australia was dependent upon knowledge from Europe and the United States.

[2] References to the online sources of the case study universities in the Netherlands are removed in order to maintain the confidentiality of participants at these universities.

Similar to developments in the Netherlands, the first applied psychology practitioners were appointed in Australia in the 1920s (APS, 2014), and the Second World War created a niche for clinical practice, which stimulated the development of clinical psychology education. The first specialist program in clinical psychology was developed at the University of Western Australia in 1956, and a decade later a professional master's program commenced (APS, 2014). Professional doctoral programs were introduced much later in the 1990s (APS, 2014). Development of clinical psychology programs in Australia after the Second World War mirrored developments in Europe and the United States.

The rise in the number of clinical psychologists motivated the need for a professional organisation and regulation of the discipline. The Australian Psychological Society (APS) was founded in 1966 with 941 original members. Clinical psychologists were invited to register with the APS, and since 2008 are required to have completed a programme that is accredited by the Australian Psychology Accreditation Council, APAC (2010). Today, clinical psychology education is offered at 30 out of 40 Australian universities (see Table 4). Psychology degrees in Australia are standardised, are committed to a scientist-practitioner model, and quality is checked by APAC. APAC requires cultural issues, especially related to Indigenous Australians, to be addressed in clinical psychology training, and an analysis of curricula of two universities shows that such considerations are indeed included in the curricula.[3] Thus, cultural issues have a place in standardisation of clinical psychology in Australia.

[3] References to the online sources of the case study universities in Australia are removed in order to maintain confidentiality of the participants at these universities.

Table 4. *Psychology Education in Australia (in alphabetical order)*

University name (est.)	Type	Undergraduate	Graduate
Australian Catholic University (1991)	Public	BA; BSc; Hons	MCP; MP; DP; GD
Australian National University (1946)	Public	BP	MCP; DP; R
Bond University (1989)	Private	BSc; Hons	MCP; MP
Charles Darwin University (1988)	Public	BSc; Hons	MCP; GD
Charles Sturt University (1990)	Public	BSc; Hons	MP ; DP; R; GD; O
CQ University Australia (1992)	Public	BP; Hons	MCP; R; GD
Curtin University (1987)	Public	BP; BSc	MCP; MP; R
Deakin University (1974)	Public	BA; BSc; Hons; O	MCP; MP; DP; R
Edith Cowan University (1991)	Public	BA; BSc; Hons; DM	MP
Flinders University (1966)	Public	BA; BSc; Hons	MCP; DP; R
Griffith University (1971)	Public	BSc; BP; Hons	MCP ; MP; DCP; R; O
James Cook University (1970)	Public	BA; BP	MCP ; DCP; GDs
La Trobe University (1964)	Public	BA; BSc; Hons	MCP; MP; DP; R
Macquarie University (1964)	Public	BA; BSc; Hons; DM	MCP; MP; DP; GD
Monash University (1958)	Public	BP	GD; O
Murdoch University (1973)	Public	BA; BP; Hons	MCP; DP ; R
Queensland University of Technology (1998)	Public	BSc; Hons; DM	MCP; MP; DP; R; GDs
RMIT University (1992)	Public	BSc; Hons; O	MP; DP; R; GD
Southern Cross University (1994)	Public	BSc; Hons	GD
Swinburne University of Technology (1992)	Public	BA; BSc; Hons	MCP; MP; DP; R
University of Adelaide (1874)	Public	BSc; BP; DM	MCP; MP; R; GDs
University of Ballarat (1994)	Public	BSc; Hons	MCP
University of Canberra (1990)	Public	BSc; Hons; DM	MCP; R; O
University of Melbourne (1853)	Public	BA; BSc; Hons	MCP; MP; R
University of New England (1954)	Public	BA; BSc	MCP; R
University of New South Wales (1949)	Public	BA; BSc; BP; Hons; O	MCP; MP; R
University of Newcastle (1965)	Public	BP	
University of Notre Dame (1990)	Private	BSc; Hons; Double	R; O
University of Queensland (1909)	Public	BA; BSc; Hons	MCP; MP; DP; R; O
University of South Australia (1991)	Public	BSc; BP; DM; O	MCP; MP
University of Southern Queensland (1992)	Public	BSc; BP; Hons; O	MCP; DCP ; R
University of Sydney (1851)	Public	BP	MP; DCP; R
University of Tasmania (1890)	Public	BA; BSc; BP; DM	MCP; DP; R
University of the Sunshine Coast (1999)	Public	BSc; Hons; DM	MCP; DP; R
University of Western Australia (1911)	Public	BA; BSc; Hons.	MCP; R; O
University of Western Sydney (1989)	Public	BA; BSc; Hons	MCP; MP; GD
University of Wollongong (1975)	Public	BP	MCP; R; GD
Victoria University (1992)	Public	BSc; Hons	MCP; DCP; R; GD; O

Note. Italicised universities offer postgraduate clinical psychology education. BA = Bachelor of Arts in Psychology; BSc = Bachelor of Science in Psychology; BP = Bachelor of Psychology; Hons = Honours; DM = Double Major including Psychology; MCP = Master of Clinical Psychology; MP = Master of Psychology other than Clinical; DCP = Doctor of Clinical Psychology; DP = Doctor of Psychology other than Clinical; R; Research Master or PhD; GD = Graduate or Postgraduate Diploma; O = others

APAC accreditation of degrees enables unconstrained exchange of psychology students across Australian universities and ease of professional registration in Australia. However it complicates admittance to Australian postgraduate psychology programs for foreign students with non-APAC degrees. Even so, Australia is successful in exporting its psychology programs to the Malay Archipelago. In 2012, thirteen APAC-accredited programs were taught in Singapore, nine in Malaysia and one non-accredited degree in Indonesia (APAC, 2012a; 2012b). These flows of knowledge are unidirectional; there are no foreign institutes involved in psychology education in Australia. However, as will be argued in Chapter 4, these flows are interrupted by bottom-up interpretations of psychology in each country. The next sections discuss the developments of clinical psychology in the countries in the Malay Archipelago, starting with a short introduction of the region.

Malay Archipelago

The Malay Archipelago is a region between Australia and Southeast Asia, covering Indonesia, Malaysia, Singapore and, by most definitions, the Philippines. The term was first used by the British naturalist Alfred Russel Wallace (1869) to describe the similarities in terms of biodiversity and indigenous cultures in the region. Wallace studied the countries of the Southern Malay Archipelago, including mainland Malaysia, which he included in the 'archipelago' due to cultural, linguistic and trading links between the peninsula and the surrounding islands. The term Maritime Southeast Asia is often used synonymously with Malay Archipelago, however this term refers to the islands and thus excludes mainland parts of Malaysia. For this reason this thesis uses the term Malay Archipelago to refer to the southern Malay Archipelago – the areas of Wallace's research endeavours.

The three countries of the Malay Archipelago discussed in this chapter are Singapore, Indonesia and Malaysia. These countries have historically maintained intensive trade relations, facilitated by the shared Malay language (*Bahasa Melayu*). Indonesia and the Federation of Malaya became independent from Dutch and British colonial territories in 1950 and 1957 respectively. During this period of decolonisation, the Indonesian language (*Bahasa Indonesia*) became the official language in Indonesia. In 1963, the Federation of Malaya was reconstituted as 'Malaysia', which included mainland Malaysia, Sarawak, Sabah and Singapore. In 1965 Singapore was split off from Malaysia, and adopted English, Mandarin and Tamil as official languages in addition to Malay. The countries in the Malay Archipelago remain connected through interweaving histories, trade, cultures and languages. The Malay Archipelago countries, in turn, are linked through social, educational and economic ties with the regional neighbour, Australia, and, through postcolonial ties with Europe – including the Netherlands.

Singapore. The foundations for psychology in Singapore predated Australia and the Netherlands, as well as Indonesia and Malaysia. They were laid down when the British established the Singaporean mental asylum in 1841 (Long, 1987). This early psychiatry background remained the sole domain for psychology practice until 1952, when the Australian visiting lecturer Beryl Wright introduced psychology into the social work curriculum, (Long, 1987). Wright visited the University of Malaya (now the National University of Singapore) as part of the Colombo Plan, an aid development scheme for Asia and the Pacific originally signed in Colombo, Sri Lanka, by Australia and other Commonwealth countries (The Colombo Plan for Cooperative and Social Development in Asia and the Pacific, 2011). Thus, early developments of clinical

psychology in Singapore were characterised by a dependency on foreign knowledge mainly from Great Britain and Australia.

Psychology gradually gained recognition, and in 1979 the Singapore Psychological Society (SPS) was founded with 40 founding members (Long, 1987; SPS, 2014). Seven years later, in 1986, the first undergraduate psychology program was established at the National University of Singapore (Singh, 1998); this undergraduate program is currently accompanied by similar programs at six other universities (see Table 5). The first opportunity to train in the specialist field of clinical psychology in Singapore only became available in 1998 at the National University of Singapore (Singh & Kaur, 2002). As with the example of Australia, Singapore's clinical psychology education was dependent on imported ideas for the first decade of its existence, relying on foreign textbooks and readings and on lecturers who were trained abroad (Singh & Kaur, 2002).

More recently, in 2009, this foreign dependency has taken a new shape with the National University of Singapore starting an APAC-accredited joint clinical psychology training program with the University of Melbourne (National University of Singapore, 2008). Additionally, JCU Singapore, the offshore campus of Australia's James Cook University has been teaching APAC-accredited clinical psychology degrees in Singapore since 2003 (JCU Singapore, 2013; Naylor & Hassan, 2012). This indicates a strong Australian influence in the training of clinical psychologists in Singapore. Perhaps related to this Australian orientation, clinical psychology curricula in Singapore do not specifically address the local cultural context. Although APAC guidelines for accreditation refer to cultural awareness and competency, this 'culture' refers specifically to the Australian cultural milieu and has an emphasis on Indigenous

Australia (APAC, 2010). The history of clinical psychology in Singapore thus indicates the discipline's continued dependency on foreign knowledge.

Table 5. *Psychology Education in Singapore (in alphabetical order)*

University name (est.)	Type	Undergraduate	Graduate
EASB East Institute of Management (1984)	Private	BSc; Hons (with CMU)	
JCU Singapore (2003)	Private	BA; BP; Hons	MCP; DCP; R (with JCUA)
Melior International College (2007)	Private	BP; Hons (with CQU)	
Nanyang Technological University (1991)	Public	BA; BSc	R
National University of Singapore (1905)	Public	BA; BSc; Hons	MCP (also with UM); R
SIM University (2005)	Private	BA; BSc (with UOW)	
Singapore Management University (2000)	Public	BSc	

Note. Italicised universities offer postgraduate clinical psychology education. BA = Bachelor of Arts in Psychology; BSc = Bachelor of Science in Psychology; Hons = Honours; MCP = Master of Clinical Psychology; DCP = Doctor of Clinical Psychology; R = Research Master or PhD in Clinical Psychology; CMU = Cardiff Metropolitan University, United Kingdom; CQU = Central Queensland University, Australia; JCUA = James Cook University, Australia; UM = University of Melbourne, Australia; UOW = University of Wollongong, Australia

Indonesia. As in the cases of Australia and Singapore, clinical psychology was first introduced into Indonesia during the colonial era. In 1941, at the end of colonisation and toward the beginning of the Second World War, Dutch colonial scholars set up clinics and taught psychology courses to teachers and medical students (see Table 2; Utami Mumandar & Munandar, 1987). After the Second World War and during the struggle for Indonesian independence, most Dutch psychologists returned to the Netherlands, leaving a scarcity of trained practitioners. The newly independent Indonesian government was quick to call for the development of local psychology training. In 1953, Professor of psychiatry, Slamet Iman Santoso, returned from the Netherlands to develop the first psychology graduate program at the National University of Indonesia (*Universitas Indonesia*) in Jakarta (Satiadarma, 2012; Singh, 1998). However, this psychology program was not fully independent of colonial

influence: it was based on European programs and texts, and was largely taught by graduates from the Netherlands and West Germany (Utami Mumandar & Munandar, 1987). Thus, initial development of psychology in Indonesia depended upon knowledge from Europe.

In 1959, at a time when there were still only around 10 to 15 psychologists in Indonesia, the Association of Indonesian Psychologists (*Ikatan Sarjana Psikologi Indonesia*, now *Himpunan Psikologi Indonesia*, HIMPSI) was founded (Utami Mumandar & Munandar, 1987), perhaps indicating faith in the expansion of psychology in the country. Two years later, the first Faculty of Psychology was established at the University of Padjadjaran (*Universitas Padjadjaran*), after which psychology was adopted by other universities (see Table 6). Clinical psychology developed as a specific sub-discipline in Indonesia between the 1960s and 1990s (Satiadarma, 2012). It was taught in three state universities, which remain the sole providers of clinical psychology education in the country (see Table 6). However, an additional nine universities offer 'professional psychology' programs which are comparable to clinical psychology education. Clinical and professional psychology together, constitute the majority of postgraduate programs in psychology in Indonesia. However, despite the expansion in training opportunities, the number of clinical psychologists in Indonesia remains low.

Although psychology education is not regulated or accredited by the Indonesian Association of Psychologists, in 1974 the Psychological Consortium (Utami Mumandar & Munandar, 1987), an advisory body, standardised training for clinical psychologists to a five-and-a-half year sequence. This was ratified by the government in the early 1990s (Satiadarma, 2012).The professional organisation for psychologists states the importance of preparing for practice in the Indonesian cultural context (Himpunan

Psikologi Indonesia, 2012), online curricula do not directly show how this focus on Indonesia is translated in training (e.g. Universitas Gadjah Mada, 2014; Universitas Indonesia, 2014). However, the focus on practice in Indonesia is visible in the training in professional psychology in private universities with religious affiliations, such as the Muhammadiyah University of Malang (*Universitas Muhammadiyah Malang*) which interweaves Islamic perspectives with clinical psychology theories (Universitas Muhammadiyah Malang, 2010).The existence of religiously inspired training programs in Indonesia suggests that the country has started to culturally appropriate what was initially western clinical psychology.

Table 6. *Psychology Education in Indonesia (in alphabetical order)*

University name (est.)	Type	Undergraduate	Graduate
IKIP PGRI Semarang (1981)	Private	DM	
Universitas Ahmad Dahlan (1960)	Private	S1	
Universitas Airlangga (1954)	Public	S1	MPP; DP; R
Universitas Bhayangkara Jakarta Raya (1995)	Private	S1	
Universitas Brawijaya (1963)	Public	S1	
Universitas Ciputra (2006)	Private	DM	
Universitas Diponegoro (1957)	Public	S1	
Universitas Gadjah Mada (1949)	Public	S1	MCP; MP; R
Universitas Gunadarma (1981)	Private	S1	
Universitas Hang Tuah Surabaya (1987)	Private	S1	
Universitas HKBP Nommensen (1954)	Private	S1	
Universitas Indonesia (1950)	Public	S1; BA (with UQ)	MCP; MP; R
Universitas Islam Indonesia (1945)	Private	S1	MPP
Universitas Islam Negeri Malang (2004)	Public	S1	
Universitas Islam Negeri Syarif Hidayatullah Jakarta (1957)	Public	S1	
Universitas Jayabaya (1958)	Private	S1	
Universitas Katolik Atma Jaya (1960)	Private	S1	MPP; R
Universitas Katolik Soegijapranata (1964)	Private	S1	MPP, R
Universitas Katolik Widya Mandala Madiun (1960)	Private	S1	
Universitas Kristen Krida Wacana (1967)	Private	S1	
Universitas Kristen Manahata (1965)	Private	S1	
Universitas Kristen Satya Wacana (1956)	Private	S1	MSc
Universitas Mercu Buana (1985)	Private	S1	

Table 6 *(continued)*

University name (est.)	Type	Undergraduate	Graduate
Universitas Merdeka Malang (1964)	Private	S1	
Universitas Muhammadiyah Gresik (1987)	Private	S1	
Universitas Muhammadiyah Jember (1987)	Private	S1	
Universitas Muhammadiyah Malang (1964)	Private		MPP; R
Universitas Muhammadiyah Prof. Dr. HAMKA(1960)	Private	S1	
Universitas Muhammadiyah Purworejo (1964)	Private	S1	
Universitas Muhammadiyah Sidoarjo (1987)	Private	S1	
Universitas Muhammadiyah Surabaya (1964)	Private	S1	
Universitas Muhammadiyah Surakarta (1960)	Private	S1	MPP
Universitas Muria Kudus (1982)	Private	S1	
Universitas Negeri Makassar (1964)	Public	DM	
Universitas Negeri Malang (2004)	Public	DM	
Universitas Negeri Surabaya (1964)	Public	S1	
Universitas Padjadjaran (1957)	Public	S1	MCP; MP; DP
Universitas Pancasila (1966)	Private	S1	
Universitas Pelita Harapan (1993)	Private	S1	
Universitas Pendidikan Indonesia (1954)	Public	S1	
Universitas Persada Indonesia Y.A.I (1985)	Private	S1	MPP; DP
Universitas Sanata Dharma (1955)	Private	S1	
Universitas Sebelas Maret (1976)	Public	S1	
Universitas Sumatera Utara (1952)	Public	S1	
Universitas Tarumanagara (1959)	Private	S1	MPP; R
Universitas Trunojoyo Madura (2001)	Public	S1	
Universitas Udayana (1962)	Public	S1	
Ubaya Universitas Surabaya (1968)	Public		MPP; R
Sultan Agung Islamic University (1962)	Private	S1	

Note. Italicised universities offer postgraduate clinical psychology education. S1 = Strata-1 in psychology (standardised undergraduate training); DM = Double Major incl. Psychology; BA = Bachelor of Arts in Psychology; MCP = Master of Clinical Psychology; MPP = Master of Professional Psychology; MP = Master of Psychology other than Clinical; DP = Doctor of Psychology other than Clinical; R = Research Master or PhD; UQ = University of Queensland, Australia.

Malaysia. Clinical psychology in Malaysia substantially differs from that of Indonesia, despite both countries initially relying on western psychology. Psychology was introduced in the 1960s, prior to the separation of Singapore in 1965, and before the National University of Singapore split off from the University of Malaya (*Universiti Malaya*). More than a decade later, in 1973, developments of psychology in Malaysia were facilitated by a conference on psychology and counselling organised by American Fulbright scholar Jerome Sattler (J.M. Sattler, personal communication, June 6, 2014). One year later Wan Mohammad Rafaei Bin Wan Abdul Rahman and Abdul Halim

Othman started teaching psychology courses as part of the medicine and education curricula (Rahman, 2005; Ward, 1987). Rahman and Othman were both trained abroad, but made efforts to teach a psychology with a Malaysian identity (Othman & Bakar, 1993). These first psychology courses were developed in Malaysia in 1974, which is more than 20 years after the first psychology graduate program was initiated in Indonesia. However, the discipline expanded relatively rapidly. In 1979, only five years after psychology's introduction into the country, Malaysia's first Department of Psychology was founded at the National University of Malaysia (*Universiti Kebangsaan Malaysia;* Khan, Verma, & Subba, 2012). Thus development of psychology in Malaysia started considerably later compared to Singapore and Indonesia.

Clinical psychology education developed toward the end of the 1990s at the National University of Malaysia (Ng, 2012a, 2015; Universiti Kebangsaan Malaysia, 2014). During this time a clinical psychology program at the International Islamic University of Malaysia (*Universiti Islam Antarabangsa Malaysia*) was also developed (Haque & Masuan, 2002; Singh, 1998); the first university in Malaysia to teach clinical psychology from an Islamic perspective (Rahman, 2005). However, this clinical psychology program has been non-active since 2010 (Ng, 2012a). In addition, the private institute HELP University started offering clinical psychology in 2009. Thus two universities currently offer postgraduate clinical psychology programs (see Table 7). Both the National University of Malaysia and HELP University address the integration of clinical psychology in the Malaysian cultural context through a specific module (HELP University, 2011, 2012; Universiti Kebangsaan Malaysia, 2013). As in Indonesia, Malaysia also focuses on local practice, however, there are less opportunities for clinical psychology training in Malaysia.

Table 7. *Psychology Education in Malaysia (in alphabetical order)*

University name (est.)	Type	Undergraduate	Graduate
HELP University (1986)	Private	BSc, BP (also joint with FU)	MCP; MP
International Islamic University Malaysia (1983)	Public	BSc	MSc; R
International Medical University (1992)	Private	BSc; Hons	
Monash University Sunway Campus (1998)	Private	BSc; Hons	GD; R
Sunway University (1987)	Private	BSc; Hons; O	MSc; R
UCSI University (1986)	Private	BA; Hons	
Universiti Kebangsaan Malaysia (1970)	Public		MCP; MP
Universiti Malaysia Sabah (1994)	Public	BP; Hons; O	MP
Universiti Pendidikan Sultan Idris (1997)	Public		MSc; R
Universiti Selangor (1999)	Private	BP	
Universiti Teknologi Malaysia (1972).	Public	BP	MSc, O
Universiti Tunku Abdul Rahman (1972)	Private	BSc; Hons	
Universiti Utara Malaysia (1984)	Public		MSc; R
University College Shah Putra (1997)	Private	BP; Hons	
University of Nottingham Malaysia Campus (2000)	Private	BSc; Hons; O	MSc; R
University Tun Hussein Onn Malaysia (2000)	Public		MSc; R

Note. Italicised universities offer postgraduate clinical psychology education. BA = Bachelor of Arts in Psychology; BSc = Bachelor of Science in Psychology; BP = Bachelor of Psychology; Hons = Honours; MCP = Master of Clinical Psychology; MP = Master of Psychology other than Clinical; MSc = Master of Science in Psychology or coursework/research combined; R = Research Master or PhD in Clinical Psychology; GD = Graduate Diploma or Postgraduate Diploma; O = Others; FU = Flinders University, Australia

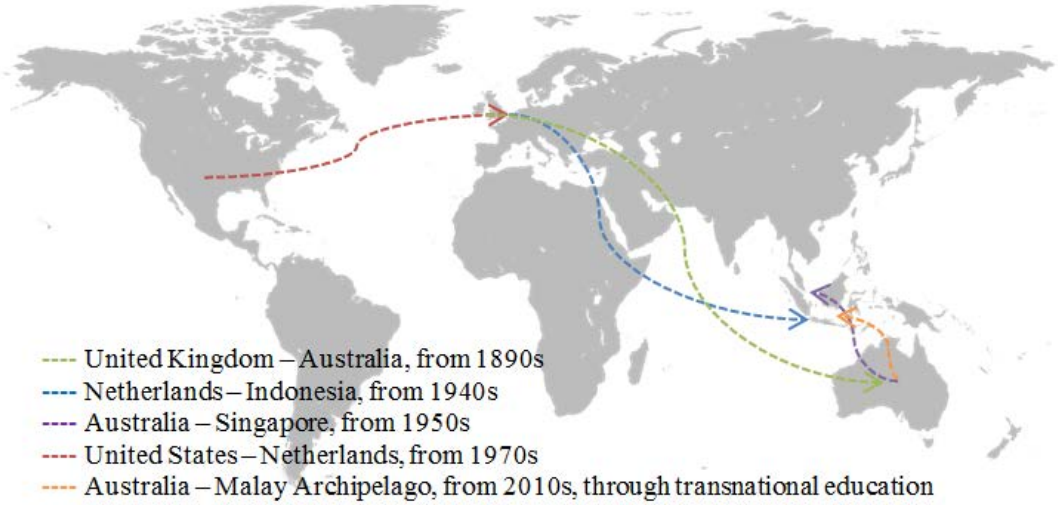
Clinical psychologists in Malaysia have called for further development of the discipline (Khan et al., 2012; Ng, 2015). One of the identified needs is more opportunities for training (Khan et al., 2012). The number of clinical psychologists is reported to be dire, but seems to be improving. In 2012, the Malaysian Society of Clinical Psychology (MSCP), the professional organisation for clinical psychologists, counted 96 members (Ng, 2012a), the majority of its new members are locally trained clinical psychologists (MSCP, 2013). Additionally, clinical psychology has recently become more embedded in Malaysia. The MSCP was established as a registration and regulatory body for clinical psychologists in 2010 (MSCP, 2012; 2012a), and together with the National University of Malaysia and HELP University, the MSCP is currently

working towards registration of clinical psychologists and accreditation of training programs.

Knowledge Flows in Clinical Psychology

The above histories indicate that knowledge flows in clinical psychology have been unidirectional and uneven, moving from the north to south and from west to east (see Figure 1). The Netherlands is the only country in this paper that has not been colonised; rather, it has been a colonising country. Initial ideas and models of clinical psychology in the Netherlands were based on experiences from within the country and from neighbouring Germany, although foreign ideas from the United States were imported to the Netherlands a few decades later. In contrast, for colonised countries, early experiences in clinical psychology were foreign, materialised through academic programs (in Australia), clinics (in Indonesia), mental asylums (in Singapore), and through foreign educated scholars (in Malaysia). Although clinics and education programs were gradually taken over by local specialists, often they remained dependent upon foreign knowledge and expertise for at least several decades. Therefore psychology and clinical psychology in Australia and the Malay Archipelago may be considered, at least initially, to be Euro-American imports, and the early development of the discipline represents a (post)colonial continuation of the incorporation of foreign knowledge into the region (Geerlings, Lundberg, & Thompson, 2013; Geerlings, Thompson, & Lundberg, 2013). Indeed some contemporary scholarly research in this area maintains that this (post)colonial dependency on western knowledge in clinical psychology continues into the present day (L.O. Ng, personal communication, August 7, 2014).

Figure 1. *Clinical Psychology Knowledge Flows in the Case Study Countries*



New flows from Australia to Singapore and, to a smaller extent, to Indonesia and Malaysia occur with transnational education. Especially influential in these flows is APAC, which through its accreditation prioritises ideas and experiences that are important to the Australian cultural context. Transnational application of APAC accreditation may lead to neo-colonial tendencies in clinical psychology education in which APAC defines the priorities of psychology education in the Malay Archipelago and thereby restricts the development of alternative clinical psychologies within local regions. This analysis invites a postcolonial critique of the knowledge flows in psychology; these flows draw attention to power disparities in the production of knowledge in clinical psychology.

The situation of standardisation across borders highlights the critical need to enhance cultural perspectives in clinical psychology. Accreditation and standardisation rest on the premise of human commonality rather than on human diversity. Concerns about the neglect of cultural difference by mental health professionals have been widely voiced in the literature since the 1960s (Chong, Mohamad, & Er, 2013; Davidson, 1993; Haque, 2010; Kazarian & Evans, 1998; Ng, 2012a; Sinha & Sinha, 1997). There is a concern that the current system may train a generation of clinical psychologists

who are 'culture-blind' (Kazarian & Evans, 1998, p. 9), and are not able to effectively address cultural diversity in their client groups. This, in turn, may negatively influence their ability to meet the mental health needs in their country of practice. On a larger scale, culture blindness perpetuates a system of uneven production of knowledge and ideas in psychology and clinical psychology in which Euro-American perspectives are prioritised over perspectives from 'non-western' countries, or from diverse communities in 'western' countries.

The histories of clinical psychology presented in the previous sections draw attention to (post)colonial knowledge flows. However, they also illustrate that knowledge flows are never stable, but are challenged, interrupted and re-created. For example, Australia has appropriated (post)colonial flows and is directing newly developed knowledge flows to the Malay Archipelago. In addition, flows from the Netherlands to Indonesia have been interrupted by localising, religious approaches in clinical psychology in Indonesia. Furthermore, Malaysia has challenged flows from the west by focusing on practice in local cultural context. These instances indicate that although clinical psychology may have historically been based upon western models, these have been adjusted to some extent to Australian and Malay Archipelago cultural contexts. Such cultural negotiations are central to this thesis, and a theoretical framework for analysing how (post)colonial flows of knowledge are opened up is discussed in the following two chapters.

Conclusion

Clinical psychology, the example of transnational knowledge in this thesis, has, since its inception, been conceptualised and developed as part of society; its ideas and practices cannot be separated from the culture(s) from which it originates and in which

it is practiced. Despite some critiques on the western cultural bias in clinical psychology from academics and practitioners, the close relationship between (post)colonial cultural imperialism and transnational training and practice of clinical psychology deserves more attention. The issue is often neglected in research and lacks significant theorisation. Therefore, this thesis outlines a framework for analysing cultural negotiations of (post)colonial transnational flows of knowledge, using the example of clinical psychology. The multidisciplinary theoretical framework for analysing transnational knowledge is discussed in the next two chapters.

4. Mapping Negotiations and Deterritorialisations: Towards a Cultural Anthropology Study of Clinical Psychology[4]

This chapter maps an analytical space for the anthropological study of cultural negotiations in transnational knowledge. It examines and reviews a selection of exemplary interdisciplinary theories about globalisation, deterritorialisation and power/knowledge, that suggest that students, academics, and practitioners can influence transnational knowledge in clinical psychology, although the effects may be limited by several factors.

From a social science perspective, contemporary higher education may contain intrinsic properties of cultural imperialism. Higher education is a key instrument in establishing truths and prioritising specific knowledges and skills to prepare students for future citizenship. In the current climate of globalisation, new forms of 'global citizenship' have developed in which students are being prepared for entering the international workforce (Ng, 2012b). In clinical psychology, this international focus

[4] An adaptation of this chapter was published as:
Geerlings, L.R.C., & Lundberg, A. (2014). Globalisation and deterritorialisation: An example of an academic discipline in the Malay Archipelago. In A. Kwan, E. Wong, T. Kwong, P. Lau, & A. Goody (Eds.), *Research and Development in Higher Education: Higher Education in a Globalized World, 37* (pp. 137 – 146). Hong Kong, 7–10 July 2014.

This paper was awarded with the *Taylor & Francis Prize for Best Paper by a New Researcher*.

A sequel to this chapter is currently in review:
Geerlings, L.R.C., & Lundberg, A. (in review). Global discourses and power/knowledge: Theoretical reflections on futures of higher education in the Asian Century. *Asia-Pacific Journal of Education, Special Issue on Exploring Leadership and Learning Theories in Asia.*

implies that students are prepared to work with models based on understandings of shared humanity, rather than on difference and uniqueness. Despite perceived benefits of the emphasis on universals in terms of greater applicability of clinical psychology degrees in larger areas, 'globalised' psychology knowledge may be at the expense of diversity and local expertise (Bourn, 2011). In addition, 'global' psychological models or theories do not necessarily translate to all cultural contexts (see Chapter 1). Theoretically, internationalisation of academic disciplines can provide space for cultural negotiation (Yang & Welch, 2010); at the same time, however, disciplines can become vehicles for cultural imperialism. This may be the case where Anglo-American academic traditions are taking a leading role in defining knowledge and research practices (Yang, 2005), producing the one-way flows in clinical psychology previously noted (see Chapter 3). Through standardisation, globalisation of clinical psychology education thus carries the risk of cultural imperialism, neo-colonialism, and of spreading epistemological hegemonies (Rizvi, 2007).

There is a growing need to study the cultural consequences of globalisation of knowledge in clinical psychology education. Therefore, this chapter examines critical theories from anthropology and philosophy to open up a space for discussion on the cultural effects of globalisation of clinical psychology education. It reviews the theories of Appadurai (1996) on globalisation, Deleuze and Guattari (1977, 1988, 1994) on deterritorialisation, and Foucault (1977, 1978, 1984, 1985, 1988, 1994, 1997) on power and knowledge. These theories help critique western hegemony in clinical psychology and draw attention to multiplicities in understandings, nuanced contexts, and the complex interplay of power and knowledge claims. This opens up a critical space in the notion of a unified clinical psychology and highlights the importance of cultural anthropology to the study of clinical psychology.

Theoretical Positions

Critical theories of globalisation and deterritorialisation are significant in forming an understanding of current processes of clinical psychology training and practice. These theories, originally emerging from anthropology, philosophy and cultural studies, have been taken up in a range of interdisciplinary contexts. They are particularly pertinent to this thesis. However, before proceeding, a few comments on the theoretical underpinnings of this chapter are needed.

Firstly, by moving away from grand theories of globalisation this chapter helps to nuance the understanding of the knowledge flows described in the previous Chapter 3, which presented globalisation as an export process from the 'west' to the 'rest' of the world, including the Malay Archipelago. A limitation of such a one-way power relation is that it regards people as passive recipients of foreign ideas and products. Instead, Chapter 3 provided glimpses of cultural appropriation of clinical psychology in countries in the Malay Archipelago – thus, people actively interpret and negotiate foreign influence.

Furthermore, a representation of globalisation as westernisation incorrectly suggests that cultures are static and delineated. Such a grand theory represents culture as merely a static mosaic of difference overlying geographical territories, such as 'the west', and it assumes that homogenous identities are exported in globalisation processes. However, regions, countries or cities in Europe, Australia, and the United States – all categorised as 'the west' – are very different and diverse. Likewise, people in different places, cities, regions, and countries in Singapore, Malaysia and Indonesia which may share some similarities, are not an homogenous 'Malay Archipelago' cultural group. Rather than treating cultures as delineated and unchanging, anthropologists and other cultural theorists have suggested that cultural forms are

interdependent, interrelated and fluid (Spivak, 2008), and that globalisation can have localising effects (Appadurai, 1996). For these reasons, this chapter ascribes to theories that critique grand narratives of globalisation.

The theories in this chapter also critique the idea of globalisation as a process to which a causal power can be prescribed. Instead, they suggest that globalisation is also an idea, or an imaginary, that is an outcome of people's deeds and that inspires further actions. As a result, globalisation is not a reality that can be taken for granted, and thus the notions of 'global knowledge' and 'universally applicable knowledge' likewise require further scrutiny. The notion of 'globalisation' may have different meanings to different people, none of which is more 'true' than the other. In other words, globalisation may not be anchored in epistemological and ontological realism. The chapter discusses this point in more detail.

Globalisation and Deterritorialisation

Critical analysis of cultural negotiations of clinical psychology knowledge logically commences with an examination of globalisation as a main driver of the transnational movement of knowledge. This exploration starts with the influential theorist of the cultural effects of globalisation, Arjun Appadurai.

Appadurai (1996) understands globalisation as forming an important place in the *social imaginary*. According to Appadurai, the imaginary is an important social practice, and globalisation is characterised by a complex network of transnational constructions of 'imaginary landscapes' (1996, pp. 27, 31). Furthermore, social imaginaries are shared worldviews that create meaning and aspirations, and their tangible and intangible effects are experienced when people act upon them. In other words, transnational constructions of social imaginaries form the basis for enactments

of globalisation. This implies that globalisation is not an outside force that subjugates people; rather, people dynamically enact globalisation. Through the social imaginary, globalisation thus provides people with power to act, or "to imagine otherwise", and to shape their worlds (Yang, 2006, p. 208).

Social imaginaries depend upon people's interpretation of encounters with global flows. Appadurai theorises global cultural flows within five dimensions: people, information and images, technologies, capital, and ideologies. He labels these dimensions: ethnoscapes, mediascapes, technoscapes, financescapes and ideoscapes respectively (Appadurai, 1996, p. 33). The suffix 'scape' underlines the subjectivity, irregularity and fluidity of the flows; they are ambiguous processes that create new and unpredictable perspectives or imaginary worlds (Marginson & Sawir, 2005), which define how people enact globalisation.

Specifically relevant to the study of higher education is the extension of Appadurai's theory to the notion of *eduscapes* (Forstorp & Mellström, 2013). Eduscapes are our imaginaries of globalisation of higher education which transverse Appadurai's five global flows. Eduscapes are thus the imaginaries of higher education that take shape in how intellectuals, education policy makers, lecturers, students and other actors represent globalisation, and how they enact such processes.

Appadurai theorises that as an effect of globalisation, global flows are increasingly deterritorialised (Appadurai, 1996, p. 38). He describes deterritorialisation in terms of "overseas movement", "displacement" or "travel" (Appadurai, 1996, p. 38), all referring to movement from one geographical territory to another. Thus, Appadurai's notion of deterritorialisation refers to some form of geographical movement. According to this reading of deterritorialisation, global flows of people, information and images, technologies, capital, and ideologies, must have moved from

one geographical place, region or country to another in order to be part of globalisation. Accordingly, clinical psychology only became part of globalisation when it was introduced in other places in the world, such as from Europe to Australia and Indonesia; or from Australia to Singapore and Malaysia. In other words, it was the geographical movement of the discipline that defined it as part of globalisation. Appadurai's theory of globalisation thus implicitly relies on a *geographical* notion of deterritorialisation, which problematically analyses globalisation as processes of geographical movement.

Paradoxically, Appadurai's reliance on geographical flows in globalisation relates to a problematic idea of stasis. His notion of global flows, as dependent on geographical movement, creates a binary in which 'things' (people, information and images, technologies, capital, and ideologies) were stagnant and fixed to territories at some stage – at least before globalisation moved them. According to this idea, clinical psychology was fixed in the United States before it moved to other geographical places, such as countries in Europe, Australia and the Malay Archipelago.

Similarly, Appadurai's idea that cultural effects of globalisation involve rupture and spatial movement is based on the assumption that cultures were tied to geographical places before globalisation processes rendered them mobile. In this conceptualisation, cultures are located as the place "from which *something begins its presencing*" (Bhabha, 2012, p. 5; italics in original), and they are described by their margins and borders – ever incommensurable. Thus, the idea that clinical psychology was 'American' before it became part of globalisation assumes a homogenised and static 'American' culture. In other words, the concept of rupture in the face of globalisation rests upon assumptions of a substantiated and once territorialised culture – the very notion that Appadurai (1996) tries to deconstruct.

A more nuanced understanding of deterritorialisation was formulated in the collaborative works of the French philosopher Gilles Deleuze and psychoanalyst Félix Guattari. They originally described deterritorialisation as part of their philosophy of rhizomatics. The image-based thought on which they base this philosophy is the botanical rhizome: plants such as ginger, galangal and turmeric – tropical plants found in the Malay Archipelago. The underground root system of these plants form horizontal networks in which nodes of the root may spread out in all directions. Each node of the roots of these tropical plants holds the potential to connect and multiply, creating ever growing networks under the ground. When severed from its root network and replanted, a node will continue to grow into a new root network and sprout into a plant. Significant to rhizomatic theory, there is no origin or hierarchy in the rhizome; every node holds the potential to expand the network or start a new one (Deleuze & Guattari, 1988; Lundberg, 2013). In short, rhizomatics defies calculations or centrality, and supports multiplicities and non-linearity.

In the philosophy of rhizomatics, *deterritorialisation* is referred to as processes of intrinsic change that, like the roots of gingers, push and pull in multiple directions, changing through lines of flight (Deleuze & Guattari, 1988, p. 3). In other words, deterritorialisation is an ability to re-create, to re-design, or to re-shape. It is potentiality. Deterritorialisation makes seemingly stable relations virtual, that is, preparing them for more distant or different actualisations, or reterritorialisation (Parr, 2010). As a result of these processes of continuous change 'things' are never stable, and can be best understood in terms of patterns, potentiality, and relationships (Deleuze & Guattari, 1977), or, to use concepts from physics, as quantum fields (Lundberg, 2013).

Notions of deterritorialisation show how clinical psychology is always in processes of change. For example, territorialisation of a psychological idea takes place

when this idea is fixed on paper in a textbook; de- and reterritorialisation of this text occur when it is interpreted and taught by an academic to a student audience; the teachings are deterritorialised when listened to by students, and are reterritorialised when students interpret the teachings to create new meanings, write assignments, or discuss the teachings with their peers, and so forth. Thus, rather than the hierarchical tree model of origins and essence (tap roots), linear development (trunks) and diverging academic disciplines (branches), the arboreal image on which traditional western philosophy bases notions of knowledge (Lundberg, 2013, pp. 16-17), clinical psychology – like all knowledge – is rhizomatic. Thus, clinical psychology knowledges are never fixed but are always interpreted and re-actualised: deterritorialised and reterritorialised.

As a result of continuous de- and reterritorialisation of knowledges, clinical psychology can be considered a territory of change: each time knowledge and practices related to clinical psychology are used by students, academics, or practitioners, they are inevitably changed. Nevertheless, professional organisations try to pin down lines of flight through which clinical psychology diversifies. In line with the theory of rhizomatics, standardisation of clinical psychology education should be understood as a specific actualisation of the discipline, and as a way through which, for instance, APAC exerts cultural influence on the discipline. Similarly, the American Psychological Association (APA) is trying to close the clinical psychology territory through, among other processes, the Diagnostic and Statistical Manual (DSM) diagnostic system, and guidelines for education and practice. These canonical bodies of knowledge and skill become "fixed spaces of enclosure" (Edwards & Usher, 2000, p. 66), or manifestations of dominant theories and practices that are considered universally applicable and appropriate. Clinical psychology is thus characterised by simultaneous stasis and flow.

Relating deterritorialisation to the social imaginary, clinical psychology is interpreted in line with imaginaries of education – or eduscapes. For example, because clinical psychology is perceived to be a part of globalised education, its knowledges and practices will be interpreted by people in the Malay Archipelago to align with this idea. Fixed spaces of enclosure, such as books or guidelines, become part of the social imaginary of 'universal' clinical psychology. Cultural negotiations in clinical psychology are thus influenced by ideas of globalisation and eduscapes. Each re-interpretation or negotiation of clinical psychology theory or practice can be regarded as a cultural influence on the discipline. This means that in theory, academics, students and practitioners 'on the ground' have the opportunity to influence, and to re-imagine and redesign clinical psychology training and practice – depending on their eduscapes.

The combined theories of Appadurai and Deleuze and Guattari thus point to people's ability to re-interpret and change academic disciplines. Yang calls this "the power to imagine otherwise" (2006, p. 208), and regards it as an important aspect of the decolonisation of research. In theory, change in the imaginaries and enactments of clinical psychology can be initiated from every network node, as much in the United States as in Australia, in the Netherlands, or in Indonesia, Singapore or Malaysia – the networks are non-hierarchical and rhizomatic. This is especially noticeable when clusters of social imaginaries are highly charged (or at a point of paradigm shift), for example, when an idea becomes very influential and changes other ideas; such intellectual endeavours could have significant effects on clinical psychology.

In practice, however, it is difficult to change influential clusters or social imaginaries. Some nodes or clusters may have a greater ability to initiate change than other others. In order to analyse how these differences in the creation of knowledge and

truth are related to power, the classical work of Michel Foucault is of continuing importance.

Discourses and Power/Knowledge

The interdisciplinary philosopher Michel Foucault theorises that knowledge and power are interwoven, which he denotes as *power/knowledge*. He explains: "It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power" (Foucault, 1977, p. 52). In the study of clinical psychology training and practice, this means that clinical psychology theory and knowledge always refers to some kind of power and implies power effects. Foucault critically analysed 'truths' through epochs of epistemologies, called *epistemes*. In other words, he sought to discover what was considered 'truth' at different times, without seeing the present as a linear progression from a causal past. An important epistemological consequence is that 'truth' can never be more than "a thing of this world", it is never more than a social construction (Foucault, 1994, p. 133). Foucault's critical epistemology thus aligns well with the other theorists described in this chapter who critique the taken for granted nature of knowledge.

The notion of *discourse* plays a central role in Foucault's theory of power/knowledge. Discourses can be defined as "the domain of subconscious knowledge" (Foucault, 1974, in Ball, 2012), that guide the "games of truth" which define which 'things' become articulable as knowledge (Deleuze, 1988, p. 63). For example, in his three volumes of *The History of Sexuality* (1978, 1985, 1988), Foucault describes how in the eighteenth and nineteenth centuries a discourse of sexuality came to define how people looked at pleasure, kinship relations and interpersonal relations from a particular point of view related to sex, and how this discourse excluded other

views on these topics. Thus, discourses are filters through which people see the world and which define what is considered knowledge and truth.

Knowledges are produced and reinforced by discourses. For example, the discourse of science creates filters through which we construct certain realities. Based on these realities, specific social imaginaries are constructed which affect our epistemology and ontology – our ways of knowing and being in the world. Thereby, discourses are able to produce and reinforce certain knowledges, while hindering the development of alternative knowledges. Discourses of science also dismiss 'other' knowledges as 'unscientific' and therefore not truthful. Because of the power-effects of discourses of science, 'scientific' knowledges are taken for granted and their truth value is unquestioned. Through the nuanced interrelations of perspectives, truths, and social imaginaries, discourses shape people's realities and the questions that they, in their roles as intellectuals, students, or citizens, do and do not ask.

Discourses of science problematically prioritise knowledges that are developed in the 'west'. Criteria for scientific knowledge are largely defined as knowledge that is based on 'western' experiences (Appadurai, 2006), on 'western' research methods (Yang, 2006), and disseminated in the English language (Ng, 2012b). A recent study concluded that 96% of psychological research published between 2003 and 2007 was conducted with participants representing only 12% of the world's population, namely from the United States and western Europe (Arnett, 2008). In addition, Chapter 3 showed that curricula of clinical psychology in the Malay Archipelago depend on these western knowledges. Western knowledges are considered part of a scientific or global discourse, while cultural knowledges on healing and wellbeing that may exist in the cultures of Indonesia, Singapore and Malaysia are excluded from this discourse, and are therefore not considered 'truthful'. The prioritisation of western knowledge in clinical

psychology, in turn, remains largely unquestioned due to the power/knowledge effects of scientific discourses.

Mapping Cultural Influences

The combined theories discussed above provide an analytical space through which cultural influences on clinical psychology training and practice can be studied. In this analytical landscape power/knowledge effects of discourses are accompanied by subtle negotiations of knowledge through daily encounters. The concept of deterritorialisation offers a distinct way of analysing the cultural influences of clinical psychology training and practice, through an analytical cartography. By mapping the territory of clinical psychology powerful discourses are uncovered, but also subtle changes in the discipline and nuanced cultural influences. Consequently, cartography may better represent nuances of cultural influence and dynamics of change than historical tracings of 'developments' in the discipline. However, in practice, as investigations of the movement of academic disciplines rely on data that trace 'developments' in disciplines – such as in Chapter 3 – it becomes clear that cartographies require different and more nuanced data. In this regard Deleuze and Guattari argue that mapping is "oriented toward an experimentation in contact with the real" (1988, p. 12), requiring various kinds of data with multiple entry points, and relying on continuous processes of interpretation and re-interpretation. Consequently, mapping is subject to multiple interpretations.

A mapping of clinical psychology illustrates that regardless of the discipline's ability to transverse domains while retaining some scientific 'essence', clinical psychology's knowledge and practices are always changing when they are subject to interpretation and re-actualisation. Clinical psychology territories are numerous,

intertwined, always in becoming stasis *and* flow. To give an example from the Malay Archipelago, the territory of clinical psychology in Singapore closely resembles the territorialisation of the discipline in Australia due to Singapore's dependency on knowledge flows from Australia. The Australian territory, in turn, consists of appropriated Euro-American clinical psychology territories (see Chapter 3). This situation seems to rely on a discourse of a universal, scientific clinical psychology. However, as argued previously, cultural negotiation takes place on multiple levels, including through teachings, learnings and practices. A nuanced analysis of ways of teaching and practicing clinical psychology is required in order to understand and map various de/reterritorialisations of clinical psychology in Singapore – as well as in the other countries under investigation in this thesis. As such a mapping requires detailed information, the number of case studies for data collection in this thesis will be narrowed down to two universities in Singapore (representing the Malay Archipelago), two in Australia and two in the Netherlands (representing Europe).

Conclusion

This chapter theorised how cultural imperialism, which is taking place through globalisation of education and knowledges, is undermined. Powerful discourses of science and social imaginaries of globalisation and higher education shape clinical psychology's disciplinary knowledge; however, at the same time, cultural negotiation takes place each time these knowledges and practices are interpreted and applied. Academic disciplines are in continuous change; they are themselves territories, mapping their terrains. With a review of Appadurai's social imaginary through Deleuze and Guattari's notion of deterritorialisation and Foucault's power/knowledge, this chapter has created analytical spaces for mapping the cultural negotiations and

delineations at the territories of academic disciplines. These analytical spaces open up the possibility of the further study of the cultural effects on globalisation, including case studies of clinical psychology, through detailed mapping using multiple entry points.

Cultural anthropology provides a unique vantage point from which these effects can be studied. Cultural anthropology is dedicated to the study of culture from postcolonial and anti-imperialist perspectives, and it is the discipline that has established a sustained critique of its own colonial origins (Behar & Gordon, 1996; Clifford & Marcus, 1986). In line with developments in anthropology that argue against cultural essentialism, a research focus on the subjective and lived experiences of teaching, learning and practicing clinical psychology in the Malay Archipelago – as is done in the case studies – would help understand how fixed spaces of enclosure are re/deterritorialised in daily practices, and how people resist cultural imperialism through education. Another entry point for mapping, from a psychological perspective, is provided in the next chapter.

5. Negotiating Clinical Psychology in Diverse Societies: In Search of Multicultural Counselling Competencies[5]

Taking a psychological perspective, this chapter explores cultural negotiations in clinical psychology through the model of multicultural counselling competency (MCC). Examining MCC outside its original American context, in Singapore, Australia and the Netherlands, demonstrates that there is some overlap and difference in strategies for multicultural practice. This chapter argues that MCC may be useful in the critical study of cultural negotiation in clinical psychology.

After exploring a cultural anthropology perspective on the research issue in the previous Chapter 4, this final theoretical chapter explores relevant psychological literature. A psychological perspective on cultural sensitivity in clinical psychology training and practice provides insights into how the discipline conceptualises culture, and has dealt with cultural influences. Such perspectives are invaluable to this research, and provide another entry point through which cultural negotiations in clinical psychology are mapped.

Psychological literature recognises culture as an important influence on mental health. People's behaviour and identity, and manifestations of distress, are shaped by cultural beliefs, values and worldviews (Berry, 2002). In addition, cultural norms and sanctions for behaviour influence or reinforce certain conduct, which is the reason that

[5] An adaptation of this chapter has prepared for publication:
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behavioural norms arise from cultural consensus, and 'normal' and 'abnormal' behaviour are defined differently across cultures (Kleinman, 1986). This explains why specific manifestations of mental disorders in the DSM (American Psychiatric Association, 2000, 2013) are less or more prevalent in certain cultural groups (Thakker & Ward, 1998). Moreover, cultural contextualisation of abnormal behaviour and stigmatisation of mental health problems affect help-seeking behaviour; culturally non-western individuals are less likely to seek mental health care (Chen & Mak, 2008). As a result, diagnosis of mental health problems, the type of treatment received, and the treatment outcomes of people from non-western cultures may be affected (Hwang et al., 2008).

This picture leads to a critical questioning of the adequacy of the cultural 'one-size-fits-all' model in clinical psychology. Critique largely focuses on the prioritisation of 'western' perspectives, topics and practices in psychology. Most psychological research is conducted by American and European researchers and with homogenous Caucasian, educated and economically secure research participants (Arnett, 2008; Henrich et al., 2010; Matsumoto, 2001). Consequently, clinical psychology's knowledge is considered less relevant and less applicable in non-western cultures, or to people from non-western minority cultural groups (Fernando, 2003; Gerstein, 2009; Sue & Sue, 2008; Thakker & Ward, 1998). In response to these concerns, the fourth and fifth editions of the DSM have included cultural components, such as an appendix of culture-bound syndromes and guidelines for conducting a cultural interview (American Psychiatric Association, 2000, 2013). However, contemporary literature continues to draw the same conclusion as researchers in the 1970s – clinical psychology fails to adequately address cultural diversity (e.g. Atkinson, Morten, & Sue, 1979;

Samuda, 1975), suggesting there is a long road ahead for cultural diversity in clinical psychology.

The only known psychological theory to address cultural negotiation in clinical psychology practice was developed in the United States. This is the model of multicultural counselling competency (MCC), which was developed within the context of growing awareness for the role of clinical psychology in racial inequality, and aimed at assisting psychologists in cross-cultural practice (Sue et al., 1982). In contrast, psychologies focusing on concerns specific to populations and cultural groups have developed in Asia in parallel. These psychologies, termed "indigenous psychologies", generally do not inform clinical psychology training and practice cross-culturally (Allwood & Berry, 2006). Thus, to date, MCC is the only known theoretical model that addresses culturally sensitive practice of 'western' clinical psychology. Therefore, this chapter investigates this model in detail, and explores the use of MCC for the study of cultural negotiation in this thesis.

Multicultural Counselling Competency

The first model of MCC, published in 1982, specifies that MCC is comprised of *awareness*, *knowledge* and *skills* (Sue et al., 1982). Multicultural awareness refers to practitioners' consciousness of cultural differences, their own biases, the effects of their own beliefs and values on clients, and circumstances for culturally appropriate services. Multicultural knowledge refers to familiarity with clinical psychology, cultural groups, socio-political structures of inequality and institutional barriers to mental health care. Multicultural skills refers to the ability to communicate adequately and appropriately with a variety of cultural groups, and to exercise adequate interventions on behalf of culturally diverse clients (Sue et al., 1982). MCC was expanded in 1992 to emphasise

the importance of counsellor awareness of culture as an overarching construct (Sue et al., 1992), and, in 2001, with dimensions of social justice and characteristics of ethnic groups in the United States (Sue, 2001). Other authors added multicultural relationship (Sodowsky, Taffe, Gutkin, & Wise, 1994) and multicultural encounters (Campinha-Bacote, 1994) to the model. However, the original 1982 MCC model remains most influential.

American research indicated several factors associated with psychologists' MCC, including satisfaction with multicultural workshops (Allison, Crawford, Echemendia, LaVome, & Knepp, 1994; D'Andrea, Daniels, & Heck, 1991; Tummala–Narra, Singer, Li, Esposito, & Ash, 2012), and cross-cultural professional experience (Hansen et al., 2006; Sehgal et al., 2011). In addition, psychologists who identified as cultural minorities reported higher levels of MCC (Pope-Davis et al., 1995). Thus factors such as identification as a cultural minority, receiving quality cultural training and professional cross-cultural experiences may contribute to psychologists' MCC.

Research suggests that MCC may help American psychologists to provide adequate services for their diverse clientele. MCC has a demonstrated positive impact on client outcomes in the United States (Worthington, Soth-McNett, & Moreno, 2007). American evidence also demonstrates that MCC enhanced cultural knowledge and self-awareness of practitioners (Sammons & Speight, 2008), enhanced cultural empathy (Burkard & Knox, 2004; Chao, Wei, Good, & Flores, 2011), and decreased racial prejudice (Castillo, Brossart, Reyes, Conoley, & Phoummarath, 2007; Chao et al., 2011). No negative results of MCC have been identified. As a result of these findings, MCC is increasingly integrated in guidelines for practice and in professional psychology training programs (APA, 2003; Ridley & Kleiner, 2003). However, to date,

MCC's relevance in non-American contexts has yet to be studied empirically in the Malay Archipelago.

MCC may be limited to the American cultural situation. The majority of MCC research is produced by American researchers, and participants in such research were mainly female psychologists of Euro-American descent (Worthington et al., 2007). Consequently, the applicability of the MCC model may be reduced to working with American minority clients from the perspective of majority-culture Americans. As a result, Euro-American psychology students are more likely to benefit from MCC training than their peers from cultural minority groups (Chao et al., 2011); MCC may be less relevant to helping cross-cultural practice among practitioners who are not from a mainstream 'white' American culture. This indicates that, for MCC to be relevant to cultural groups outside the United States, MCC research needs to expand its research base.

MCC Applied Cross-Culturally

A possible pathway for exploring the cultural relevance of MCC in non-American contexts is through an analysis of literature on MCC in different countries with diverse cultures, such as countries in the Malay Archipelago. This chapter explores MCC in the case study countries under investigation in this thesis: the Netherlands, Australia, and Singapore. A focus on these countries provides a broad cultural scope through which MCC can be analysed, and sheds light on the use of MCC in this thesis as a model for studying cultural negotiations in clinical psychology.

A surprisingly limited amount of literature has been published relating to MCC in the Netherlands, Australia and Singapore. With two exceptions (Boedjarath, 2011; Van Mens-Verhulst, 2003), literature related to cultural competency and practice has

defined culture narrowly in terms of origins or ethnicity (e.g. Chinese, Indigenous or migrants) instead of defining culture broadly including influences of ethnicity, race, religion, gender, sexuality, and social class. Therefore, the theoretical explorations of MCC outlined below focus solely on cross-cultural practice and therapists' competency in working with different ethnic groups. Each section describes the cultural composition of the country under investigation and the available literature on MCC.

The Netherlands

The Netherlands is a culturally diverse country located in western Europe. The multicultural composition of the country is traditionally described as a binary with about 80% of the population being native Caucasian Dutch (*autochtonen*) and 20% being people with a migratory background or with a parent with such a background (*allochtonen*; Centraal Bureau voor de Statistiek, 2014). Migrants in the Netherlands are of diverse origin, including people with an Indonesian heritage who arrived in the Netherlands before and after Dutch colonialism; migrants from Surinam and the (former) Netherlands Antilles; multiple generations of Turkish and Moroccan people who came to work in the Netherlands in the 1960s and 70s; Eastern Europeans who migrated via the open borders in the European Union; and refugees from various parts of the world (Centraal Bureau voor de Statistiek & Sociaal Cultureel Planbureau, 2013).

In the 1960s Dutch psychology practitioners realised that they worked almost exclusively in a Caucasian Dutch environment and with similar clients, which led to attempts to broaden the reach of the profession (Bekker & van Mens-Verhulst, 2008; Knipscheer, Drogendijk, & Mooren, 2011; Van Dijk, 2008). One result was the opening of a chain of mental health care institutions between 2006 and 2010 that focused on providing cross-cultural services (i-Psy, n.d.). In addition, an emerging body of

literature focused on therapist characteristics called *interculturele competentie,* intercultural competency (Bekker & van Mens-Verhulst, 2008), reflecting a growing interest in multicultural practice. However, despite attention to cultural issues in clinical psychology, little research has been conducted on MCC.

Only one study has piloted MCC in the Netherlands. This research developed a training focused on 'intercultural competency' in line with Sue et al.'s (1992) MCC model (Kramer & Sbiti, 2007). The authors identified three focal points for training and practice related to therapists' knowledge, skills, and attitude towards reflection on their own background, the client's background, and culturally appropriate interventions (Kramer, 2004; Kramer & Sbiti, 2007). In addition, the authors identified therapist's curiosity towards the client's meanings and their relation to therapy as an overarching construct that facilitated intercultural competency (Kramer & Sbiti, 2007). The training in intercultural competencies was reported to be positively appreciated by psychology professionals and trainees, although no outcome measures were used to assess cultural competency. These findings suggest that MCC (Sue et al., 1992) might inform cross-cultural practice in the Netherlands. However, more research is required to validate the model in Dutch settings.

Australia

Australia is a very culturally diverse country with an Indigenous population and a long migration history. Australia is home to Aboriginal and Torres Strait Islander peoples, while nearly half of Australia's population was born overseas or had at least one overseas-born parent (Australian Bureau of Statistics, 2012b). The first migrants who settled in Australia from 1788 onwards were of European background, primarily of British ancestry. More recently, the population has diversified with migrants and former refugees from, among others, parts of Europe, Asia, the Pacific, Middle-East and Africa

(Australian Government, 2012). In the aftermath of the country's colonial past, Australia is currently in reconciliation with its Indigenous peoples in an attempt to enhance cultural harmony. This means, among other things, that issues faced by Indigenous Australians are prioritised in policy and research. As a consequence of the reconciliation framework and the country's culturally and linguistically diverse population, it is important for Australian psychologists to be competent in addressing the needs of their multicultural clientele.

Given this multicultural context, it is surprising that little research has been conducted on cultural competency of psychologists in Australia. A 2007 survey revealed that Australian psychologists felt only 'moderately comfortable' with counselling Aboriginal clients, Torres Strait Islander clients, or clients from migratory and non-English speaking backgrounds (Pelling, 2007). To date, only one study has explored MCC in an Australian context. That study used an instrument designed to assess Australian mental health professionals' perceived competence in practicing with migrants new to Australia (Khawaja, Gomezi, & Turner, 2009). The three scales of the instrument (Multicultural Awareness, Knowledge and Skills) are similar to the knowledge, skills and awareness components of Sue et al.'s (1982) tripartite model. The study showed that clinical experience and supervision focusing on multicultural issues was related to clinical psychology students' perceived cultural awareness, but not the other scales (Lee & Khawaja, 2012). However, the instruments' focus on migrants new to Australia excludes practice with Indigenous Australians, which is disconcerting in the context of reconciliation.

The near absence of MCC literature in Australia cannot be explained from a general lack of attention to culture in psychology; cross-cultural research and practice have received increasing attention in this multicultural country. Chapter 3 described the

emphasis on multicultural practices in guidelines issued by professional organisations and accreditation bodies. In addition, research and policies on adequate psychological practice with Indigenous Australians are considered important contributors to reconciliation and social justice in Australia (Dudgeon & Pickett, 2000; Ranzijn, McConnochie, Day, Nolan, & Wharton, 2008; Sanson et al., 1998). Thus, despite attention to cultural issues in clinical psychology, Australian research has focused mainly on topics other than MCC.

Nevertheless, research into cross-cultural practice has resulted in a few practical recommendations that are related to MCC. Psychologists in cross-cultural practice with Indigenous Australians are advised to take time to engage with the community, to be flexible in choosing the meeting places and times, to adjust their approach to therapy, and to openly discuss their limitations in working cross-culturally (McConnochie, Ranzijn, Hodgson, Nolan, & Samson, 2012; Vicary & Andrews, 2000). The latter strategy of discussing possible barriers to effective therapy with Indigenous Australians relies on multicultural awareness as outlined by Sue et al. (1992): in order to be able to discuss barriers to therapy, therapists need to be aware of their own cultures, clients' cultures and culturally appropriate interventions. The literature on best practices in multicultural settings further indicates that psychologists reportedly rely on their experience when practicing cross-culturally, rather than on formal education (McConnochie et al., 2012), suggesting that acquired multicultural skills may be important for effective practice. Thus MCC, despite receiving little attention in research, may still inform cultural negotiations in clinical psychology practice in Australia, as MCC may be behind the best practices outlined in the literature.

Singapore

Singapore is a culturally diverse city-state located in the Malay Archipelago. Fifty years ago, in 1965, Singapore split off from the Malaysian Federation, eight years after Malaya gained independence from British colonial rule. A long history of migration into Singapore has yielded a mixed population of about 74% Chinese, 13% Malays, 9% Indians and 3% of people with other ethnicities including Eurasians and Caucasians (Department of Statistics, 2015). The Singaporean government now promotes a multiracial society based on meritocracy (Moore, 2000). Singapore thus celebrates its cultural diversity, and as a result of the combination of multilingualism, multi-religiosity and multiculturalism, Singaporeans consider themselves a diverse people. For clinical psychologists in Singapore, cross-cultural practice is considered an everyday encounter (Tan, 2002b). Consequently, it is of central importance to universities in Singapore to prepare future practitioners of clinical psychology for multicultural practice through the development of cultural sensitivity.

Empirical research on MCC has yet to be conducted Singapore; to date most literature on culture and psychology has revolved around the issues of practicing western psychology in a society that identifies as "essentially Asian" (Yeo, 1993, p. 29). The literature suggests that social and behavioural norms in Singapore are different from 'western' norms promoted in clinical psychology – for example, individuality – and consequently, conventional, 'western' oriented therapeutic practice is considered to be less effective in the Singaporean context (Ow & Osman, 2003; Tan, 2002b). Clinical psychologists in Singapore thus have to adjust their practice to an Asian multicultural context (Tan & Goh, 2002), but yet amid these stated concerns MCC has not been identified as a possible pathway.

Qualitative research shows that to adjust their practice to suit culturally different clients, Singaporean therapists rely on personal characteristics such as: being non-judgmental, empathic and respectful; on cultivating ongoing professional growth; on a flexible approach to practice; and on their own experience. These strategies overlap considerably with those used by American therapists in their cross-cultural practice (Jennings et al., 2008). Both Singaporean and American therapists emphasise the centrality of good therapeutic relationships and empowerment through the therapeutic alliance in cross-cultural practice – drawing on experience, professional development, humility and self-awareness to inform multicultural practice (Jennings et al., 2008). The importance of experience was also stated by Australian psychologists (McConnochie et al., 2012). Furthermore, the centrality of self-awareness and humility highlights the importance of therapist awareness, while the other strategies may indicate a gradual acquisition of multicultural knowledge and skills. Such possible connections between the reported qualitative themes and the three domains of MCC indicates the potential usefulness of research into MCC in Singapore.

On 'Culture' in MCC

Concerns about cross-cultural psychology practice have arisen in each of the countries investigated in this chapter. In the United States, the Netherlands, Australia, and Singapore, psychological literature expresses an awareness of the multicultural character of modern societies combined with a realisation that psychologists may play a part in promoting social justice and equality. In this regard, cross-cultural practice is considered to be part of clinical psychologists' ethical obligations; psychologists can do their part in reducing racism and discrimination. Under conditions of globalisation and increasing migration, psychologists need to be prepared to practice with an increasingly

diverse clientele. The question of how psychologists culturally negotiate clinical psychology is thus very important as it can inform cultural sensitivity training.

Overall, the research considered in this chapter suggests that MCC may have to be adjusted to the specific cultural contexts of the Netherlands, Australia or Singapore, in order to provide insights into cultural negotiations in clinical psychology. The specific societal, political and cultural contexts of psychology differ among the countries studied in this paper, as do the proposed strategies for practice and research priorities. MCC was developed in the specific context of racial inequality in the United States; the model is tailored to help 'white' American psychologists work with ethnic minority clients. Dutch ideas of 'intercultural competency' seem to parallel the MCC model but may be specific to help psychologists bridge the institutionalised binary between native Dutch and migratory Dutch. In Australia, reconciliation provides a priority national framework through which issues for Indigenous Australians in psychology are studied. MCC has not been part of this important framework; instead, a body of literature describing best practices with Indigenous Australian clients has developed. Finally, in Singapore, a long history of incorporating foreign knowledge in clinical psychology has given rise to concerns related to practicing western-based psychology with Asian clients. Despite established racial differentiation in Singapore, guidelines on best practices in cross-cultural therapy have yet to be established.

This literature review reveals there are some similarities across these diverse countries in best practices for cross-cultural therapies. In the Netherlands, the implementation of multicultural training, consistent with Sue et al.'s (1992) model of MCC, has shown positive results (Kramer & Sbiti, 2007). In Australia, a specific instrument was developed that mirrors Sue et al.'s (1982) tripartite model, to assess competency in working with new migrants in the country (Khawaja et al., 2009), but

not with Indigenous Australians. In Singapore, therapists' self-reported best practices for cross-cultural clinical psychology overlapped with those reported by therapists in the United States (Jennings et al., 2008), indicating a similarity in how psychologists in different countries approach the notion of cultural diversity. Thus, although cultural competency has been considered in the literature from each country, MCC has not been specifically adopted as a model. How cultural negotiations of clinical psychology in cross-cultural practice relate to each other, and whether these can be summarised as a universal MCC model, remain questions for further research.

Conclusion

MCC may provide insight into how people culturally negotiate the one-size-fits-all model in clinical psychology, but possibly requires modification in each case study under investigation. Thus, there are two ways in which MCC may inform a critical mapping of cultural negotiation in this thesis. Firstly, the tripartite model of multicultural awareness, knowledge and skills could indicate ways (awareness, knowledge and skills) in which transnational knowledge in clinical psychology is culturally negotiated during training and practice. In this thesis this will be analysed through interviews. Secondly, MCC provides a framework for testing the cross-cultural applicability of transnational knowledge in psychology. Therefore, this thesis uses a survey measuring MCC constructs in the case study countries of the Netherlands, Australia and Singapore. The findings of the MCC survey can then be compared with American research. For example, MCC in the American context is associated with cross-cultural practice experience, satisfaction with cultural training and identification as a cultural minority. Therefore, the following three Chapters 6 – 8 utilise the model of

MCC as an entry point to critically investigate cultural negotiation in the country case studies of the Netherlands, Australia, Singapore.

6. Negotiating Clinical Psychology in the Netherlands: A Case Study Using Multicultural Counselling Competency[6]

This chapter is the first of three country case studies of multicultural clinical psychology training and practice using a survey of multicultural counselling competency (MCC) and open-ended interviews. It maps cultural negotiations in clinical psychology training and practice in the Netherlands through statistical analysis of MCC hypotheses in line with American research, and interpretative phenomenological analysis (IPA) of interviews.

This case study of the Netherlands is the first of a series of three country case studies to use MCC to assess the universality of clinical psychology knowledge, and to highlight pathways for cultural negotiation in clinical psychology. The tripartite model of MCC states that clinical psychologists need to develop multicultural awareness, knowledge and skills for cross-cultural practice (Sue et al., 1982). Only one previous study of MCC has been conducted in the Netherlands, which revealed that training focused on MCC was positively appreciated by psychologists (Kramer & Sbiti, 2007). This suggests that the American-developed MCC model could potentially inform how practitioners in the Netherlands culturally negotiate clinical psychology; however, this has yet to be empirically studied (see Chapter 5). Therefore, this chapter outlines the

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results of a survey of MCC, as well as a qualitative investigation of cultural negotiation of clinical psychology the Netherlands.

In this chapter multicultural clinical psychology training and practice is explored at university master's level, the first professional clinical psychology training experience of future practitioners in the Netherlands. Upon graduation, master's level clinical psychologists can work as therapists under supervision of an experienced clinical psychologist (*GZ psycholoog*). Two additional years of education and supervised practice at a tertiary institution are required to work independently. However, such post-master training places are highly restricted, and many psychologists remain practicing at master's level, thus master's is frequently the highest level of training acquired and the last opportunity to prepare for multicultural practice.

Data were collected from two universities, one located in the urbanised west of the country, and the other in a less densely populated eastern area. Both universities provide a one-year program in clinical psychology, with a very similar curriculum. In addition, both universities are embedded in the Dutch multicultural society, which is characterised by Caucasian Dutch and various groups of migratory Dutch with cultural heritages from, among other regions, Indonesia, Morocco, Turkey, Suriname, the (former) Dutch Antilles and Eastern Europe (see Chapter 5).

To evaluate the applicability of MCC in this context, it is hypothesised that satisfaction with cultural training (Allison et al., 1994; D'Andrea et al., 1991; Tummala–Narra et al., 2012), professional practice experience (Hansen et al., 2006; Sehgal et al., 2011), and identification as a cultural minority (Pope-Davis et al., 1995), will be associated with MCC. Cultural aspects of clinical psychology training and practice in the two Dutch universities is further assessed by supplementing the quantitative MCC data with more exploratory interview data. Analysis of the interviews

allows evaluation of the usefulness of the tripartite model of awareness, knowledge and skills in culturally negotiating clinical psychology knowledge in multicultural training and practice in the Netherlands.

The research focuses on two questions. Firstly: how transferable is MCC to the context of clinical psychology training and practice in the Netherlands? It was hypothesised that, after controlling for the effects of social desirability (Constantine & Ladany, 2000), satisfaction with cultural training, cross-cultural practice experience, and identification as a cultural minority, would be associated with students', academics' and alumni's multicultural counselling competency (Study 1a). The second question asks how students, academic staff and alumni of clinical psychology in universities in the Netherlands culturally negotiate clinical psychology during training and practice. This qualitative question is explored using interview data (Study 1b).

Study 1a: Survey

Method

Participants. In total 132 participants responded to the survey, however 26 participants responded to less than half of the questions and were excluded from the analysis, bringing the sample size to 106. The final sample consisted of 22 students of clinical psychology master's programs (age: $M = 25.09$, $SD = 3.77$), 10 academics currently teaching into these programs (age: $M = 43.00$, $SD = 10.71$), and 74 alumni of these programs (age: $M = 33.49$, $SD = 12.23$). Seventy participants were affiliated with University A and thirty-seven participants with University B. Demographic information of survey participants is detailed in Table 8.

Table 8. *Survey Participant Characteristics in the Netherlands (n = 106)*

	Students (*n* = 22)		Academics (*n* = 10)		Alumni (*n* = 74)	
	Freq.	%	Freq.	%	Freq.	%
Gender						
Male	2	9.1	4	40	13	17.6
Female	20	90.9	6	60	61	82.4
Nationality						
Dutch	16	72.7	10	100	62	82.2
Double*	0	0	0	0	1	.9
Other	6	27.3	0	0	12	16.8
Identification						
Caucasian Dutch**	15	68.2	10	100	60	80
Other Dutch***	0	0	0	0	4	5.3
Asian	3	13.6	0	0	3	5.6
Other	4	18.2	0	0	8	10.7
Cross-cultural experience						
Yes	3	13.6	0	0	14	18.7
No	19	86.4	10	0	61	81.3

Note. Identification = cultural identification.
* Double nationality which includes the Dutch nationality;
** Caucasian Dutch are participants who identified as *autochtoon;*
*** Other Dutch including participants with a Netherlands Antilles identification.

Instruments. The survey included a demographic questionnaire, an assessment of satisfaction with cultural training, and an assessment of MCC. Importantly, research indicates that social desirability is considered as a possible covariate of self-reported MCC (Constantine & Ladany, 2000), so an assessment of social desirability was also included in the survey. To assess readability and clarity, the survey was piloted among two graduates and one student of a clinical psychology program at an Australian university, and revisions took place based on the received feedback. To allow participants in the three countries under investigation to fill in the same survey, the questionnaire was in English. No language difficulties were expected as clinical psychology training in the Netherlands is also partly conducted in English.

Demographics questionnaire. A demographic questionnaire was constructed in line with previous studies on MCC (e.g. Lee & Khawaja, 2012; Pope-Davis et al.,

1995) and included age, gender, university affiliation and role, cultural background and cultural training or work experiences. Minority identification was constructed based on the self-reported cultural backgrounds; people who identified as Caucasian Dutch were categorised as a cultural majority.

Satisfaction with cultural training. Four statements on satisfaction with cultural training within clinical psychology training were included in the questionnaire based on a review of the study by Tummala-Narra et al. (2012). Participants were requested to respond on a 7-point Likert scale ranging from *strongly disagree* to *strongly agree,* to statements such as "*Awareness, knowledge and clinical skills required for clinical psychology practice in multicultural Netherlands are adequately addressed in my clinical psychology program*." The sum of the item scores provided the measure of satisfaction with multicultural training, with higher scores indicating greater satisfaction.

Multicultural Awareness Knowledge and Skills Survey (MAKSS). The MAKSS (D'Andrea et al., 1991) consists of 60 questions or statements that could be answered on a 4-point Likert-scale, ranging from *very limited* or *strongly disagree* to *very good* or *strongly agree*. The MAKSS has three subscales reflecting Sue et al.'s (1982) tripartite model: Multicultural Awareness (items 1 – 20, e.g. "*At this point in your life, how would you rate your understanding of the impact of the way you think and act when interacting with persons of different cultural backgrounds?*"), Multicultural Knowledge (items 21 – 40, e.g. "*What do you think of the following statement?: the difficulty with the concept of "integration" is its implicit bias in favor of the dominant culture*.") and Multicultural Skills (items 41 – 60, e.g. "*In general, how would you rate your skill level in terms of being able to provide appropriate counselling services to culturally different clients?*").

The MAKSS has been successfully used in MCC research and has good psychometric properties, with Cronbach alpha's of .75, .90 and .96 for Multicultural Awareness, Knowledge, and Skills respectively (D'Andrea et al., 1991). Low inter-correlations between the subscales (D'Andrea et al., 1991) and confirmatory factor analysis (Guy-Walls, 2007) have shown independence of the three constructs of the MAKSS. Finally, a Wilcoxon matched pairs test for comparison of pre- and post-test results confirmed internal consistency and construct validity (Ponterotto, Rieger, Barrett, & Sparks, 1994).

A few modifications were made to adapt the MAKSS for use in the Netherlands. Explicit reference to the United States in items 35, 37 and 38 were replaced with references to the Netherlands, and reference to "Europe and Canada" were replaced by other countries investigated in this research: Australia, Singapore, Malaysia and Indonesia. Additional adaptations were made for cross-cultural application of the MAKSS in all three case study countries. The term "white" was removed from the phrase "white mainstream clients" and the terms "gay men" and "gay women" were replaced with the phrases "men who are sexually attracted to men" and "women who are sexually attracted to women" respectively.

Marlowe-Crowne Social Desirability Scale Short Form (MCSDS-SF). A 13-item short form of the MCSDS-SF (Reynolds, 1982) was used to assess the influence of social desirability on participants' responses. The MCSDS-SF contains 13 short statements (e.g. *"I'm always willing to admit it when I make a mistake"*) with a *true* or *false* forced-choice response format. The MCSDS-SF has a Kuder-Richardson-20 reliability of .76 and a correlation of .93 with the full MCSDS, and is recommended as a viable short form for measuring social desirability in response tendencies (Reynolds, 1982).

Procedure. Institutional Human Research Ethics Committee approval was obtained prior to data collection. Colleagues at the participating universities sent an email to students, academic staff teaching into the clinical psychology program, and alumni of the clinical psychology master's programs with details of the study.[7] Invitation emails were standardised and included a link to the online questionnaire hosted on Qualtrics survey software. The first item in the online survey requested informed consent, which was required to start the questionnaire. Data were exported into IBM SPSS for analysis.

Statistical analysis. The data analysis plan was prepared for all three country case studies. After data screening and assumptions testing, correlational analyses were conducted to screen for possible collinearity between the MAKSS scales. Correlations tested for covariates to include in hypothesis testing, such as social desirability and age. Two MANOVAs were conducted with group (students, academics, alumni) and university as independent variables respectively, and the three MAKSS subscales as dependent variables, to test for covariates of group and university to include in hypothesis testing.

A correlation analysis was conducted to test the hypothesis that satisfaction with cultural training was associated with MCC. To test the hypotheses that multicultural experience and minority identification were associated with MCC, two one-way between-subjects MANOVAs were conducted with the independent variables of

[7] As a separate list of clinical psychology alumni was unavailable for one university, alumni of all programs, university-wide, were emailed the survey. The email stated that the survey was for alumni of clinical psychology only, and a question to check whether participants were alumni of clinical psychology and not other degrees was added to the survey. The survey automatically ended when participants identified as alumni from programs other than clinical psychology master's programs.

multicultural experience and minority identification and the MAKSS scales as dependent variables, with social desirability and age as covariates.

Results

Data screening. Maximum likelihood estimation was used to manage occasional missing values in the MAKSS and MCSDS-SF of 27 participants. This method uses all available data to identify the parameter values that have the highest probability of producing the sample data. It is preferred over single imputation methods because it requires less stringent assumptions and provides a relatively unbiased solution to missing data without removing cases (Baraldi & Enders, 2010). Missing demographic data were not imputed.

The MAKSS and MCSDS-SF scores were normally distributed. The MAKSS Awareness and Skills scales and the MCSDS-SF had equal variances for the two universities, $F(1, 105) = .05$, $p = .829$; $F(1, 105) = 1.77$, $p = .187$; $F(1, 105) = .30$, $p = .586$, respectively, however, the MAKSS Skills scale had significant greater variability for university A, $F(1, 105) = 4.63$, $p = .034$. The MAKSS Awareness, Knowledge and Skills scales and the MCSDS-SF had equal variances for the groups of students, academics and alumni, $F(2, 104) = .28$, $p = .756$; $F(2, 104) = .65$, $p = .524$; $F(2, 104) = .16$, $p = .854$; $F(2, 104) = .59$, $p = .558$, respectively.

The reliability of the subscales of the MAKSS and the MCSDS-SF, using Cronbach's *alpha,* was acceptable for Knowledge (.74) and social desirability (.72), good for Skill (.88), but was poor for Awareness (.52) – consistent with previous reports for MAKSS Awareness (D'Andrea et al., 1991).

Preliminary MCC results. Correlations of age, satisfaction with cultural training, the MAKSS subscales and MCSDS-SF are detailed in Table 9, while means and standard deviations of the MAKSS subscales by group are listed in Table 10.

Table 9 shows that the MAKSS subscales were significantly inter-correlated: Awareness and Knowledge, $r = .31$, $p = .001$; Awareness and Skills, $r = .27$, $p = .004$; Skills and Knowledge, $r = .87$, $p < .001$. This suggests the MAKSS subscales each measured a related but distinct aspect of the MCC model. The correlation between Skills and Knowledge was quite high at $r = .87$, however, literature suggests that highly inter-correlated dependent variables can be included in MANOVA without a significant loss of power (Cole, Maxwell, Arvey, & Salas, 1994). Therefore, all three scales of the MAKSS were included in the analysis.

Social desirability significantly correlated with Skills, $r = .38$, $p < .001$, and age significantly correlated with Awareness, $r = .20$, $p = .035$, but not with Knowledge or Skills (see Table 9). Therefore social desirability and age were used as covariates in further analyses of the MAKSS.

Effects of age were further explored in relation to group (students, academics, alumni). A one-way ANOVA with between-subjects independent variables of group (students, academics, alumni) and age as dependent variable indicated significant differences between groups, $F(2, 104) = 9.99$, $p < .001$. A significant Levene's test ($p < .001$) indicated that variances of groups of students, academics and alumni were not equal, necessitating the use of Tamhane's *T2* to adjust for unequal variances. Although results should be interpreted with caution due to unequal variances, post-hoc tests suggested that all three groups differed significantly: Academics were significantly older ($M = 43.00$, $SD = 10.71$) than students ($M = 25.09$, $SD = 3.77$, $p < .001$) and alumni ($M = 33.49$, $SD = 12.230$, $p = .030$), and alumni were significantly older than students ($p = .006$). Therefore, age was also entered as a covariate in further analysis of the MAKSS subscales, next to social desirability.

Table 9. *Correlations between the Study Variables (n = 106)*

	Age	Satisfaction	Awareness	Knowledge	Skills
Satisfaction	-.15	–			
Awareness	.20*	-.09	–		
Knowledge	.18	.03	.31**	–	
Skills	.05	.03	.27**	.59**	–
MCSDS-SF	.06	-.01	-.04	.15	.38**

Note. Satisfaction = Satisfaction with cultural elements in clinical psychology training; Awareness = MAKSSS Awareness scale; Knowledge = MAKSS Knowledge scale; Skills = MAKSS Skills scale; MCSDS-SF = Social desirability on MCSD-SF. * $p < .05$ (2 tailed); ** $p < .001$ (2 tailed)

Table 10 shows variability in means for the MCC subscales for groups of students, academics and alumni. A one-way MANOVA with the between-groups independent variable of group (students, academics, alumni) and the MAKSS subscales (Awareness, Knowledge, Skills) as dependent variables was conducted to assess group differences in MCC. This analysis also used Pillai's Trace, and showed a significant Box's *M* test, $p = .022$. No significant differences between groups of students, academics and alumni on MAKSS subscales were detected, $F(6, 206) = 1.78$, $p = .105$, so groups of students, academics and alumni were combined in further analyses.

Table 10. *Means and Standard Deviations for Variables (n = 106)*

	Students (*n* = 22)		Academics (*n* = 10)		Alumni (*n* = 74)	
	M	*SD*	*M*	*SD*	*M*	*SD*
MAKSS Awareness	2.53	.22	2.58	.16	2.62	.20
MAKSS Knowledge	2.44	.26	2.36	.31	2.57	.28
MAKSS Skills	2.58	.34	2.40	.30	2.70	.36
MCSDS Social Desirability	.46	.20	.56	.25	.52	.24

Note: MAKSS scales score range: 1 – 4; MCSDS score range: 0 – 1.

A one-way MANOVA with the between-groups independent variable of respondents' university and the MAKSS subscales (Awareness, Knowledge, Skills) as dependent variables was conducted to assess university differences in MCC. A significant Box's *M* test ($p = .038$) indicated unequal variances of the dependent

variables across universities, and supported the use of Pillai's Trace. There were no significant differences between universities in MAKSS subscales, $F(3, 103) = 2.20$, $p = .092$, so the data of two universities were combined in further analyses.

Hypothesis testing. To test the hypothesis that satisfaction with cultural training was associated with MCC, a correlational analysis was conducted. Associations of satisfaction with cultural training with each of the MAKSS scales (Awareness, Knowledge, Skills) were not significant (all ps > .05; see Table 9).

To test the two hypotheses that multicultural experience and minority identification were associated with MCC, a one-way between-subjects MANOVA was conducted with the independent variables of multicultural experience and minority identification and the MAKSS scales (Awareness, Knowledge, Skills) as dependent variables, with social desirability and age as covariates. A non-significant Box's M test ($p = .297$) indicated equal variance-covariance matrixes of the dependent variables across groups of students, academics and alumni. This suggested that while controlling for the effects of social desirability and age, cross-cultural experience had a significant main effect on the MAKSS subscales, $F(3, 99) = 3.52$, $p = .018$, while a non-significant trend was suggested for minority identification, $F(3, 99) = 2.59$, $p = .057$. Univariate ANOVAs detected a significant main effect of cross-cultural experience on MAKSS Knowledge, $F(1, 101) = 4.00$, $p = .048$, and on Skills, $F(1, 102) = 9.66$, $p = .048$, but not on Awareness, $F(1, 101) = .00$, $p = .986$. No interaction effects were identified, $F(3, 99) = 1.26$, $p = .291$.

Discussion

It was hypothesised that satisfaction with cultural elements in training (Allison et al., 1994; Tummala–Narra et al., 2012), cross-cultural experience (Hansen et al., 2006; Sehgal et al., 2011) and identification as a minority (Pope-Davis et al., 1995)

would be associated with MCC. However only cross-cultural experience had a significant effect on two dimensions of MCC: knowledge and skills. The importance of cross-cultural experience is consistent with previous findings from Hansen et al.'s (2006) exploratory study, in which practicing psychologists reported that cross-cultural experiences were most valuable in their development of cultural competency. The present findings extend the work of Hansen et al. (2006), using a standardised measure of MCC, and reveal that professional cross-cultural engagement is more important for (future) psychologists' acquired MCC than formal cultural training. They suggest that psychologists rely on their cross-cultural experiences in culturally negotiating clinical psychology knowledge.

Study 1a aimed to assess the transferability of MCC to the Dutch context. While professional cross-cultural experiences benefit multicultural knowledge and skills, no main effect of cross-cultural experiences on multicultural awareness was detected, and no effects of satisfaction with cultural training and minority identification were detected. This suggests that overall the MAKSS may be insufficient to assess cultural competency in the Dutch context. The MAKSS reflects the cultural context of the United States in which it was originally developed, and thus may be less applicable in the Netherlands. The Netherlands is not a 'settler country' like the United States, and while both countries have a mixed population of a 'white' majority with different minority groups, it cannot necessarily be assumed that Dutch and American cultural groups have similar experiences, or that Dutch and American clinical psychologists have equivalent perceptions and experiences of multi-cultural practice.

Due to a different cultural context, psychologists in the Netherlands are likely to have different experiences than American practitioners. MAKSS responses revealed that 41% of participants disagreed with the statement that minority experiences in the

Netherlands are similar to experiences of minorities in Australia and Singapore, suggesting that Dutch respondents regard their multicultural situation as unique. In view of this, the high amount of missing data may also reflect a mismatch of the MAKSS questions and MCC model with the experiences of the Dutch participants. As this was the first known study to use the MAKSS in a Dutch context, the relevance and reliability of this American instrument has yet to be established in the Netherlands. The findings in the present research suggest that the MAKSS does not adequately sample experiences of multicultural practice in the Netherlands.

However the suggestion that the null results are due to a poor cultural fit of the MAKSS is tentative, as the absence of significant effects on MCC may also be related to methodological differences of the present study compared to previous research. For example, Allison et al. (1994) and Tummala-Narra et al. (2012) previously used self-constructed questionnaires to measure how useful different experiences were for practitioners' MCC development. Furthermore, Allison et al. (1994) did not specifically define MCC in their measure, while Tummala-Narra et al. (2012) used other MCC scales than the MAKSS (Gamst, Dana, & Der-Karabetian, 2004). In addition, the participants of the present study included students, academics and alumni of clinical psychology, while Allison et al. (1994) and Tummala-Narra et al. (2012) sampled practitioners only. Further research could help clarify the effect of these variations in samples, definitions and rating scales of MCC.

To conclude Study 1a, the findings reveal that cross-cultural practice experiences are more important than formal cultural training; cross-cultural experience was associated with higher levels of multicultural knowledge and skills. These findings suggest that psychologists rely on their cross-cultural experiences in culturally negotiating clinical psychology knowledge. Other hypotheses of effects of cross-

cultural experience on multicultural awareness, and of minority identification and satisfaction with cultural training on MCC, were not confirmed. This is likely due to differences in the cultural context of training and practice of clinical psychology, thereby raising questions about the relevance of the MAKSS in the Netherlands, and the cross-cultural transferability of MCC.

In order to ascertain whether MCC informs cultural negotiations in clinical psychology, the following Study 1b was designed using qualitative interviews with students, academics and alumni of clinical psychology programs. The interviews explored how cross-cultural clinical psychology training and practice was subjectively experienced in the Netherlands, and assessed whether multicultural awareness, knowledge and skills are used for cultural negotiation in clinical psychology.

Study 1b: Interviews

Method

Participants. Fourteen people were interviewed, including 5 students (age: M = 26.4, age range: 25 – 34 years), 5 academics (age M = 50, age range: 31 – 66 years, one academic did not report age), and 4 alumni of clinical psychology programs in two universities in the Netherlands (age: M = 45, age range: 27 – 58 years). Eight participants were affiliated with University A and six with University B. A further eight participants identified as Caucasian Dutch, three as non-majority Dutch and another three as non-Dutch. Eight were female and six were male. Additional demographic information collected is not reported in order to maintain confidentiality.

Procedure. The majority of the participants were recruited for the interviews via the Study 1 survey (n = 13). That questionnaire ended with an invitation for an

interview and the option to leave contact details. Eighteen people left their contact details and were contacted by the MPhil candidate, of which thirteen were participated in the interview. One further participant was recruited through snowball sampling.

All semi-structured interviews were conducted face-to-face at the participants' universities or workplaces, or in public places nominated by the participant. All interviews were conducted by the MPhil candidate and interviewing time averaged 30 minutes (range: 20 – 45 minutes). Written informed consent was obtained before the interviews started (see Appendix II). Interviews were audio-taped and were transcribed verbatim with NVivo qualitative data analysis software.

An interview outline of open-ended questions (see Appendix III) was designed to invite participants to describe and reflect upon their experiences of studying (e.g. *"How much consideration for cultural issues is included in your training program?"*), teaching (e.g. *"How do you think that students can best be prepared for multicultural practice?"*), or practicing clinical psychology (e.g. *"Can you tell me about a multicultural clinical practice situation you encountered?"*). The outline was piloted with one clinical psychologist in Singapore not otherwise involved in the study, and minor modifications were made. The outline was used in a flexible manner and interviewees were invited to introduce topics or ideas related to the research.

Qualitative analysis used an interpretative phenomenological analysis (IPA) framework to gain insights into the lived experiences of events from the perspective of the participant (Larkin, Watts, & Clifton, 2006; Smith et al., 2009). This approach allowed for discovery of new themes and constructs, as opposed to the confirmatory approach used in Study 1a. To ensure validity of the analysis and transparency about the interpretative role of the researcher, one analysis was participant-audited while another was independently audited by an experienced IPA researcher. Although there

are no clear criteria to establish transparency of IPA, both auditors considered the interpretations sufficiently similar to their own interpretations and highly plausible, it was thus decided that no further auditing was required.

After data familiarisation, descriptive, linguistic and conceptual comments on the transcripts were noted. Based on these comments, themes were constructed that focused on the participant's experiences. These themes were organised into groups based on similarity in meaning, with each group representing a superordinate theme, thereby generating a list of superordinate themes for each of the 14 transcripts.

To form three homogenous samples for IPA, student, academic and alumni interviews were then analysed in three separate groups. Group analyses focused on identifying patterns and constructing master themes that summarised the experiences of each group (students, academics, alumni). Superordinate themes were included in master themes if they were present in half of the interviews or more (Smith et al., 2009).

Results

IPA analysis generated 4 master themes for students, 4 for academics, and 3 for alumni, which are listed in Table 11. These themes map both cultural delineations and negotiations (see Chapter 4), that are taking place in clinical psychology training and practice in the Netherlands.

Table 12 shows theme identification per interview. There was significant overlap in the master themes between the student (S1 – S5), academic (T1 – T5, for Teacher) and alumni (G1 – G4, for Graduate) interviews. Therefore, the following section discusses the master themes for students, academics and alumni together. The description of each superordinate theme is illustrated with a de-identified quote from a

participant (italicised). Brackets are used to identify material that was omitted, added or changed in the participant's quotes for clarification and confidentiality.

Table 11. *Master and Superordinate Themes per Participant Group*

Master themes	Superordinate themes		
	Students (*n* = 5)	Academics (*n* =5)	Alumni (*n* = 4)
1. Culture of clinical psychology	a. Practicing western knowledge (5) b. Negotiating cultural values (4) c. Enhancing responsivity towards society (4)	a. Limited utility of scientific evidence (4) b. Enhancing responsivity towards society (4)	a. Practicing western knowledge (4) b. Struggling with ethnocentrism (3) c. Limitations of clinical training (3) d. Enhancing responsivity towards society (4)
2. Cultural influences on clinical psychology training	a. Restricted liberty amidst regulations & requirements (4) b. Managing diversity in the classroom (5)	a. Restricted liberty amidst regulation & requirements (5) b. Managing diversity in the classroom (5) c. Bearing responsibility (4)	
3. Practicing cross-culturally	a. Communicating cross-culturally (4) b. Tapping onto minority experiences (4)	a. Communicating cross-culturally (4) b. Person-centred practice (4)	a. Communicating cross-culturally (3) b. Tapping onto minority experiences (3) c. Person-centred practice (3) d. Building an empathic relationship (3)
4. Learning cultural competency	a. Importance of awareness training (5) b. Importance of cultural knowledge (4) c. Learning through experiential activities (5)	a. Importance of awareness training (5) b. Learning through experiential activities (5) c. Learning through personal involvement (4)	a. Importance of cultural knowledge (3) b. Learning through experiential activities (4) c. Learning through personal involvement (4)

Note. Number of interviews for each theme is noted in parentheses.

Table 12. *Distribution and Overlap of Superordinate Themes per Participant Group*

	Students					Academics					Alumni			
	S1	S2	S3	S4	S5	T1	T2	T3	T4	T5	G1	G2	G3	G4
Shared themes*														
1a Western knowledge	X	X	X	X	X			X			X	X	X	X
1c Responsivity society	X	X	X	X			X	X	X	X	X	X	X	X
2a Regulation	X	X	X	X		X	X	X	X	X				
2b. Managing diversity	X	X	X	X	X	X	X	X	X	X				
3a Communicating	X	X	X	X			X	X	X	X		X	X	X
3b Minority experiences	X	X	X	X							X	X	X	
3c. Person-centred			X			X	X		X	X		X	X	X
4a Awareness training	X	X	X	X	X	X		X	X	X	X		X	X
4b Cultural knowledge	X	X		X	X		X	X	X	X				
4c Experiential activities	X	X	X	X	X	X		X	X	X	X	X	X	X
4d Personal involvement						X	X		X	X	X	X	X	X
Student themes														
1b Cultural values		X	X	X	X	X			X			X		
Academic themes														
1a Scientific evidence						X	X		X	X				
2c Responsibility							X	X	X	X				
Alumni themes														
1b Ethnocentrism											X	X	X	
1c Limitations training	X		X					X			X	X	X	X
1d Diversification				X					X	X	X	X	X	X
3d Empathic relationship	X											X	X	X

Note. An X indicates that the particular theme was present in that interview

* Shared themes were present in at least half of the interviews in two or three participant groups

Culture of clinical psychology. All participants experienced clinical psychology knowledge and practice as influenced by the cultures in which it developed and in which it is practiced. These cultural influences were experienced differently by participant groups.

Practicing western knowledge. Students and alumni felt that by practicing clinical psychology they were practicing a discipline based on western ideas:

Well there's a lot of effort to bridge the gap between ethnic cultures and as we call it: "our western view of complaints and disease." But still the main root of psychology is western-orientated.

Students and alumni considered that assumptions related to American behaviourism, psycho-analysis, Cartesian mind-body dualism, and male-dominated science have resulted in a bias in clinical psychology knowledge towards people who have received western education, who live in individualistic societies and who handle their emotions in specific ways. Clinical psychology, in other words, was perceived as western-biased.

Struggling with ethnocentrism. Alumni experienced clinical psychology as powerful in defining norms that are deemed to be universally applicable, and in prescribing how clinical psychology should be practiced either within one's culture or multiculturally. Thus, clinical psychology was experienced as ethnocentric, which was at times difficult for participants who did not identify as of a culturally western mainstream:

I'm just going to be me. And also because I'm multicultural I'm not like: 'it's that there, that-that, we don't do that! It's always like that!' [as clinical psychology prescribes]. We think some of them are like this, but there are others like this too […] and we are more open to everything.

Limited utility of scientific evidence. Academics considered scientific evidence as a source of bias in clinical psychology knowledge. Scientific knowledge neglects cultural and personal variation, and was therefore not always useful to inform clinical psychology practice:

If you truly treat patients, broad numbers and studies mean nothing. They are just a framework for you to treat the individual. But it is always about

the individual and it's not about […] the big groups, because they tell you nothing about the individual.

Participant groups experienced cultural influences differently. Alumni mainly experienced limitations of their western-oriented clinical psychology education in their multicultural practice, while students wondered how they should negotiate implicit western cultural values in psychotherapies in their future multicultural practice.

Limitations of clinical training. Alumni recalled their clinical psychology training as uniform, as based on western majority culture, as propagating a western outlook on the psyche and the individual, and as teaching them a direct style of interaction. Due to these biases some alumni experienced their clinical psychology training limited as a preparation for multicultural practice:

I think I became very aware of the differentiation between an I-oriented culture and a we-oriented culture when I first started working with [clients with an Asian background]. And I felt like I was walking on eggs because my whole training and outlook didn't match the outlook or the way people from [Southeast Asia] were oriented towards their world.

Negotiating cultural values. Students were predicting that in multicultural practice they would struggle with the implicit western values underlying psychotherapies, creating biases towards individualist, atheist, rationalist cultures:

I think it's a point of view on personal growth and that sort of things, but I'm not sure if in Asian cultures that's such an important thing to be your best self and get everything out of you that you are able [to]. And I think that in therapy that's really for us really important.

Students feared that their training in western therapeutic methods would affect their ability to practice cross-culturally with clients who would hold different values.

Therefore, students, and also academics and alumni, wished to increase clinical psychology's responsivity towards Dutch multicultural society.

Enhancing responsivity towards society. All participant groups recognised diversity in clinical psychology training across countries, such as different emphases in research, therapies, and training requirements. These differences suggested the possibility of broadening clinical psychology training to better cater for the needs of the changing multicultural society:

> *Not particularly within the field of clinical psychology but within other fields I think there is more interest and more work done and more educational opportunities looking at culture and to find out your own culture as well.*

Examples of such 'other fields' were: multidisciplinary perspectives, cultural psychologies, religious approaches, and new methods for therapy.

Cultural influences on clinical psychology training. In addition to cultural influences on the discipline, students and academics identified cultural impacts on clinical psychology training. These influences reveal the important context of clinical psychology education in the Netherlands.

Restricted liberty amidst regulations and requirements. Academics experienced restricted freedom in designing or adjusting the program due to the large influence of entry requirements to post-master clinical psychology education:

> *To put it bluntly, our program is more or less dictated by the post-master training programs. They have entry requirements and we, yeah, we have to make sure that our students when they graduate fulfil those entry requirements and that dictates to certain extend the kind of courses we give them.*

A result of having to fulfil the many entry requirements in one-year training programs is an experience of time scarcity. According to academics and students, time pressure in clinical psychology training restricted the attention to cultural training:

> *The master is very short and a lot of attention goes to the thesis and internship. I think that's also a good thing but I think there isn't really room for much anymore additions […] Even the courses on how you can treat someone* within *our culture are minimal.*

Managing cultural diversity in the classroom. Another cultural influence on clinical psychology training was cultural diversity in the classroom, which according to academics, has increased over the past years.

Academics considered diversity of the student population a resource: "*I hope that there is intermingling between the international students and the Dutch students. And I hope that, that way students can learn about cultural differences."* Likewise, cultural diversity among academics may provide different perspectives in clinical psychology that could aid students' development of cultural awareness.

However, other academics worried about their ability to meet the needs of their culturally diverse student population. The next theme was especially pertinent to academics who regarded cultural diversity as a challenge.

Bearing responsibility. Academics felt responsible for addressing cultural diversity in the classroom, and for addressing cultural issues in clinical training in general. They rationalised that cultural training is not a structural part of the curriculum, therefore they would have to provide it to students themselves. Some academics felt they needed more training, or supervision, to carry this burden:

> *I think we really need a course for teachers to prepare them for teaching international students. Talk a lot more about cultural issues, give a lot of*

examples so that the teachers don't have to figure this out for themselves. Because that will be to the disadvantage of the students.

The next master theme reveals participants' ideas of how psychologists can culturally negotiate clinical psychology during training and practice.

Practicing cross-culturally. Participants identified several strategies for cultural negotiation in clinical psychology practice.

Communicating cross-culturally. Being able to effectively communicate cross-culturally was identified by all three participant groups as an important skill for multicultural practice and in multicultural supervision or teaching. Communication skills included adjusting to different cultural norms and styles of communication, identifying communication and translation difficulties, recognising different means of communication, and ensuring mutual understanding:

The way of communicating, the way of asking questions, the reason to ask questions. Yes hierarchy, very important. Some styles in the English phrases you use. Sometimes an email from an [international] student can come across as impolite even though they don't mean to be impolite. Just because they translated their own language into English and it didn't come out right.

Tapping onto minority experiences. Students and alumni expressed the idea that practitioners with a culturally different background – or those who experienced being a minority elsewhere – may have an advantage in multicultural practice in two ways; by cultural matching, and by tapping on their minority experiences as a basis for shared understanding with cultural minority clients:

We will talk in our native language and I know their cultural background, and maybe they will also think: "This psychologist will understand me better than the Dutch psychologist […]. They are also a foreigner here and

I'm also foreigner." So there may be an issue about adaptation, or things that I can relate to as well, I think.

In addition, international students benefitted from having teachers with a cultural minority background to provide them support.

Person-centred practice. Academics and alumni regarded person-centred practice as culturally sensitive practice. Person-centred practice included trying to understand the background, the social situations, experiences and expressions of individuality, and to adjust the therapeutic approach to these unique circumstances. For these practitioners, theories about culture may have formed stereotypes that hindered their understanding of clients:

Actually I tried [culturally sensitive practice] once with a woman [with a Southeast Asian background], but I really hated it. I thought well it's a more collective culture and there my framework interfered. It really interfered with me adjusting to the framework of my patient. So it was just over-simplifying in your head […]. And after that [I decided to] look at the social situation, look at her context and then [our] contact, and that really helped.

Building an empathic relationship. Next to concentrating on clients' experiences, academics also focused on building a relationship of trust with culturally different clients. As practitioners, these academics displayed more empathy and care for clients' emotional needs to make them feel understood and respected:

[Cross-cultural practice] experience has taught us a great deal of sensitivity in care and taking things more slowly and taking more time to establish a personal relationship, building trust and explaining much more of what is implicit in our approach.

Learning cultural competency. Participants identified two training needs and two strategies for achieving those training needs.

Importance of awareness training. Students and academics identified a need for awareness training, especially for culturally mainstream students. Three awareness foci were identified. Firstly, awareness of cultural difference and cultures of clients: *"What I see is the problem with the students, because the students didn't [sic] really know how important [the cultural] background is for the client."* Secondly, awareness of one's own cultural background and biases: "*I think knowledge is important, but knowing your own framework is even more important. So how do* you *look at a culture?"* Thirdly, awareness of the biases of clinical psychology: "*I'm very heavily trained in one view, and while I believe it's a good view, I'm not naive enough to believe it's the* only *view."*

Importance of cultural knowledge. In addition, students and alumni identified a need for cultural knowledge training. Basic information about the countries, cultures, religions and belief system of their culturally different clients may help practitioners to better understand and connect with them: "*You have to know about their culture and religion in order for you to understand what their depression in this case means to them and how it, how it expresses itself."*

Two strategies for cultural learning were identified: learning through experience and through personal involvement and dedication.

Learning through experiential activities. All participant groups regarded experiential activities as important for cultural competency training. Two types of experiential activities were identified: cross-cultural professional practice and more personal, social experiences. The latter included travelling and engaging with people

from a different cultural background on a personal level. Experiential activities helped create cultural awareness on a personal level:

> *What I believe is that if you experience yourself that your basic assumptions are not* the *assumptions, then that experience may be worth it. But to read in a book that you might be doing this somewhere technically, I doubt that it will make you [more culturally competent].*

Learning through personal involvement. Academics and alumni emphasised the personal dedication required for cultural competency learning. They remembered how tough and frustrating it was to develop an awareness of their own cultural biases, and their struggle in adjusting to culturally different clients: *"It's been quite a learning process! It wasn't easy. We felt that everything we'd normally do didn't work!"* Next to dedication and perseverance, academics and alumni felt that students with personal characteristics such as being open-minded and being emotionally mature were more likely to develop cultural competency. One academic even argued that personal characteristics alone determined one's cultural competency:

> *There will always be people even after ten years of training they won't understand it anyway. So yes, you may – I think I could defend the statement that you can't get training in multicultural things. You either understand it or you don't understand it.*

Discussion

Study 1b assessed how students, academics and alumni of clinical psychology programs negotiate clinical psychology training and practice through the model of MCC. The results of the interview analysis revealed themes that were partly consistent with the tripartite structure of MCC (Sue et al., 1982). Participants' definitions of cultural awareness overlapped with Sue et al.'s (1982) multicultural awareness concept.

Like multicultural awareness, the themes *importance of awareness training* and *tapping onto minority experiences* described competencies such as being attentive and receptive towards the client's and one's own cultural backgrounds, and towards circumstances for referral to a culturally matching practitioner. Furthermore, basic information on different cultural heritages, religions and beliefs systems, and knowledge on the cultural history of clinical psychology overlapped with Sue et al.'s (1982) cultural knowledge. Finally, Sue et al.'s (1982) multicultural skills of communicating appropriately and accurately verbally and non-verbally and delivering adequate intervention skills were summarised in this study as *communicating cross-culturally* and *person-centred practice*. These findings suggest that, to a certain extent, MCC informs cultural negotiation of clinical psychology in the Netherlands.

The analysis revealed further elements of cultural negotiation that may be specific for the context of the Netherlands. An additional aspect related to multicultural awareness was identified: an awareness of the cultural biases of clinical psychology. Participants also introduced another aspect of multicultural skills: appropriately showing empathy and sympathy in practice, and building solid therapeutic relationships based on trust. This aspect to multicultural skills resembles the dimension of multicultural counselling relationship described by Sodowsky et al. (1994) as practitioners' openness and warmth toward clients. These specific cultural negotiations were not included in Sue et al.'s (1982) MCC, which shows that the model is insufficient to inform multicultural practice in the Netherlands.

The analysis reveals how the clinical psychology knowledge territory was culturally perceived in the Netherlands. Participants experienced clinical psychology's knowledge and practices as valuable but of limited use in multicultural practice due to their reliance upon research and values related to homogenous, individualistic, western

societies. The generic nature of scientific knowledge was also considered unhelpful in multicultural practice. These concerns could be summarised as critiques of ethnocentrism in clinical psychology. Such concerns have previously been voiced quite widely (Arnett, 2008; Bekker & van Mens-Verhulst, 2008; Berry, 2002; Henrich et al., 2010; Knipscheer et al., 2011; Matsumoto, 2001; Sue & Sue, 2008; Van Dijk, 2008), and the interview data suggest these concerns and the related need for cultural negotiation are currently very pertinent to the practice of clinical psychology in the Netherlands.

However, despite concerns about ethnocentrism, participants' cultural negotiations in clinical psychology are restricted. Clinical psychology' responsivity to the changing Dutch multicultural society is restricted by regulation of clinical psychology master's programs. The predetermined program delineates the knowledge territory of clinical psychology, but neglects cultural topics. Cultural issues could not be addressed due to time-pressure. Thus, the rigidity of the regulation of clinical psychology training into short one-year programs limits the cultural negotiations in clinical psychology.

The restriction of cultural negotiations in clinical psychology training evokes a particular response from academics. They feel personally responsible for preparing their students for multicultural practice. While the efforts of academics are laudable, it is problematic that students' cultural competency learning depends upon their individual teacher's determination to address cultural issues. In addition, academics with already high workloads felt burdened with this responsibility. They expressed the need for extra training and support in preparing students for multicultural practice and in teaching and supervising cross-culturally. The analysis of the interviews suggests it

is beneficial to structurally address cultural issues in clinical psychology training, to ease the workload of academics, and to ensure students' learning.

The analysis of the interviews confirmed the main finding in Study 1a; that cross-cultural experiences are important for cultural competency. Interview participants identified cross-cultural interactions and experiences during multicultural practice, in cross-cultural social relationships, or during travel abroad as important pathways for learning to culturally negotiate clinical psychology. Furthermore, interview participants recalled that the process of learning how to negotiate clinical psychology required a great deal of personal investment and dedication. It is therefore important that universities create an environment that facilitates multicultural encounters and social relations so that students and academics are enabled to explore multicultural, multi-linguistic and multi-religious topics to improve their cultural sensitivity.

Concluding Study 1b, these interviews provided insights into how students, academics and alumni of clinical psychology experienced cultural negotiation in clinical psychology. A limitation must be acknowledged, in that the interviews were possibly not fully representative of the population of students, academics and alumni of clinical psychology due to the possibility of self-selection bias: those with strongest opinions may be more likely to volunteer to be interviewed. However, together, the participants adequately represented different age groups, genders, and included both Caucasian Dutch, minority Dutch and foreigners.

Conclusion

This chapter described the first study of cultural negotiation in clinical psychology training and practice in the Netherlands utilising the theory of MCC. Using mixed methods, the survey assessed the applicability of existing knowledge on MCC in

the Dutch context, while the interviews invited new understandings on cultural negotiations taking place during cross-cultural training and practice. Students, academics and alumni of clinical psychology identified cultural competencies that partly correspond to Sue et al.'s (1982) tripartite MCC model of awareness, knowledge and skills. However MCC requires modification and extension in order to inform cultural negotiation of clinical psychology in the Netherlands. For example, perceived western ethnocentrism and unresponsiveness of clinical psychology towards multiculturalism were important considerations that were not detected by the MAKSS but which indicate where MCC may require modification.

7. Negotiating Clinical Psychology in Australia: A Case Study Using Multicultural Counselling Competency[8]

This second case study of cultural negotiation in clinical psychology investigates training and practice in Australia. Surveys and interviews among students, academics and alumni of clinical psychology programs in two universities in Queensland demonstrate that clinical psychology is considered culturally western and ethnocentric, and requires cultural adjustment. Cultural negotiations in clinical psychology are prioritised in the context of reconciliation.

This second case study follows the format introduced in the previous chapter, in using MCC to assess the universality of clinical psychology knowledge, and to highlight pathways for cultural negotiation in clinical psychology. The tripartite model of MCC states that clinical psychologists need to develop multicultural awareness, knowledge and skills for cross-cultural practice (Sue et al., 1982). Only one study of MCC has previously been conducted in Australia, which revealed that clinical experience and supervision focused on multicultural issues relates to clinical psychology students' perceived cultural awareness (Lee & Khawaja, 2012). The research conducted for this thesis is the first known to use the MAKSS (D'Andrea et al., 1991), and qualitative interviews regarding cultural negotiations in clinical psychology

[8] An adaptation of this chapter has been prepared for publication:
Geerlings, L.R.C., Thompson, C.L., Bouma, R., Hawkins, R. (ready for submission). Preparing for multicultural practice: An exploratory study of multicultural counselling competency in two Queensland universities, Australia. *Anticipated submission to the Australian Psychologist.*

training and practice among students, academics and alumni of clinical psychology programs in Australia.

Data were collected in two universities that both provide two-year masters and three-year doctoral programs in clinical psychology. Both universities are located in Queensland, a northern Australian state which is home to large populations of Aboriginal and Torres Strait Islander peoples (Australian Bureau of Statistics, 2012a), multiple migrant groups with ancestry from the United Kingdom, Europe, Asia, the Pacific, Middle-East and Africa, and former refugees from various parts of the world (Australian Government, 2012). To evaluate the applicability of MCC in this context, a survey of MCC was utilised to test hypotheses in line with American research. It was hypothesised that satisfaction with cultural training (Allison et al., 1994; D'Andrea et al., 1991; Tummala–Narra et al., 2012), professional practice experience (Hansen et al., 2006; Sehgal et al., 2011), and identification as a cultural minority (Pope-Davis et al., 1995) would be associated with MCC. Cultural aspects of clinical psychology training and practice in the two Australian universities was further assessed by supplementing the quantitative MCC data with more exploratory interview data.

The research focuses on two questions, identical to those presented in the previous Chapter 6. Firstly: how transferable is MCC to the context of clinical psychology training and practice in Australia? It was hypothesised that, after controlling for the effects of social desirability (Constantine & Ladany, 2000), satisfaction with cultural training, cross-cultural practice experience, and identification as a cultural minority would be associated with students', academics' and alumni's multicultural counselling competency (Study 2a). The second question asks how students, academic staff and alumni of clinical psychology in Queensland universities

culturally negotiate clinical psychology during training and practice. This qualitative question is explored using interview data (Study 2b).

Study 2a: Survey

Method

Participants. Of 40 respondents, 31 participants completed the survey and are included in this study, including 19 students of professional clinical psychology master's or doctoral programs (age: $M = 31.89$, $SD = 12.06$), 7 academics currently teaching into these programs (age: $M = 53.00$, $SD = 7.35$), and 5 alumni of these programs (age: $M = 34.00$, $SD = 7.81$). Twenty-one participants were affiliated with University A and eight participants with University B. One academic and one alumnus did not report their university affiliation. Demographic information of survey participants is detailed in Table 13.

Table 13. *Survey Participant Characteristics in Australia (n = 31)*

	Students ($n = 19$)		Academics ($n = 7$)		Alumni ($n = 5$)	
	Freq.	%	Freq.	%	Freq.	%
University ($n = 29$)						
A	15	78.9	3	50	3	75
B	4	21.2	3	50	1	25
Gender						
Male	5	26.3	3	42.9	1	20
Female	14	73.7	4	57.1	4	80
Nationality						
Australian	13	68.4	6	85.7	3	60
Double*	1	5.3	1	14.3	2	40
Other	5	26.5	0	0	0	0
Identification						
Indigenous	0	0	0	0	0	0
Caucasian	12	63.2	7	100	4	80
Asian	5	26.3	0	0	0	0
Other	2	10.5	0	0	1	20
Cross-cultural experience						
Yes	0	0	3	43.9	0	0
No	19	100	4	57.1	5	100

* Double nationality which includes the Australian nationality.

Instruments. The instruments used in this research were described in Chapter 6. They include a questionnaire regarding demographics in line with previous research (e.g. Lee & Khawaja, 2012; Pope-Davis et al., 1995), four statements on satisfaction with cultural training, the Multicultural Awareness Knowledge and Skills Survey (D'Andrea et al., 1991), and the Marlowe-Crowne Social Desirability Scale - Short Form (Reynolds, 1982). Psychometric properties of these instruments are detailed in the previous Chapter 6.

A few modifications were made to adapt the MAKSS for use in Australia. Explicit references to the United States in items 35, 37 and 38 were replaced with references to Australia, and reference to "Canada" was replaced by Singapore and Indonesia, countries neighbouring Australia and both included in this research. As in the Netherlands case study, the term "White" was removed from the phrase "White mainstream clients" and the terms "gay men" and "gay women" were replaced with the phrases "men who are sexually attracted to men" and "women who are sexually attracted to women" respectively.

Procedure. Data collection followed the procedure described in Chapter 6. Institutional Human Research Ethics Committee approval was obtained, the survey was piloted with one student and two graduates of a clinical psychology program at an Australian university not otherwise involved in the study, and minor revisions made. Institutional collaborators forwarded an email with details of the study to the students, academics and alumni of clinical psychology master's or doctoral programs, with a link to the questionnaire hosted on Qualtrics online survey software. Data were exported into IBM SPSS, and statistical analysis followed the steps of the previous chapter.

Results

Data screening. Maximum likelihood estimation was used to manage occasional missing data in the MAKSS and MCSDS-SF for 15 participants, as in Study 1a (see Chapter 6).

The MAKSS and MCSDS-SF scores were normally distributed. The MAKSS Awareness, Knowledge and Skills scales and the MCSDS-SF had equal variances for the two universities, $F(1, 27) = .36$, $p = .553$; $F(1, 27) = 1.38$, $p = .250$; $F(1, 27) = .61$, $p = .443$; $F(1, 27) = .35$, $p = .561$, respectively and equal variances for the groups of students, staff and alumni, for the MAKSS Awareness, Knowledge and Skills scales, $F(2, 28) = .77$, $p = .473$; $F(2, 28) = .40$, $p = .674$; $F(2, 28) = .40$, $p = .674$, respectively, and for the MCSDS-SF, $F(2, 28) = .80$, $p = .462$.

The Cronbach's *alpha* reliability of the subscales of the MAKSS and the MCSDS-SF was good for Skills (.89), acceptable for Knowledge (.77), questionable for Awareness (.65), and poor for the MCSDS-SF (.58), although considered adequate for the use as a covariate only.

Preliminary MCC results. Table 14 lists the results of a correlational analysis conducted to assess collinearity between the dependent variables, and the necessity to include covariates. The MAKSS scales were significantly inter-correlated: Awareness and Knowledge, $r = .75$, $p < .001$; Awareness and Skills, $r = .50$, $p = .004$; Skills and Knowledge, $r = .65$, $p < .001$, suggesting the MAKSS scales each measured a related aspect of the construct of MCC. All scales were included in further analysis.

Social desirability was not significantly related to the MAKSS scales, indicating that there was no need to covary social desirability in further analyses of the MAKSS. Only age significantly correlated with MAKSS Skills, $r = .38$, $p = .039$, and a non-significant trend was detected for Awareness, $r = .36$, $p = .050$, but not for Knowledge,

$r = .32$, $p = .081$. A one-way ANOVA showed significant differences in age between groups of students, academics and alumni, $F(2, 27) = 8.91$, $p = .001$. Thus, age was used as covariate in further analysis of the MAKSS.

Table 15 shows variability in means for the MAKSS scales for groups of students, academics and alumni. A one-way MANOVA with the between-groups independent variable of group (students, academics and alumni) and the MAKSS subscales (Awareness, Knowledge, Skills) as dependent variables was conducted to assess group differences in MAKSS scores. Box's M test was not significant ($p = .293$), indicating homogeneity in variance of the dependent variables for the groups of students, academics and alumni, and so Pillai's Trace test statistic was used. There were no significant differences in MAKSS scale scores for groups of students, academics and alumni, $F(6, 54) = 1.68$, $p = .144$, so data for groups were combined for further analysis.

A one-way MANOVA with the between-groups independent variable of respondents' university and the MAKSS subscales (Awareness, Knowledge, Skills) as dependent variables was conducted to assess university differences in MCC. A non-significant Box's M test ($p = .168$) indicated equal variance-covariance matrixes of the dependent variables across universities. Using Pillai's Trace, no significant differences were detected in any of the MAKSS subscale scores for universities, $F(3, 25) = .72$, $p = .547$, so the data for both universities were combined for the next analysis.

Table 14. *Correlations with Study Variables (n = 31)*

	Age	Satisfaction	Awareness	Knowledge	Skills
Satisfaction	-.39*	–			
Awareness	.36*	-.23	–		
Knowledge	.32	.02	.75**	–	
Skills	.38	-.16	.50**	.65**	–
MCSDS-SF	-.49**	.27	-.20	-.22	-.26

Note. Satisfaction = Satisfaction with cultural elements in clinical psychology training; Awareness = MAKSSS Awareness scale; Knowledge = MAKSS Knowledge scale; Skills = MAKSS Skills scale; MCSDS-S = Social desirability on MCSDS – Short Form. * $p < .05$ (2-tailed); ** $p < .001$(2-tailed)

Hypothesis testing. A correlational analysis conducted to test the hypothesis that satisfaction with cultural training was associated with MCC indicated that satisfaction with cultural training was not significantly related to the MAKSS scales (all *p*s > .05; see Table 14).

To test the two hypotheses that multicultural experience and minority identification were associated with MCC, a one-way between-subjects MANOVA was conducted with the independent variables of multicultural experience and minority identification and the MAKSS scales (Awareness, Knowledge, Skills) as dependent variables, with age as covariate. A non-significant Box's *M* test ($p = .210$) indicated equal variance-covariance matrixes of the dependent variables across groups, and Pillai's Trace was used. There were no significant effects on any of the scales of the MAKSS of identification as a cultural minority, $F(3, 24) = 2.14$, $p = .122$, or of cross-cultural experience, $F(3, 24) = 1.08$, $p = .376$. Finally, no significant interaction of minority identification and cross-cultural experience could be calculated due to an empty cell: there were no people with cross-cultural experience who also identified as a cultural minority. This counter-intuitive result may be related to the definitions of the variables of minority identification and cross-cultural experiences.

Table 15. *Means and Standard Deviations for Variables (n = 31)*

	Students (*n* = 19)		Academics (*n* = 7)		Alumni (*n* = 5)	
	M	*SD*	*M*	*SD*	*M*	*SD*
MAKSS Awareness	2.61	.19	2.74	.30	2.60	.27
MAKSS Knowledge	2.50	.28	2.67	.38	2.56	.31
MAKSS Skills	2.57	.34	2.85	.41	3.00	.31
MCSDS-SF Social Desirability	.53	.16	.37	.23	.42	.18

Note: MAKSS score range: 1 – 4; MCSDS-SF score range: 0 – 1.

Discussion

It was hypothesised that satisfaction with cultural training, cross-cultural experience and minority identification would be positively associated with MCC, however no such effects were found. One possible interpretation is that, as with the case in the Netherlands, the MAKSS is not a useful measure of MCC in the Australian context. The MAKSS was developed and validated in the United States and implicitly relies upon an American cultural situation (Worthington et al., 2007). It cannot necessarily be assumed that the experiences of Aboriginal and Torres Strait Islander peoples, and various migratory peoples with different ancestries and histories in Australia are similar to the cultural groups in the United States.

Results from Study 2a indicate that MCC may be less applicable in an Australian context than in its original American setting. Participants' responses on the adjusted item 37 of the MAKSS revealed that over 45 percent of the participants *strongly disagreed* or *disagreed* with the statement that experiences of minorities in Australia are similar to experiences of minorities in neighbouring countries such as Singapore. The perception that cultural experiences differ in Australia compared to other countries suggests that MCC may be not be fully cross-culturally transferable from the United States to Australia. A large proportion of the participants may have experienced the MAKSS questions – and MCC – as not applicable to Australia.

However, the suggestion that the null results are due to a poor cultural fit of the MAKSS is tentative, as clearly the absence of significant effects on MCC may be related to the small sample size (n = 31), and relatedly, to low observed power of the statistical analyses (range .010 – .477). Moreover, small cell sizes necessitated the collation of groups of people with diverse cultural identifications under the category 'minority'. It would be more nuanced to analyse effects of identification with each different group. Another possibility, which could be tested by future research, is that it is actually participants' perceptions of minority status that are important, rather than ethnicity.

As in Study 1a of the Netherlands, another explanation for the inconsistency of results with previous findings from the United States may be related to the incommensurability of different research methodologies (see Chapter 6). Again, further research could help evaluate the contribution of variations in samples, rating scales and definitions of MCC and associated factors to the inconsistency of the present findings and previous American research.

To conclude Study 2a, hypotheses of factors associated with MCC were not confirmed, likely due to differences in the cultural context between Australia and the United States. This raises questions about the relevance of the MAKSS in Australia, and the cross-cultural transferability of MCC. In order to address this concern, Study 2b uses qualitative interviews with students, academics and alumni of clinical psychology programs to explore how cross-cultural clinical psychology training and practice was subjectively experienced in Australia.

Study 2b: Interviews

Method

Participants. Twelve participants were interviewed, including eight students (age *M* = 26.3, range: 22 – 31 years) and four academics (age *M* = 50.3, range: 45 – 57 years). Nine participants were female, and three male. Seven participants identified as Caucasian Australian, while five people did not fit into this category. Further demographic information is not reported in order to maintain confidentiality.

Procedure. Participants were recruited for the interviews via the Study 2a survey (*n* = 6) and through snowball sampling (*n* = 6). All semi-structured interviews were conducted face-to-face on-site at the participating universities except for one telephone interview. All interviews were conducted by the MPhil candidate, and interviewing time averaged 30 minutes (range: 20 – 41 min). Interviews were audio-taped and transcribed verbatim with NVivo analysis software. The use of the interview outline was the same as outlined in the previous Chapter 6.

Interpretative phenomenological analysis was used to analyse the interviews, following the same method as described in Chapter 6. To ensure transparency regarding the interpretative role of the MPhil candidate, one analysis was independently audited and it was determined that no further auditing was required. The twelve interviews were divided into two groups (students, academics) to summarise experiences for each group. Superordinate themes were ranked under master themes if they were present in at least half of the interviews of that particular group (Smith et al., 2009). IPA generated four master themes for students which overlapped with four master themes for academics. The themes are listed in Table 16 and described in the results section below.

Table 16. *Master and Superordinate Themes per Participant Group*

Master themes	Superordinate themes	
	Students (*n* = 8)	Academics (*n* = 4)
1. Culture of clinical psychology	a. Focused on western culture (8) b. Mono-cultural (5) c. Formalised through accreditation (3)*	a. Focused on western culture (4) b. Formalised through accreditation (2)
2. Cultural influences on clinical practice	a. Extra factors in practice (8) b. Value impositions through clinical judgement (7)	a. Extra factors in practice (4) b. Value impositions through clinical judgement (3) c. Influence on connecting (3)
3. Strategies for cross-cultural practice	a. Adapting to the client (4) b. Talking about cultural differences (7) c. Taking more time (4) d. Applying cultural knowledge (6)	a. Adapting to the client (3) b. Being aware of one's biases (2) c. Unconditional positive regard (2)
4. Learning/teaching cultural competency	a. Learning through social interactions (7) b. Learning through awareness training (5) c. Learning through coursework (6) d. Learning by transforming (5) e. Taking responsibility for cultural competency learning (4)	a. Learning through social interaction (2) b. Learning through awareness training (2) c. Learning through coursework (3) d. Role-modelling through supervision (2)

Note. Number of interviews per theme is noted in parentheses.
*This theme did not meet the criteria for being present in at least half of the interviews of the group, but was included due to its significance to the research question.

Results

Table 17 shows significant overlap in the superordinate themes between the student and academic staff interviews. Therefore, superordinate themes were collated into shared master themes, which are discussed for students and academics together. Participant quotes are fully de-identified and brackets are used to identify material that was omitted, added or changed in the participant's quotes for clarification and confidentiality.

Table 17. D*istribution and Overlap of Superordinate Themes per Participant Group*

	Students								Academics			
	S1	S2	S3	S4	S5	S6	S7	S8	A1	A2	A3	A4
Shared themes*												
1a. Focused on western culture	X	X	X	X	X	X	X	X	X	X	X	X
1b. Formalised through accreditation		X	X				X		X	X		
2a. Extra factors in practice	X	X	X	X	X	X	X	X	X	X	X	X
2b. Value impositions… role	X	X	X		X	X	X	X	X	X		X
3a. Adapting to the client	X	X				X	X		X	X		X
4a. Learning ... social interactions	X	X	X	X	X	X		X		X	X	
4b. Learning ... awareness training	X	X	X	X	X					X	X	
4c. Learning through coursework	X		X		X	X	X	X	X	X		X
Student themes												
1c. Mono-cultural		X	X	X			X	X				
3b. Talking … cultural difference	X	X	X	X	X			X				X
3c. Taking more time	X		X	X		X						
3d. Applying cultural knowledge	X	X	X	X	X			X	X			
4d. Learning by transforming		X	X	X	X	X						
4e. Taking responsibility … learning				X	X	X		X				
Academic themes												
2c. Influences on connecting			X				X		X	X		X
3b. Being aware of one's biases			X						X		X	X
3c. Unconditional positive regard			X	X					X		X	X
4c. Role-modelling …. supervision					X				X		X	

* These themes were present in at least half of the interviews in both participant groups

As outlined below, the master themes and some of the superordinate themes partly overlapped with the themes identified in the interviews in the Netherlands.

Culture of clinical psychology. Similar to the participants in the Netherlands, students and academics in the Australian universities experienced the clinical psychology knowledge territory as culturally western. However, at the same time they regarded clinical psychology as a standardised, universal discipline.

Focused on western culture. All participants regarded clinical psychology knowledge and practices to be culturally western. This was mainly experienced during practice:

I suppose a lot of our concepts that we learn about and our techniques […] have a very western feel to it. And I suppose when you are training, you

don't really consider it. It is only when you actually go out and have more of a multicultural clientele or client-base, that you then realise, oh, how do I actually, you know, adjust my way of thinking or even my way of talking to people to fit with their, I guess.... just to be more culturally appropriate.

Participants rationalised that the western "feel" to clinical psychology may be related to clinical psychology's historical development in the west and its continued reliance on knowledge based on research and values from the west.

Mono-cultural. Because clinical psychology was considered mono-cultural, students expressed concern about how their western-oriented clinical psychology training would prepare them for multicultural practice. For example, when asked if the clinical psychology program was an adequate preparation for practice in Australia, one student responded:

I think for Australia yes. By and large maybe about 70 percent or 80 percent, 90 percent, depending on what's the population, I can't remember, are white people. I think by and large yes. But I guess working with minority groups and with the Aboriginal [peoples], probably not as much.

Students thus expressed a similar concern to Dutch academics' theme *limitations of clinical training.* These participants in the Netherlands and Australia feel responsible and concerned about their ability to meet the diverse mental health needs in their multicultural societies.

The first two themes show that clinical psychology was regarded as influenced by culture. However, the accreditation of clinical psychology degrees was another cultural influence – one that resulted in a perception of clinical psychology as formal and universal.

Formalised through accreditation. Unique to the case study of Australia, students and academics identified accreditation of professional psychology degrees by the Australian Psychological Accreditation Council (APAC) as an important aspect of clinical psychology. Accreditation, and the idea that programs are standardised, diverted participants' attention from scrutinising their curricula:

> *When you're doing [the program] you just assume that it is all standard, really. Yes, so I guess I didn't have and still don't have much knowledge on, you know, how subjects get chosen and what content gets into the program.*

The quote above indicates that accreditation was perceived as an assurance of the quality of clinical psychology programs, and a reliance upon accreditation could prevent critical examination of the curriculum.

Cultural influences on clinical practice. Participants of the two Australian university case studies largely focused on clinical practice in their interviews, as nearly all participants, including students, reported to have practical experience. In clinical psychology practice, participants considered culture to be an important factor that could complicate therapeutic relationships, clinical judgement, and practice in general. Academics expressed more confidence in practicing cross-culturally than students. Academics identified culture as *"just another difference",* while students expressed concerns regarding their competence in dealing with cultural issues.

Extra factors in practice. Both participant groups (students and academics) experienced cultural influences on clients' and practitioners' values and beliefs, on their ideas about psychology, and on their communication styles and behaviour. In multicultural practice, such influences were regarded as additional factors that a practitioner should work with:

I would be happy to work with people from another culture, [but] I'm more effective with someone from my own culture, yes, because it's easier as well. I believe it's easier […] because then you just don't have to address these other things that may come up.

Cultural differences between psychologists and clients could thus complicate practice. This shows the need for cultural negotiation in clinical psychology practice.

Influences on connecting. Academics and some students also experienced cultural influences on clients' openness and disclosure in practice. Thus, culture influenced how clients and practitioners understood each other and connected in the therapeutic relationship. This was also experienced during cross-cultural supervision:

[T]he [international] students' hypotheses of what's going on [with their Australian clients], they're having trouble sort of developing that. And in turn I'm also having trouble helping them with that. And I think it has been that, I don't know, I put it down to cultural differences. […] It just seems that a connection couldn't be made.

Value impositions through clinical judgements. Both groups experienced clinical judgements based on classification systems and theories of psychopathology as possible value judgements based on western culture. The value-laden nature of clinical psychology was also identified in the previous case study of students in the Netherlands (see Chapter 6), however, in the Australian context, participants mainly feared that narrow norms for behaviour and western-biased models for psychopathology could lead psychologists to make *"erroneous assumptions"* of psychopathology or to *"over-pathologise"*. Finding a balance between clinical categorisation and openness towards clients' experiences was reported as challenging:

Ah... yes that is a bit of a struggle, to kind of marry those two. I'm trying to be open towards other people's experiences, but having your own idea of what you think and what you think pathology is and what psychology is and how it works – that can be difficult sometimes.

Strategies for cross-cultural practice. Participants identified several strategies for cultural negotiation in clinical psychology. Some overlapped with the themes identified by the Dutch participants.

Adapting to the client. An adaptability of the psychologist's behaviour and communication styles, therapeutic approach, and application of clinical psychological models and procedures was considered an important strategy for multicultural practice:

I think I just used my own style really, and that is to be interested in the person, interested in their [personal] background. Ask when I was unsure, ask for their opinion or ask what their experience of something is. And even checking if I was being too direct, or asking something that was uncomfortable.

The type of adaptability of the therapist's therapeutic approach and communication style to the client was called *client-centred practice* in the Netherlands. In addition to client-centred practice, Australian students discussed cultural differences with their clients in order to gain cultural knowledge.

Talking about cultural differences. An important strategy for cross-cultural practice identified by students was to engage in a dialogue with the client about cultural differences:

You sort of have a bit of a feedback session and say, well maybe at the end of the session: "I just want to bring something up, that you are from, you know, such-and-such culture, and I need to say that I haven't had much experience in working with this culture and I really want to make sure if we are

a good fit for each other. So if there's anything I need to know about working with you, or if there's anything that I do that I am not aware of that would make you uncomfortable, it would be really good if you could just tell me because that is going to help me, you know, to make this a safe place and make me help you feel comfortable." So just sort of putting it out there, I suppose.

In such a cultural dialogue, it was assumed that clients would inform psychologists of their cultural backgrounds, ideas and preferences which would help to bridge cultural distance, and gain more insight and empathy for clients' perspectives.

Taking more time. Students felt that processes of understanding and working with cultural factors in clinical psychology practice were time-consuming and would press their training and practice schedules:

[E]specially to pass placements […] you can't just use your time as you wish to. If you think that "oh I might just need some more time to get to know this person" on a placement or in many clinics, I think you might get one chance with someone. So yes, I think you'd be quite time-pressured to come up with something from the model and send them home with some CBT or whatever model. And I think that may not fit so well with someone from another culture.

This sense of time pressure experienced by students in Australia was also identified in the case study of the Netherlands (*restricted liberty amidst regulations & requirements*; see Chapter 6). It can be associated with regulation of clinical training. Participants felt the need to take more time for adequate cross-cultural practice in order to establish a good working relationship. This theme thus also relates to the theme *building an empathic relationship,* which was identified in the interviews conducted in the Netherlands (see Chapter 6).

Applying cultural knowledge. Also similar to students in the Netherlands, students in Australia identified the need to be knowledgeable of cultural influences on values, beliefs, psychopathology and clinical psychology practice. Such knowledge would help psychologists to develop empathy for clients', to manage the expectations of the clients' behaviours, and to assist in clinical judgement. In these ways, cultural knowledge can thus help students culturally negotiate clinical psychology, which contributes to their perceived cultural competency:

> *I have felt like before I did those [cultural training] courses and [before I had] that knowledge, I don't think I was inappropriate in the way I worked with people, but […] I felt like making it up sort of thing. Like just doing what I thought, [what] felt to be the right thing. So yes, doing those courses gave me the actual knowledge that I needed to do it properly!*

Being aware of one's biases. Academics highlighted the importance of cultural self-awareness – being conscious of how one's own cultural background, values, beliefs, behaviour and expectations influence cross-cultural practice:

> *You need to know who you are first and you need to know your worldviews, how is it that you come to be who you are, before you can even begin to understand someone else. […] If you're not aware of what is driving your opinions, your decisions, your beliefs, your own views, how can you understand someone else's?*

An awareness of one's cultural biases was also identified as an important cultural competency in the case study of Netherlands (see Chapter 6).

Unconditional positive regard. Finally, academics and some students identified unconditional positive regard as a strategy for cultural negotiation in clinical

psychology. Positive regard included open-mindedness and interest in the client, paying attention to personal experiences, and displaying a genuine willingness to connect.

Unconditional positive regard was considered a universally applicable skill as it focuses on shared human values of connection: *"Essentially people are people. We all want connection."* Unconditional positive regard was thus not specific for cross-cultural practice, but shows how cultural negotiations in clinical psychology can be based on personal experiences – clinical psychology is culturally negotiated through establishing personal connections and relations.

Teaching and learning cultural competency. Students and academics in the case study of Australia identified the need for learning how to practice cross-culturally in professional clinical psychology training. Different strategies for learning how to culturally negotiate clinical psychology were identified: engagement, cultural awareness training, supervision and coursework. At a personal level, students recounted learning how to practice cross-culturally as a transformation.

Learning through social interactions. Similar to the participants in the Netherlands (see Chapter 6), students and academics also preferred to learn through experiential activities because *"you can learn only that much from a book."* Social interactions with clients, lecturers, supervisors, peers or colleagues, especially with those of different cultural backgrounds, were essential for learning how to practice cross-culturally. Likewise, cultural training workshops delivered by cultural minority facilitators were helpful:

> *And I think it was that personal experience [shared by the Indigenous workshop facilitator] that really made it for me, made me understand what they experience, whereas I don't think a Caucasian person can give me that. They can teach me all the skills and tell me: "so if they are not looking at you they*

are not being disrespectful, and blah, blah, blah" – but I think it means more and I get a better understanding of the culture and of the experiences of the person when it's coming from someone who is coming from that culture.

Learning through awareness training. Students and academics in Australia, similar to participants in the Netherlands, identified the need for training in awareness of the influence of one's own culture and their clients' cultures and of cultural influences of clinical psychology. Participants considered awareness training especially important for culturally mainstream students or practitioners:

But because *I am from a [cultural minority] background, I sort of have an appreciation of the importance of understanding culture, but I do worry about my peers, especially the white, you know, the white ones who have not much exposure to different types of culture.*

Learning through coursework. Students and academics both expressed the need to include cross-cultural training in the coursework curriculum of their training, with a specific focus on application in multicultural practice:

I think it is good to have a baseline sort of awareness towards culture and cultural issues and then you're kind of asking how that translates into skills and whether you're actually something different with clients, and that is something to discuss and to work into a bit more.

Role-modelling through supervision. Academics identified the importance of supervision for preparing students for cross-cultural practice. Supervision provided an opportunity to discuss difficulties on a more individual level, and academics felt they could role-model cultural awareness for their students: *"I don't know that I teach them in inverted commas. I never* teach *them anything. Through demonstration, it is through modelling, it is through living that."*

Learning by transforming. Students experienced learning to practice cross-culturally as a key professional and personal transformation. The personal dedication required for such profound learning experiences was also identified by academics and alumni in the Netherlands (see Chapter 6).

The transformation was overwhelming and anxiety-provoking for a few students: *"I feel a bit overwhelmed thinking about how much practice I am going to need to feel competent in working cross-culturally"*. However, learning to practice cross-culturally was also considered a positive transformation: "*I definitely appreciate it. It is a different way of viewing the world, it is helpful for me to see that there's [sic] different ways of viewing things!"*

Taking responsibility for cultural competency learning. Students emphasised the need to take responsibility for negotiating clinical psychology as part of an ethical obligation to reconciliation. These students sometimes strongly advocated cultural training, and sometimes engaged in extracurricular activities:

> *There are Australian Aboriginals and these are the main kind of focus group, like in terms of minorities, and that have got [to deal with] so many issues and such huge misunderstandings. So you've got the whole gap thing, and there's the Stolen Generation. So they completely ignore all that [in our training program], all those cultural aspects! I think that is ridiculous!*

While this theme partly overlaps with the theme *enhancing responsivity to society,* which was identified in the Netherlands, it should be understood in the specific socio-historical context of Australia.

Discussion

Study 2b assessed how students, academics and alumni of clinical psychology programs negotiate clinical psychology training and practice. The themes emerging

from the interview data partially reflect the constructs of Sue et al.'s (1982) tripartite model of MCC. For example, the themes *being aware of one's own biases* and *learning through awareness training* overlapped with the multicultural awareness concept, including awareness of cultural differences, and awareness of one's heritage and biases and their effects on clients. Only one participant identified Sue et al.'s (1982) dimension of awareness of sensitivity of circumstances for referral to a culturally matching practitioner. This may imply that (future) psychologists could benefit from learning about culturally appropriate services available in Australia.

Cultural knowledge on cultural heritages of people in Australia and cultural influences on clinical psychology was broached in the themes *applying cultural knowledge* and *learning through coursework*, and partly overlapped with the concept of multicultural knowledge. Dimensions of multicultural knowledge related to institutional barriers to mental health care and socio-political structures of inequality were identified by two participants, summarised as *taking responsibility for cultural competency learning*. Participants who were knowledgeable about inequality were more determined to develop their cultural competency, suggesting that training aimed towards improving students' knowledge of cultural discrimination may help motivate future practitioners to culturally negotiate clinical psychology.

Cultural skills identified by participants partly reflected Sue et al.'s (1982) multicultural skills. The theme *adapting to the client* covered all Sue et al.'s (1982) skills of communicating appropriately and accurately, understanding and selecting a variety of verbal and non-verbal responses, and delivering adequate intervention skills.

Group comparisons show that academics expressed more confidence in their competency in cross-cultural practice than students, perhaps a result of their greater level of experience (Hansen et al., 2006; Lee & Khawaja, 2012; Pope-Davis et al.,

1995; Sehgal et al., 2011). Academics and students both culturally negotiated clinical psychology in cross-cultural practice, but their strategies differed. Academics relied on universally applicable skills such as positive regard and cultural self-awareness, while students relied on cultural knowledge or on information provided by clients. Thus students focused on the cultural 'other' in their strategies for multicultural practice – knowing about clients – while academics focused on themselves: being mindful of one's biases and being open towards clients. This focus on professional skills rather than on cultural knowledge marks an important difference in the perception of cultural competency. It suggests that cultural negotiation in clinical psychology can be based on perspectives brought into practice by practitioners and clients.

Participants identified further dimensions of cultural competency which are not included in the MCC model. Awareness of the cultural ethnocentrism of clinical psychology was summarised as *value impositions through clinical judgement*. The conscious and appropriate use of *unconditional positive regard* and *talking about cultural differences* are newly identified skills that aid cultural negotiation. These cultural competencies are not assessed by the MAKSS and reflect the limited applicability of MCC in an Australian context. Clinical psychology knowledge requires ongoing cultural negotiations to be useful in these Australian universities.

Comparing these results to the case studies in the Netherlands (Studies 1a and 1b; see Chapter 6), shows overlap and difference cross-culturally. For example, in line with the results from the Netherlands and in accordance with contemporary literature (Arnett, 2008; Berry, 2002; Davidson, Sanson, & Gridley, 2000; Henrich et al., 2010; Matsumoto, 2001; Sue & Sue, 2008), the interviews show that clinical psychology is experienced as culturally western in Australia. Participants in both countries expressed

the need to learn how to negotiate clinical psychology knowledge and practices; this was done mainly through experiential activities and social interactions.

Strategies for cultural negotiation included knowledge, skills and awareness in both countries; however, the specific negotiations were different as they were based on the perceptions of the cultural context. To illustrate, only in the Australian case studies did students express feeling responsible for ethical clinical psychology practice to help create a more equal society. There are many different cultural groups in Australia, and psychologists are especially aware of their roles in reconciliation with Aboriginal and Torres Strait Islander peoples, who are the original inhabitants of the country (e.g. Isaacs, Pyett, Oakley-Browne, Gruis, & Waples-Crowe, 2010; Paradies, Harris, & Anderson, 2008; Westerman, 2004). Study 2b thus demonstrated that the unique framework of reconciliation is relevant to multicultural practice in Australia and is likely to influence how clinical psychology is culturally negotiated.

Concluding Study 2b, these interviews revealed that students and academics of clinical psychology programs in two Australian universities culturally negotiate clinical psychology based on perceptions of the cultural context by practitioners and clients (through cultural dialogues). However, a limitation of this study is that the interviews may not be fully representative of the population of students and academics of clinical psychology due to the possibility of self-selection bias. In addition, these identified themes may be especially relevant to Queensland and may differ in other parts of Australia.

Conclusion

This chapter described the first mixed-methods study of cultural negotiation in clinical psychology training and practice in Australia using the theory of MCC. The

survey assessed the applicability of existing knowledge on MCC in Australia, and the interviews in Study 2b invited new understandings on cultural negotiation in cross-cultural practice. Taken together, the data showed that the MCC model (Sue et al., 1982) is insufficient to understand cultural negotiation in clinical psychology in Australia. MCC needs to be expanded with dimensions of cultural competency specific to Australia, such as openly conversing about culture in the context of practice. In the context of great cultural diversity in Australia, students and academics especially emphasised working in in Indigenous contexts, indicating the continued importance of Australia's colonial history. Thus, cultural negotiations through awareness, knowledge and skills should be understood in the important cultural context of reconciliation in Australia. This context was not detected by the MAKSS and shows where MCC may require modification for use in Australia.

8. Negotiating Clinical Psychology in Singapore: A Case Study Using Multicultural Counselling Competency[9]

This chapter discusses the case study of cultural negotiation in clinical psychology training and practice in Singapore. Combined survey and interview results demonstrate that MCC is limited in understanding multicultural practice in Singapore as the model neglects the unique situation of teaching and practicing a 'western' discipline in a self-identified 'Asian' context.

This third case study, of the country of Singapore, follows the format introduced in the previous chapters. It utilises MCC to assess the universality of clinical psychology knowledge, and to highlight pathways for cultural negotiation in clinical psychology. The American-developed MCC model states that clinical psychologists need to develop multicultural awareness, knowledge and skills for cross-cultural practice (Sue et al., 1982); however a critical evaluation of the applicability of MCC in Singapore has yet to be conducted. Literature reported that psychologists' self-reported best practices for cross-cultural practice overlapped with those reported by practitioners in the United States (Jennings et al., 2008), indicating a similarity in how psychologists in Singapore and the United States approach the notion of cultural diversity (see Chapter 5). However, the cultural context in Singapore has been defined as "essentially Asian" (Yeo, 1993, p. 29), with four distinct groups (Chinese, Indians, Malays and

[9] An adaptation of this chapter has been prepared for publication:
Geerlings, L.R.C., Thompson, C.L., & Tan, G. (ready for submission). Preparing for multicultural clinical psychology practice in Singapore: A mixed-methods survey and qualitative study of multicultural counselling competency. *Anticipated submission to a psychology journal.*

others, including Eurasians), and thus differs considerably from the United States. The research conducted for this thesis is the first known study to use the MAKSS (D'Andrea et al., 1991) among students, academics and alumni of clinical psychology programs in Singapore.

To evaluate the applicability of MCC in this context, it was hypothesised that satisfaction with cultural training (Allison et al., 1994; D'Andrea et al., 1991; Tummala–Narra et al., 2012), professional practice experience (Hansen et al., 2006; Sehgal et al., 2011), and identification as a cultural minority (Pope-Davis et al., 1995) would be associated with MCC. Cultural aspects of clinical psychology training and practice in the two universities in Singapore was further assessed by supplementing the quantitative MCC data with more exploratory interview data. Analysis of the interviews allows evaluation of the usefulness of the tripartite model of awareness, knowledge and skills in understanding cultural negotiation of clinical psychology practice in Singapore.

The research focuses on two questions, identical to those presented in the previous Chapters 6 and 7. Firstly: how transferable is MCC to the context of clinical psychology training and practice in Singapore? It was hypothesised that, after controlling for the effects of social desirability (Constantine & Ladany, 2000), satisfaction with cultural training, cross-cultural practice experience, and identification as a cultural minority would be associated with students', academics' and alumni's multicultural counselling competency (Study 3a). The second question asks how students, academic staff and alumni of clinical psychology in universities in Singapore culturally negotiate clinical psychology during training and practice. This qualitative question is explored using interview data (Study 3b).

Study 3a: Survey

Method

Participants. In total 33 participants completed the questionnaire, including 16 students of professional clinical psychology master's or doctoral programs (age: M = 30.75, SD = 6.24), 9 academics currently teaching into these programs (age: M = 41.11, SD = 10.89), and 8 alumni of these programs (age: M = 31.50, SD = 6.05). Thirteen participants were affiliated with University A and 20 participants with University B. Demographic information of participants is detailed in Table 18.

Table 18. *Survey Participant Characteristics in Singapore (n = 33)*

	Students (n = 16)		Academics (n = 9)		Alumni (n = 8)	
	Freq.	%	Freq.	%	Freq.	%
Gender						
Male	2	12.5	0	0	2	25
Female	14	87.5	9	100	6	75
Nationality						
Singaporean	12	75	0	0	8	100
Other	4	25	9	100	0	0
Cultural identification						
Chinese	10	62.5	1	11.1	5	62.5
Malay	1	6.3	0	0	2	25
Indian	1	6.3	2	22.2	1	12.5
Other	4	25	6	66.7	0	0
Cross-cultural experience						
Yes	4	26.7	9	100	1	83.3
No	10	66.7	0	0	5	16.7

Instruments. The instruments used in this research were previously described in Chapter 6. They include a demographics questionnaire in line with previous research (e.g. Lee & Khawaja, 2012; Pope-Davis et al., 1995), four statements on satisfaction with cultural training, and the Multicultural Awareness Knowledge and Skills Survey (D'Andrea et al., 1991), and the Marlowe-Crowne Social Desirability Scale - Short

Form (Reynolds, 1982). Psychometric properties and characteristics are outlined in Chapter 6.

A few modifications were made to adapt the MAKSS for use in Singapore. Explicit reference to the United States in items 35, 37 and 38 was replaced with reference to Singapore, and reference to "Canada" was replaced by Australia, Indonesia and Malaysia, countries neighbouring Singapore and countries investigated in this thesis. Similar to Studies 1a and 2a (see Chapters 6 & 7), the term "White" was removed from the phrase "White mainstream clients" and the terms "gay men" and "gay women" were replaced with the phrases "men who are sexually attracted to men" and "women who are sexually attracted to women" respectively.

Procedure. The procedure was identical to Studies 1a and 2a (see Chapters 6 & 7). Institutional Human Research Ethics Committee approval was obtained, the survey was piloted among two graduates and one students of a clinical psychology program at an Australian university not otherwise involved in the study, with minor revisions made. Institutional collaborators forwarded an email with details of the study to students, academics and alumni of clinical psychology master's or doctoral programs, including a link to the online questionnaire hosted on Qualtrics online survey software. Data were exported into IBM SPSS, and analysed followed that of Studies 1a and 2a (see Chapters 6 & 7).

Results

Data screening. The MAKSS and MCSDS-SF scores were normally distributed. Maximum likelihood estimation was used to manage some occasional missing values on the MAKSS and MCSDS-SF for 14 participants.

The MAKSS Awareness, Knowledge and Skills subscales and the MCSDS-SF had equal variances for the two universities, $F(1, 31) = 1.91$, $p = .177$; $F(1, 31) = 0.14$,

$p = .709$; $F(1, 31) = .01$, $p = .904$; $F(1, 31) = .00$, $p = .973$, respectively. Equal variances were also confirmed for the groups of students, academics and alumni, for the MAKSS Awareness and Skills subscales, $F(2, 30) = .09$, $p = .915$; $F(2, 30) = .79$, $p = .463$, respectively, and for the MCSDS-SF, $F(2, 30) = 1.92$, $p = .164$. However, the MAKSS Knowledge subscale had significantly lower variability for students than for academic and alumni groups, $F(2, 30) = 4.34$, $p = .022$.

The reliability of the subscales of the MAKSS and the MCSDS-SF was good for Knowledge with Cronbach's *alpha* of .89, acceptable for Skills at .78, and for the MCSDS-SF at .70. Cronbach's *alpha* reliability of the Awareness subscale was unacceptably low in this study at .44; nevertheless, the scale was included in the analyses to allow comparison of the present findings with the two case studies of the Netherlands and Australia. The findings of the Awareness scale are interpreted with caution.

Preliminary MCC results. Correlations of age and satisfaction with cultural training, with the MAKSS and MCSDS-SF variables are presented in Table 19. The MAKSS scales were significantly inter-correlated: Awareness and Knowledge, $r = .54$, $p = .001$; Awareness and Skills, $r = .40$, $p = .019$; Skills and Knowledge, $r = .65$, $p < .001$, suggesting the MAKSS subscales each measured a related aspect of the construct of MCC. All scales of the MAKSS were included in further analysis.

Social desirability and age were correlated with MCC to assess the need to covary these variables with MCC in the MANOVA for hypothesis testing. Table 19 shows that correlations between social desirability, age and MAKSS subscales were not significant, indicating that there was no need to use social desirability or age as covariates in further analyses of the MAKSS.

Table 20 shows variability in means for the MCC subscales for groups of students, academics and alumni. A one-way MANOVA with the between-groups independent variable of group (students, academics and alumni) and the MAKSS subscales (Awareness, Knowledge, Skills) as dependent variables was conducted to assess group differences in MCC. The results indicated significant group differences in MAKSS Awareness, $F(2, 30) = 3.75$, $p = .035$, and Skills, $F(2, 30) = 15.34$, $p < .001$. Group differences for Knowledge were not significant, $F(2, 30) = 2.81$, $p = .076$. Variances were equal between groups (Box's M $p = .529$), suggesting Tukey *HSD* post-hoc tests. For Awareness, Tukey *HSD* tests showed a trend instead of significant differences, with Academics ($M = 54.00$, $SD = 2.78$) having higher scores on Awareness than students ($M = 50.50$, $SD = 3.85$, $p = .058$) and alumni ($M = 49.88$, $SD = 3.48$, $p = .055$). Group differences on Skills were significant, academics ($M = 59.23$, $SD = 4.67$) scored significantly higher on Skills compared to students ($M = 49.75$, $SD = 3.71$, $p < .001$) and alumni ($M = 49.87$, $SD = 5.19$, $p < .001$). No statistically significant group differences were detected in Knowledge scores, all ps $> .05$. These results suggested the need to covary group in further analysis of MCC.

A one-way MANOVA with the between-groups independent variable of respondents' university and the MAKSS subscales (Awareness, Knowledge, Skills) as dependent variables was conducted to assess university differences in MCC. A non-significant Box's M test ($p = .476$) indicated equal variance-covariance matrixes of the dependent variables across universities, and supported the use of Pillai's Trace. This showed no significant differences in MAKSS Awareness, Knowledge and Skills scores, $F(3, 29) = .23$, $p = .875$, so the data for both universities were combined for the analysis.

Table 19. *Correlations Between the Study Variables (n = 33)*

	Age	Satisfaction	Awareness	Knowledge	Skills
Age	–				
Satisfaction	-.30	–			
Awareness	.29	-.30	–		
Knowledge	.26	-.17	.51**	–	
Skills	.34	-.05	.40*	.65**	–
MCSDS-SF	.10	.00	-.16	.03	.01

Note. Satisfaction = Satisfaction with cultural elements in clinical psychology training; Awareness = MAKSSS Awareness scale; Knowledge = MAKSS Knowledge scale; Skills = MAKSS Skills scale; MCSDS-SF = Social desirability on MCSDS-SF. * $p < .05$ (2 tailed); ** $p < .001$ (2 tailed)

Effects on MCC. To test the hypothesis that satisfaction with cultural training was associated with MCC, a correlational analysis was conducted. Satisfaction with cultural training was not significantly correlated with the MAKSS subscales (all *p*s > .05; see Table 19).

To test the two hypotheses that multicultural experience and minority identification were associated with MCC, a one-way between-subjects MANOVA was conducted with the independent variables of multicultural experience and minority identification and the MAKSS scales (Awareness, Knowledge, Skills) as dependent variables. Significant group differences in Awareness and Skills described above indicated the need to covary with group, however it was not possible to statistically control for group (students, academics, alumni) as all academics reported cross-cultural experience. Thus, the MANOVA was conducted with only cross-cultural experience and minority identification as independent variables. A variable for minority identification was constructed based on participant responses that they did not identify as part of the Chinese-Singaporean majority in Singapore. The analysis showed no significant effect on any of the MAKSS subscales for identification as a cultural minority, $F(3, 24) = 2.52$, $p = .082$; or of cross-cultural experience, $F(3, 24) = 2.83$, $p = .060$.

Table 20. *Means and Standard Deviations for Variables (n = 33)*

	Students (*n* = 16)		Academics (*n* = 9)		Alumni (*n* = 8)	
	M	*SD*	*M*	*SD*	*M*	*SD*
MAKSS Awareness	2.53	.19	2.70	.14	2.49	.17
MAKSS Knowledge	2.45	.26	2.76	.47	2.38	.41
MAKSS Skills	2.49	.19	2.96	.23	2.49	.26
MCSDS-SF Social Desirability	.40	.21	.44	.28	.38	.21

Note: MAKSS score range: 1 – 4; MCSDS-SF score range: 0 – 1.

Discussion

It was hypothesised that satisfaction with cultural elements in training, cross-cultural experience and identification as a minority would be associated with MCC, however the statistical analyses showed no such effects. One possible interpretation is that the MAKSS, being designed in the United States, is not a useful measure of MCC in the Singaporean context. As stated previously in Chapters 6 and 7, the MAKSS implicitly relies upon an American cultural situation of a 'white' majority and several minority groups. However, Singapore has a different situation with four distinct cultural groups, and the majority-minority situation in Singapore is more diffuse and not necessarily depending on skin colour. As a result, despite the modifications to remove references to 'white' from the MAKSS questions, the questionnaire may still be unsuitable for the Singaporean context. An item in the Awareness subscale, such as: *"The human service professions, especially counseling and clinical psychology, have failed to meet the mental health needs of ethnic minorities"* is problematic in Singapore, because the term 'ethnic minorities' may refer to any of the four cultural groups in Singapore. Indeed, the low Cronbach's alpha reliability of Awareness (r = .44) suggests that the subscale did not adequately assess multicultural awareness in this Singaporean sample. A large proportion of the participants may have experienced the MAKSS questions – and MCC – as not applicable in Singapore.

Furthermore, there are likely to be factors in the development of MCC in Singapore that are not detected by the MAKSS. Aspects of cultural training and practice in Singapore, such as the dependency on Australian training programs and on foreign expertise in teaching these programs, are not assessed by the MAKSS. In Singapore, clinical psychology is sometimes experienced as a "western" oriented discipline practiced in an "Asian" cultural context (Yeo, 1993). The term 'ethnic minorities' may thus relate to the entire Asian population in Singapore, as clinical psychology may not be internalised as part of the Asian culture.

However the suggestion that the null results are due to a poor cultural fit of the MAKSS is tentative, as clearly the absence of significant effects on MCC may be related to the small sample size (n = 33), and relatedly, to low observed power of the statistical analyses (range .550 – .605). Moreover, small cell sizes necessitated the collation of the diverse groups of Malay-Singaporeans, Indian-Singaporeans, Eurasians and foreigners under the category 'minority'. While some people in these four groups may indeed identify as a cultural minority in Singapore, it would be more nuanced to analyse effects of identification with these different groups. Another possibility, which could be tested by future research, is that it is actually participants' perceptions of minority status that are important, rather than ethnicity.

Interestingly, academics scored significantly higher on multicultural Skills compared to students and alumni. This could be explained by cross-cultural experience; all academics reported having experience in practicing clinical psychology in countries outside Singapore. However, the small sample size restricted the option to statistically test interaction effects. An alternative explanation for academics' higher level of reported multicultural skills may be years of experience, instead of cross-cultural experience specifically. As clinical psychology programs in Singapore largely rely on

foreign expertise (see Chapter 3), academics' cross-cultural practice experience could be in their home countries – indicating practice within familiar cultural contexts instead of actual cross-cultural experience. The separation of years of experience overall from specifically cross-cultural experience would be a useful direction for future research.

To conclude Study 3a, the rejection of all hypotheses on MCC suggest that the MAKSS is insufficient to explore the cultural negotiation in training and practice of clinical psychology in Singapore. This raises questions about the cross-cultural transferability of MCC. In order to begin address these questions, Study 3b below is designed using qualitative interviews with students, academics and alumni of clinical psychology programs to explore how cross-cultural clinical psychology training and practice was experienced in Singapore.

Study 3b: Interviews

Method

Participants. Thirteen people were interviewed, including 5 students (age: M = 33.8, age range: 26 – 40 years), 3 academics (age M = 49, age range: 33 – 58 years), and 5 alumni of clinical psychology programs (age: M = 31.6, age range: 27 – 39 years). Seven participants were affiliated with university A and six with university B. Seven participants identified as Chinese-Singaporean, two as Malay-Singaporean, one as Indian-Singaporean and three people did not fit into these categories. All participants were female. Further demographic information was not reported in order to maintain confidentiality.

Procedure. Participants were recruited for the interviews via the Study 3a questionnaire (n = 7) and through snowball sampling (n = 6). Semi-structured

interviews were conducted face-to-face at the participating universities, at the interviewees' workplaces, or in places nominated by interviewees. All interviews were conducted by the MPhil candidate, and interviewing time averaged 30 minutes (range: 25 – 36 min). An interview outline consisting of open-ended questions was used (see Appendix III), which is described in Chapter 6. Interviews were audio-taped and were transcribed verbatim with NVivo qualitative data analysis software.
Interpretative phenomenological analysis was used to analyse the interviews (see Chapter 6). To ensure transparency about the MPhil candidate's interpretative role, one analysis was participant-audited by an interviewee, and another was independently audited by an experienced IPA researcher. It was established that no further auditing was required. To form homogenous samples for IPA, student, academic and alumni interviews were analysed separately to identify patterns for each group. Themes were included in master themes if they were present in half of the interviews or more (Smith et al., 2009). IPA generated four master themes for students, academics and alumni, which are collated and listed in Table 21.

Results

Table 22 shows there was considerable overlap in the identification of superordinate themes for students, academic and alumni interviews. Therefore, the master themes for students, academic and alumni were collated and are discussed jointly (see Table 21). Participant quotes are de-identified and brackets are used to identify material that was omitted, added or changed in the participant's quotes for clarification and confidentiality.

The master themes and some of the superordinate themes overlapped with the themes identified from the interviews in the Netherlands and Australia. Overlapping and diverging themes are also highlighted below for cross-cultural comparison.

Table 21. *Collated Master Themes and Superordinate Themes per Group*

Master themes	Superordinate themes		
	Students (*n* = 5)	Academics (*n* = 3)	Alumni (*n* = 5)
1. Culture of clinical psychology	a. Universal aspects (3) b. Western modes of thought (4)	a. Universal aspects (2) b. Western therapies (3)	a. Universal aspects (5) b. Western therapies (4)
2. Cultural context in Singapore	a. Dependency on foreign expertise (4) b. Dependency on western resources (5) c. Important factor (5) d. Languages (5) d. Cultural value impositions (3)	a. Dependency on foreign expertise (3) b. Important factor (3)	a. Dependency on foreign expertise (3) b. Important factor (5) c. Underdeveloped field of practice (4)
3. Cultural competencies	a. Cultural awareness (4) b. Person-centred practice (4) c. Holding dialectic models (4)	a. Cultural awareness (3) b. Personalising practice (2)	a. Person-centred practice (4)
4. Cultural competency teaching and learning	a. Importance of supervised practice (5) b. Learning through cross-cultural engagement (5) c. Power differentials as a barrier (5) d. Insufficient training (4)	a. Investing in the supervisory relationship (2) b. Learning through cross-cultural engagement (3) c. Supervising cross-culturally (3)	a. Importance of supervised practice (3) b. Cross-cultural engagement (5) c. Power differentials as a barrier (3) d. Supervising cross-culturally (4)

Note. Number of interviews per theme is noted in parentheses.

Table 22. *Distribution and Overlap of Superordinate Themes per Participant Group*

	Students					Academics			Alumni				
	S1	S2	S3	S4	S5	T1	T2	T3	G1	G2	G3	G4	G5
Shared themes*													
1a. Universal aspects		X	X		X	X	X		X	X	X	X	X
1b. Western therapies			X	X		X	X	X	X	X		X	X
2a. Foreign expertise	X		X	X	X	X	X	X	X		X	X	
2b. Important factor	X	X	X	X	X	X	X	X	X	X	X	X	X
3a. Cultural awareness	X	X		X	X	X	X	X		X			
3b. Person-centred	X	X	X	X					X	X	X	X	
4a. Supervised practice	X	X	X	X	X				X			X	X
4b. Engagement	X	X	X	X	X	X	X	X	X	X	X	X	X
4c. Power differentials	X	X	X	X	X				X	X			X
4d. Supervising				X		X	X	X	X	X	X	X	
Student themes													
1b. Modes of thought		X	X	X	X								X
2b. Western resources	X	X	X	X	X				X				X
3c. Dialectic models	X	X		X	X								
2d. Languages	X		X	X	X							X	
2e. Value impositions	X	X		X									
4b. Insufficient training	X		X	X	X								
Academic themes													
3b. Personalising practice							X	X					X
3a. Supervisory relationship							X	X					
4c Supervising						X	X	X					
Alumni themes													
2c. Underdeveloped					X			X	X	X	X	X	X

*These themes were present in at least half of the interviews in two or three participant groups.

Culture of clinical psychology. All participants experienced clinical psychology as a discipline with aspects that are influenced by culture and possibly not cross-culturally applicable, and also with aspects that are universal.

Universal aspects of clinical psychology. Universal aspects of clinical psychology were especially apparent in the interviews in Singapore. Students, academics and alumni experienced clinical psychology's ethos, such as counselling skills, as a universally applicable aspect of clinical psychology. In addition, some participants regarded principles or theories of clinical psychology as universal:

[I] think psychology is like a science so a lot of it is based on like objective evidence and it is like thoroughly tested through many research trials

[…] in countries where psychology is much more established. So definitely the underlying theories are [relating to] something that all humans regardless of race or culture go through, so those underlying principles would definitely still be applicable.

The quote above reveals the assumption that scientific evidence is automatically universally valid, this will be discussed further in Chapter 10. In addition to universal aspects, other parts of clinical psychology were experienced as influenced by culture.

Western therapies. Academics and alumni in Singapore regarded some therapeutic approaches, such as cognitive-behavioural therapy, as more appropriate for culturally western clients than for Singaporean clients. According to one participant:

I think it's kind of like a dilemma. Because […] we were trained in [cognitive-behavioural therapy], and we were taught that it is accepted for anyone, but then again, I don't really think so, based on my own personal experience.

Therapies such as cognitive-behavioural therapy were considered western-oriented because they involved openly discussing emotions and feelings, they were not directly focused on problem-solving and they neglected spiritual or religious guidance.

Western modes of thought. Students experienced clinical psychology's evidence-based mode of inquiry as western. This 'western' mode of thought was considered implicit in clinical psychology theories and models:

I think the mode of enquiry [in clinical psychology] is […] based on more European kind of thinking styles. […] For example, like linear kind of relationships. My understanding about more eastern kind of thinking is how things are more organic and interrelated. […] Cognitive-behavioural therapy, I think is a very clear example of western-based style thinking.

Thus, according to this participant, different modes of thought might help explain why some Singaporeans feel uneasy with mainstream psychotherapies.

Cultural context of clinical psychology in Singapore. Participants in Singapore introduced many topics into the interview that related to cultural contextualisation of clinical psychology in Singapore.

Dependency upon foreign expertise. Unique to Singapore, the dependency on foreign influences was associated with an experience of clinical psychology as a discipline that is new to Singapore. This will be discussed in more detail in Chapter 10. Applying foreign-induced knowledge was sometimes challenging:

> *Going back and forth between a [university] that is quite westernised probably in its thinking and academic approach, going back to the Singaporean work force, the Singaporean system of placements, can be […] something to navigate at times.*

Dependency upon western resources. Prominent in student interviews was the lack of locally developed resources, such as literature focusing on practice in Singapore, or standardised tests with norms for the local population. This theme relates to the previous theme and shows that students experienced foreign dependency in clinical psychology especially through the absence of resources from Singapore:

> *I mean generally, the textbooks [we] have [are] also westernised. There isn't any local sort of textbook anyway. […]There probably won't be local theories!*

Important factor in clinical practice. Students, academics and alumni experienced culture as an important factor in practice. The culture factor was considered highly relevant for practice in Singapore due to the high levels of cultural diversity in the population:

Recently I [worked with] a Malay couple and they shared how their family and relatives are so involved in their family problems. And that to me is a surprise, because I am a Singaporean but I am Chinese. So I thought: "Wow! That's a culture [sic] new thing for me!" […] So [cultural diversity] is a challenge, I guess something that we need to constantly bear in mind.

Due to the high level of cultural diversity in Singapore participants emphasised the need to constantly negotiate clinical psychology.

Next to cultural diversity of the clientele, linguistic diversity was another important factor through which culture manifests in clinical practice.

Languages. Also unique to Singapore, students identified language as an important cultural influence on practice in multilingual Singapore. Clinical psychology training was conducted in English, and students identified the need for resources in other languages, such as in Mandarin. Also relevant was the nexus of language and meaning of psychological concepts:

I think language is certainly an important component of culture. How do you explain depression to a patient who is using English and Mandarin, for instance, that will be quite different. It doesn't really map quite as nicely. And the concepts are different. And the way we even pitch the idea of depression will be slightly different.

Due to the interweaving of language and culture, providing training and practice in languages other than English could also be regarded as cultural negotiations.

Another important way in which cultural factors were experienced in clinical practice was through clinical judgement, which was at times experienced as a value judgement.

Cultural value impositions. Students sometimes experienced clinical psychology norms as judgements based on western values. This theme was consistently detected in all three countries. Norms for abnormality in standardised tests, in diagnosis and in theories, were questioned and viewed as judgements based on western values:

> *[In Singapore] many children are raised by domestic helpers mostly. Or they are raised in a family where success is equated to how many marks you get, really, academic achievement. And eventually, your financial achievement, and that is just the way it is. And I am a bit worried, you know, that if you look at the psychological models about what contributes to psychopathology, does that mean that the whole society will have psychopathology? But by whose standard, by whose definition, right?*

Related to the difficulty in applying theories, methods and values in clinical psychology in the local multicultural and multilinguistic context was the experience of clinical psychology as still in its infancy in Singapore.

Underdeveloped field of practice. Alumni regarded clinical psychology as an underdeveloped field of practice in Singapore, especially in comparison to Australia. Clinical psychology was considered new to Singapore, its services are not yet fully integrated in health care, the profession is not yet well-defined or recognised: *"I don't think currently in terms of public awareness that there is much awareness of what clinical psychologists do and what we offer."*

However, despite regarding clinical psychology as a foreign product that it still being developed, alumni believed that the discipline will have an important future in Singapore. As will be discussed in Chapter 10, these perceptions of clinical psychology in Singapore influence how the discipline is culturally negotiated.

Cultural competencies. Participants identified particular cultural competencies and tapped into specific resources when practicing cross-culturally. Some of these pathways to cultural negotiation overlapped with the strategies identified in the interviews in the Netherlands and Australia, while others were unique to Singapore.

Importance of cultural awareness. Students and academics emphasised the importance of cultural awareness in culturally competent practice. Students referred to an awareness and understanding of the cultural views of their client, while academics considered reflecting on one's own culture as equally important:

> *I think anyone can or could [be culturally competent], but I think a lot of people don't have that awareness. And you know... I mean let's face it, there are a lot of bad psychotherapists out there too who don't give in to the worldview of the clients who don't come from their culture.*

This theme was identified in each case study country (see Chapters 6 & 7).

Person-centred practice. Students and alumni actively adjusted their practice based on their understanding of the cultural needs of their clients. This included adjusting the therapeutic approach, mirroring the language and concepts of the client, tailoring recommendations, or changing procedures for testing:

> *So you just take out the piece [of information from the manual] that you think is most relevant and what would be most helpful, and use your judgement to fill in the gaps […] And when there are times when we know that there are certain pieces that are not applicable here, then we just have to take the call of what [the client] really needs, and to work from there.*

Person-centred practice was also identified as a strategy for cultural negotiation by participants in the Netherlands and Australia (see Chapters 6 & 7).

Holding dialectic models. Students sometimes experienced that clinical psychology models did not align with the cultural models their clients, or they themselves, held. In order to practice clinical psychology without disrespecting alternative models or explanations, students simultaneously identified with different perspectives. For example, one participant explained how she upheld both psychological explanations of hallucinations and the belief that ancestors are talking:

> *We don't tell [clients] that it is nonsense. But at the same time we offer possible explanations for what they are experiencing. And that is useful, because [otherwise] I might just either dismiss it as a witch-doctor sort of thing: "Oh no, that's superstitious!" Or I might just think: "Oh, hallucinations or whatever, that is the western way of thinking". And what we Chinese, or like if I happen to believe in that, and I think that sometimes I do, I might then throw out all the theories of psychology, and then being biased.*

This unique response to the foreign values and explanations introduced by clinical psychology was identified only by participants in Singapore. This response to the implicit western cultural values in clinical psychology highlights the cultural non-western identification of the majority of interview participants in Singapore.

Personalising practice. A final cultural competency, employed by academics, was applying their personal characteristics and personalising practice:

> *I think [I] probably [use] my personal attributes and skills. So how have I come to be a sensitive person, and accepting, and empathic. I genuinely want someone to feel accepted and respected.*

These characteristics and skills of being receptive to the client and building rapport can be termed *unconditional positive regard*, which was also identified by academics in Australia. The experienced academics have internalised these skills, and

perhaps therefore regard them as personal characteristics. It suggests that seasoned practitioners are comfortable with culturally negotiating clinical psychology.

Cultural competency teaching and learning. Participants considered cultural competency important for practitioners in Singapore. They identified three pathways for developing cultural competency, as well as three possible barriers.

Importance of supervised practice. Similar to Australian academics, students and alumni in Singapore emphasised the importance of supervised practice for learning how to culturally negotiate clinical psychology practice. During supervised practice students learned how to apply their knowledge in the context of the health care system and the multicultural environment of Singapore:

> *I think because I was trained – I did my clinical placements here – it gives me a faster sort of root toward the way of what it is like to practice here in the real setting and that helped, I think that helped to prepare my actual work here, you know, after I graduated from the course.*

Investing in the supervisory relationship. Academics also valued supervised practice for teaching their students how to practice clinical psychology. Academics emphasised the importance of investing in the supervisory relationship, especially in the case of cultural differences between supervisor and supervisee:

> *[For] people who teach it is necessary to understand that [students] are coming from a different place. We can't just teach as we are used to in this situation, so [without trying to] understand their perspective. So we need to understand [where] they're coming from.*

Investing in the supervisory relationship was experienced differently: one supervisor perceived it as enjoyable and rewarding, while another considered it

emotionally taxing. However, these academics agreed that a good supervisory relationship is essential for teaching and learning how to practice cross-culturally.

The importance of establishing good working relations with clients and supervisees was also emphasised by alumni in the Netherlands (see Chapter 6), and the difficulty of establishing such a relation in cross-cultural situations was highlighted by academics in Australia (see Chapter 7). This demonstrates the importance of personal relations in clinical psychology training and practice; it suggests that cultural negotiations in clinical psychology are taking place in personal domains.

Learning through cross-cultural engagement. Another important pathway for cultural competency learning, according to students, academics and alumni, was through social interactions with people of different cultural backgrounds. As in the Netherlands and Australia, culturally different colleagues, fellow students, and supervisors were important sources of learning cultural negotiations.

Specifically for Singapore, foreign supervisors were considered to be helpful to students in broadening their cultural perspectives:

> *They give very different opinions and perspectives. And especially if the supervisors themselves have been through two or three different cultural experiences, that is a wealth of knowledge that we can actually tap into.*

Cultural competency can thus best be gained by engaging cross-culturally, by supervised practice, and by investing in a good supervisory relationship. However, participants also identified three barriers to cultural competency learning: power differentials, insufficient training, and supervising cross-culturally.

Power differentials as a barrier. Unique to the interviews in Singapore, students and alumni pointed to power differentials in teaching and working relationships as restrictions in cultural negotiations. For practitioners working in public

sectors, state mental health policies restricted their opportunity to experiment with methods that they deemed more culturally appropriate. For students, perceived power differentials in the student-academic relationship interfered:

> *At the end of the day as trainees, I don't think that we have a very active voice, especially if we feel like we don't have avenues to talk about [cultural issues] because […] can you do it in a safe environment in which you feel like it won't affect your grades, so it won't affect the relationship?*

Insufficient training. Similar to participants in the Netherlands and Australia, students in Singapore indicated the need to integrate cultural training into their clinical psychology programs: they opined that cultural skills training should be more prominent, literature focusing on Asian populations should be addressed, and cultural knowledge should be central in discussions during training and in supervision:

> *I can see there is conscious efforts to deal with the topic [of culture], but what I notice in the program, is that it tends to be like a touch and go kind of thing. So like: "we're going to talk about culture today, and it is going to vary in groups of people" […] But I kind of feel like there might be more to it.*

A focus on cultural training tailored towards the multicultural practice in Singapore may thus considerably help students' cultural competency development.

Supervising cross-culturally. Unique to Singapore, none of the interviewed academics were trained in the country in which they taught. In addition, they had varying degrees of local practice experience, and expressed hesitancies in commenting upon culturally competent practice in Singapore. This suggests they may be uncertain about their understanding of the cultural context of practice in Singapore:

> *I guess I don't know how well I'm doing. […] Part of my own continuing professional development […] is to get a little bit more familiar with the*

actuality of the health care placements. So when I'm saying [that I am] "trying to" [integrate culture in teaching], I'm doing that kind of from one end of it, without having had the clinical experience of working clinically within Singapore, which I think possibly would give me a slightly different perspective.

Alumni recalled experiences of cross-cultural supervision in which they found it difficult to explain their clients' worldviews to their foreign supervisor, and in which supervisors gave non-appropriate advice. One participant recalled how difficult it was to explain that adults in Singapore continue to live with their parents:

[Foreign supervisors] don't understand how an adult grown-up can live with his parents. Sometimes we talk about our clients […] and they keep saying things like: "Their relationship is very enmeshed," without actually realising that you have to take it from the perspective of a local Asian context, where these things happen. Where this thing is normal.

Participants' experiences indicate the difficulty of supervising cross-culturally and to the importance of understanding the context of cultural negotiation in clinical psychology training and practice.

Discussion

Study 3b assessed how students, academics and alumni of clinical psychology programs negotiate clinical psychology training and practice. The themes emerging from the interview data partially reflect the constructs of the tripartite model of MCC (Sue et al., 1982). Cultural awareness was identified by students and academics, and included awareness of cultural differences and reflecting upon one's own culture. Knowledge and information on cultural groups in Singapore, identified as a cultural competency, overlapped only with certain aspects of Sue et al.'s (1982) concept of multicultural knowledge, as it did not involve knowledge on institutional discrimination

or socio-political structures of inequality. Finally, students and alumni referred to person-centred practice in terms of adjusting practice based on the client's cultural needs. Similar to Sue et al.'s definition of cultural skills (1982) this involved adjusting the verbal communication to the client. However, Sue et al.'s (1982) skills of adjusting non-verbal communication, or practicing in different settings or roles, was not discussed by participants, while adjusting standardised procedures was added.

A further cultural negotiation identified by students was to dialectically hold 'western' psychological models along with alternative culturally specific ones. For students, cultural competency meant being able to deeply identify with different perspectives; cultural models may thus offer explanations for symptoms which are as valid as psychological models. As practitioners they may offer psychological models to their clients, but will also accept the models their clients hold as the basis for practice. When students adjust their practice with clients who hold alternative cultural models, they may potentially pave the way for creative and culturally inspired, therapeutic approaches based on diversity in Singapore. The unique skill in the dialectic holding of different explanatory models highlights the importance of clinical psychology's perceived foreignness in Singapore. Evident in these interviews and in the literature (Yeo, 1993), Singaporeans identify as non-western, so it becomes especially important to help practitioners to culturally negotiate the perceived binary of practicing 'western' clinical psychology in their 'Asian' context.

The interviews demonstrate that clinical psychology was mainly experienced as a foreign discipline in Singapore; despite the recognition that some aspects of the discipline may be universally applicable. This could explain the null findings in Study 3a, as this important factor to transnational clinical psychology training and practice was not measured by the MAKSS. Clinical psychology's foreignness stems from the

discipline's reliance upon foreign training programs, foreign experts and resources based on 'western' values. Additionally, participants reported that psychology services were not yet fully accepted in society. According to Tan (2002a), acceptance of clinical psychology may be a prerequisite for cultural appropriation of the discipline. Indeed, locally normed tests, guidelines and resources for practice were not yet available to participants. As a result, clinical psychology students and practitioners experienced that the discipline's models and methods did not always help them practice with their culturally, linguistically and religiously diverse clientele.

However, while participants identified the need to culturally appropriate clinical psychology to the Singaporean context, students and alumni also desired new perspectives and expressed the need to offer alternative cultural models. This undecidedness can be illustrated with the issue of foreign supervisors. Alumni recalled how foreign academics misunderstood their client's issues, and how they proposed psychological advice that the alumni considered culturally inappropriate. This suggests the alumni's desire to align clinical psychology with cultural values in Singapore – to culturally appropriate psychology. For academics, it may confirm their hesitancies to comment on cultural issues in Singapore. However, simultaneously, alumni and students sometimes considered academics' 'misunderstandings' of issues as new and fresh perspectives that they used to improve their practice. This suggests that some aspects of clinical psychology are more consciously culturally negotiated than others.

The themes emerging from the interview data highlight that cultural negotiation in clinical psychology knowledge and practice is essential for adequate training and practice in Singapore. Students emphasised the need to integrate issues related to practice in Singapore in clinical psychology training. Cultural learning mainly took place through experiential activities, including social interactions. It is therefore

important that universities create an environment in which such cross-cultural social encounters are encouraged, so that students and academics are enabled to explore cultural appropriations in clinical psychology.

There was some overlap and difference in the cultural negotiations identified in the interviews from Singapore, compared to the Netherlands and Australia. Cultural awareness, person-centred practice, and personalised practice were identified by participants in all three countries as pathways for cultural negotiation. These findings suggest that cultural negotiation mainly takes place based on the practitioners' perceptions of the client, the cultural context, and the interpersonal interactions. Unique to Singapore is the dialectic holding of models, which emphasises the perceived binary between foreign clinical psychology and cultural models, and reinforces the problematic notion of opposing categories of 'Asian' versus 'western' cultures.

Concluding Study 3b, these interviews provided insights into how students, academics, and alumni of clinical psychology programs in two universities in Singapore experienced cultural negotiation in clinical psychology. The results highlight the importance of cultural appropriation of clinical psychology in Singapore, but also the undecidedness in whether or not clinical psychology should be standardised in Singapore according to 'international' norms. A limitation may be that the interviews were not fully representative of the population of students, academics and alumni of clinical psychology due to the possibility of self-selection bias: those with strongest opinions may be more likely to volunteer to be interviewed. In addition, all participants were female and no Singaporean academics were interviewed. However, the cultural diversity in Singapore was adequately sampled, covering Chinese-Singaporeans, Malay-Singaporeans, Indian-Singaporeans, and foreigners – but no Eurasians.

Conclusion

This chapter described the first mixed-methods study of cultural negotiation in clinical psychology in Singapore. The survey in Study 3a assessed the applicability of existing knowledge on MCC in Singapore, while the interviews in Study 3b invited new understandings on cultural negotiation in cross-cultural practice. Taken together, the data demonstrated that the model of MCC (Sue et al., 1982) is insufficient to understanding cultural negotiation in clinical psychology. Students, academics and alumni of professional clinical psychology programs identified cultural competencies that partially overlap Sue et al.'s (1982) tripartite MCC model, however, the important factor of perceived foreignness of clinical psychology was not detected by the MAKSS, and shows where MCC may be unsuccessful in assisting psychologists in negotiating foreign clinical psychology into multicultural practice in Singapore. Thus, clinical psychology training may benefit from a focus on clinical practice in the 'Asian' multicultural context of Singapore to help students negotiate different explanatory mechanisms and values.

9. "Knowing How to be Culturally Sensitive": An Ethnographic Comparison of Clinical Psychology Training and Practice

> *After psychological investigation of the case studies of the Netherlands, Australia and Singapore in Chapter 6 – 8, this is the first of two chapters that re-analyse the case studies together from a cultural anthropology perspective. The themes derived from multiple sources of ethnographic data demonstrate that the territory of clinical psychology is negotiated through daily clinical psychology training and practices.*

This is the first of two chapters (9 & 10) to analyse the combined case studies of clinical psychology training and practice in the Netherlands, Australia and Singapore from a cultural anthropology perspective. The present chapter expands and deepens the conclusion drawn from the country case studies presented in Chapters 6 – 8, which argue that transnational knowledge in clinical psychology is often culturally negotiated during training and practice. This first cultural anthropology chapter demonstrates through an ethnographic investigation that people open up and re-create spaces of enclosure in clinical psychology in various ways, sometimes purposefully, sometimes less consciously. The anti-imperialist and anti-essentialist perspectives encouraged through the practice of ethnography provide insights into nuanced cultural influences on clinical psychology territories that take place during training and practice.

This chapter draws on the theoretical insights presented in Chapter 4. Through an analysis of classical and contemporary theories from anthropology and philosophy, Chapter 4 argued that clinical psychology – like any academic discipline – is being demarcated by universities and professional organisations. International curricula,

protocols and universal diagnostic systems are examples of fixed spaces of enclosure that standardise clinical psychology. These delineations, mapped in Chapter 10, create a notion of clinical psychology as a single, standard, and international discipline – a territory – that can only be applied in a particular way. However, the theories outlined in Chapter 4 also indicated that clinical psychology is influenced by culture each time it is applied. Thus, cultural negotiations that interrupt delineations of the territory take place during daily practices of clinical psychology. Together, Chapters 9 and 10 show that the territory of clinical psychology is one of simultaneous stasis and flow.

Chapter 9 maps negotiations and demonstrates that clinical psychology's power/knowledge effects are especially contested during culturally sensitive practice. Thus the title of this chapter, "knowing how to be culturally sensitive", is important from two perspectives: to enhance clinical psychology's responsiveness to multicultural societies and to contest ethnocentrism in the discipline.

Ethnographic Methods

Ethnographic data for this cross-cultural comparison are derived from three methods: fieldwork, interviews, and free-listing exercises with students, academics and alumni of clinical psychology in six universities.

The first method, ethnographic fieldwork, took place in the six case study universities in the Netherlands, Australia and Singapore. The duration of fieldwork ranged from a few days in some universities, several weeks in others, to over two years in one university. I visited clinical psychology departments, clinics and hospitals; talked with students, academics and alumni in public spaces; and worked for over two years as an administrative assistant in a clinical psychology training clinic in Singapore. A reflective journal was maintained throughout fieldwork. The ethnographic fieldwork

carried out during this research enables this chapter to summarise descriptions and experiences of clinical psychology training and practice from over one hundred students, academics and alumni of clinical psychology programs in the Netherlands, Australia and Singapore.

The second method used for this ethnographic cross-cultural comparison was interviewing. Interviewing methods were described in Chapter 6, and were previously analysed through IPA in the separate country case study Chapters 6 – 8. The present chapter re-analyses the interviews from the case studies together, from an anthropological perspective. In total 39 students, academics and alumni of clinical psychology were interviewed: ranging from practitioners with over 30 years of experience, to students new to clinical psychology. Their demographic characteristics are summarised in Table 23. Official interviewing time was 30 minutes, but interviews often changed into conversations and some interviewees talked more easily when not being recorded. To take the participants' preferences into consideration, the recording was sometimes turned off and handwritten notes were taken instead. Observations and reflections on interviews and conversations were noted in the fieldwork journal. Interview tapes, transcripts, notes and reflections were analysed with a phenomenological focus from a cultural anthropology perspective on participants' ideas, world views and lived experiences (Jackson, 1996).

The third and final ethnographic method was the use of free-listing items, which were completed by the 172 students, academics and alumni of clinical psychology programs in the Netherlands, Australia and Singapore who participated in the survey of Studies 1a, 2a and 3a. As part of the survey, participants were instructed to write down at least five words they associated with the term *culture*, and at least five words they

associated with *clinical psychology*. Their answers provide insights into linguistic descriptions and conceptualisations of culture and clinical psychology.

Table 23. *Demographic Information of Interview Participants*

	Netherlands (*n* = 14)	Australia (*n* = 12)	Singapore (*n* = 13)
Group			
Students	5	8	5
Academics	5	4	3
Alumni	4	0	5
Gender			
Female	8	9	13
Male	6	3	0
Nationality*			
Local	11	8	10
Other	3	3	3
Double	0	1	0
Age groups			
24 or below	2	3	0
25 – 36	5	6	7
37 – 48	2	1	4
49 – 60	3	2	2
61 or older	1	0	0

* To maintain confidentiality, participants' nationality instead of cultural identification is listed

The sections below map the themes resulting from a phenomenological analysis of the ethnographic methods described above. These themes differ from the themes derived from the interpretative phenomenological analysis (IPA) used in Chapters 6 – 8. As described in Chapter 2, despite sharing a philosophical basis, IPA and anthropological phenomenology diverge considerably. The themes deriving from anthropological phenomenology presented in this chapter are based on multiple types of evidence, and invoke theory, rather than being derived from theory. Anthropological phenomenology also extends from the participants' experiences to my personal experiences and reflections during fieldwork, and the practice is reflective – which is also evidenced in the more personal writing style of this chapter. Finally, as the analysis is conducted from a cultural anthropology perspective, it is written in the present tense

as the 'ethnographic present' aims to provide readers with a sense of the fieldwork (see Chapter 2).

The ethnographic analysis below is arranged under five themes based on recurring issues during fieldwork, in interviews, and in free listing exercises; which participants emphasised as important to them personally or professionally; or which I, as investigator, identified as important to the research topic. The first three themes describe how students, academics and alumni purposely negotiate clinical psychology, while the last two themes indicate less conscious cultural negotiation. Each theme, presented below, is illustrated with quotes from a participant or observations made in my fieldwork journal. Again, brackets are used to identify material that was omitted or changed from the participant quotes for clarification or confidentiality.

Being Ethically Responsible

> *I think as a group, anybody from any different culture, obviously is a minority to start with but also gets marginalised by our very westernised concrete way of dealing with issues, and I think that can be quite isolating and marginalising for the people that do manage to break through their own personal barriers and personal beliefs about seeking help* – Student, Australia.

Participants in the Netherlands and Australia express the concern, illustrated by the quote above, that the 'western' mental health care systems in which they are involved marginalise people from cultural minority groups. Although the cultural, social and historical contexts for this concern differ in the Netherlands and Australia (see Chapters 5 – 7), the presence of this theme in these two case study countries indicates that some clinical psychologists in 'western' countries are concerned about having a reputation of being culturally insensitive. Participants in the Netherlands and

Australia express a feeling of personal responsibility for ethical cross-cultural practice; hence, they emphasise the need to improve their cultural competency.

According to the participants, cultural minority clients face a double marginalisation in mental health care systems. Firstly, for people with mental health disorders, it can be *"a struggle to reach a certain level of citizenship [because] as a group they are put outside of society"* – Alumnus, the Netherlands. The idea that people with mental health disorders are excluded from society resonates with the Foucauldian critique of psychiatry as the confinement of people with mental health disorders outside society (Foucault, 1965; Hook, 2007). Furthermore, in addition to this marginalisation, cultural minority clients are marginalised *within* mental health care systems: "*Mental health care staff is almost all white and in many parts of the Netherlands ethnic patients are seen as a problem. Because "they don't speak our language and they just don't do what we say."*– Alumnus, the Netherlands. The marginalisation of clients is thus worse for clients who are non-western, non-Caucasian, and who are not fluent in Dutch (in the Netherlands) or in English (in Australia).

A further disconcerting factor for many (future) psychologists is the experience of their peers, colleagues and teachers as culturally insensitive. Almost every participant I spoke with recalled encounters of cultural insensitivity by the hands of their peers. In addition, many consider the current cultural training opportunities in the Netherlands and Australia insufficient (see Chapters 6 – 8). Hence, (future) clinical psychologists feel stuck at their current levels of cultural competency.

Limitations of cultural training are also experienced in Singapore, although the concern for marginalisation of minority clients is absent in this context. Instead, students in Singapore express a concern for being ineffective in culturally negotiating 'western' clinical psychology in practice with their 'Asian' clients. They fear a vicious

cycle at the expense of the cultural competency of students, and eventually clients:

> *I think in a way it is a circular thing, because maybe [the academics] have not received adequate training in terms of cultural stuff, and when they are not very equipped they teach us and we are not fully equipped either. And then later on if we are ever to become supervisors then how are we going to do that?* – Student, Singapore.

The quote above confirms the importance of cultural competency training for academics in order to, in turn, role model and guide their students' cultural competency development (see Chapters 7 & 8). The sense of ethical responsibility to prepare for culturally sensitive practice creates situations in interviews where participants suddenly become emotional, gesticulate wildly or raise their voice – this is important. It shows that psychologists feel the need to purposely culturally negotiate clinical psychology.

Culturally Negotiating Practice

> *I think it would take your own clinical and professional judgement to decide what works best for your client. Like in certain countries there may be no straight following of a certain manual, and sometimes because of the environment there are certain things that you can't change to make them standardised, so you just take out the piece that you think is most relevant and what would be most helpful to use your judgement to fill in the gaps* – Alumnus, Singapore.

This alumnus' experience demonstrates that standardised procedures in clinical psychology can be negotiated during practice in Singapore. Such encounters are not unusual; the quote above is one of many instances in which I am told that the ideal, standardised procedures in clinical psychology are usually adjusted during practice.

These instances show that clinical psychology is de- and reterritorialised when it is interpreted and as it is applied (see Chapter 4). Thus clinical psychology is not a stable discipline but is always slightly changing through training and practice.

Reinterpretations of clinical psychology are often shared through informal learning networks. According one participant: "*I would say training in the adjustments is done quite informally. On the job training kind of thing, where you listen to people who have more experience and you learn from them*." – Student, Singapore. However, as subtle reinterpretations may be more frequently used, they can become conveyed into new norms which potentially lead to more long-lasting changes in the clinical psychology territory: "*Well it is quite fortunate that most of the test kits have been used for a few years, so there is some sort of standardisation, so some agreement on answers that are more suitable for a country like here"* – Student, Singapore.

Experiences from Singapore such as those quoted above indicate that clinical psychology is being purposely culturally appropriated – it is slowly being adjusted from a foreign import to a discipline that better fits the Singaporean context. However, widening the range of accepted responses for standardised questionnaires was also a common cultural negotiation in clinical psychology practice in Australia and the Netherlands. Negotiation and cultural appropriation of clinical psychology thus takes place in all three case study countries.

Participants' experiences show that clinical psychologists rely upon their own insights in judging which knowledge and practices in clinical psychology are useful for their clients (see Chapters 6 – 8). In an example from Australia, standardised norms for mental disorders in the DSM are interpreted differently to enhance the diagnosis for their clients' specific situations:

What is more important is the clinician's skills, like the number of patients they have seen before and what sort of range […] they normally fall under. And yes they are saying that sometimes diagnosis is more of an experience thing rather than just following the norms or following the DSM – Student, Australia.

As the quote above illustrates, clinical psychologists rely heavily on their own professional experience and expertise in order to develop a *"professional database"* that helps them to adjust the clinical psychology territory to their own cultural contexts. This means that once psychologists have developed a sense of competency in their clinical practice, they feel more confident in making adjustments to clinical psychology that suit their clients' needs. Thus, more de- and reterritorialisations of clinical psychology take place during training and practice of seasoned practitioners (see Chapter 8).

Clinical psychologists also engage with their clients in order to assess the needs for cultural negotiation in their practice. Psychologists aim to identify individuality in the experiences of mental disorders: "*It is not so interesting to look at the disease, or the sickness but it is more interesting to look at who is sick."* – Academic, the Netherlands. This academic provides an example from professional experience in which a client's personal story explains her symptoms of distress. Suddenly throwing hands in the air, the academic excitedly exclaims: "*And all of a sudden we understood where she came from! She was not psychotic, she was just a woman with a different background!"* Experiences such as this, as just one example of many, underline the importance of psychologists' therapeutic relationships with clients. Their personal engagement with clients helps them to better understand clients' perspectives and provides them personal fulfilment in their roles as helpers.

While many practitioners express confidence in their ability to culturally negotiate their practice, some participants feel overwhelmed with cross-cultural practice, or with the prospect thereof. Students especially express less confidence in cross-cultural practice, in all three countries. In the Netherlands and Australia, students use a cultural dialogue in which they invite their clients to address their concerns about cross-cultural practice, which was described in Chapter 7 and repeated here:

> *You sort of have a bit of a feedback session and say maybe at the end of the session: "I just want to bring something up, that you are from... you know... such-and-such culture, and I need to say that I haven't had much experience in working with this culture and I really want to make sure if we are a good fit for each other. So if there's anything I need to know about working with you, or if there's anything that I do that I am not aware of that would make you uncomfortable, it would be really good if you could just tell me because that is going to help me, you know, to make this a safe place and make me help you feel comfortable." So just sort of putting it out there, I suppose* – Student, Australia.

By taking clients' preferences into consideration, students in Australia and the Netherlands are paving the way for new ways of practicing clinical psychology that are line with culturally non-mainstream perspectives.

Expanding Rhizomes

A combination of professional competency and personal attention for each client provides practitioners with the drive to make adjustments to clinical psychology. Some experiences from participants in the Netherlands, Australia and Singapore suggest that these adjustments could potentially change the clinical psychology territory

considerably. For example, a participant from Singapore, who identifies as Muslim, says it helps clients if the practitioner at times incorporates religious counselling:

> *Singapore is very secular, so we are supposed to work secularly, but when I would see a Muslim client, and usually they tend to turn to religion to help them cope, so I'll be using those techniques. So, coping with prayer, with reading the Quran, different kinds of religious rituals that could help them* – Alumnus, Singapore.

The blending of clinical psychology techniques with other techniques is common practice in all three case study countries (see Chapters 6 – 8). By including different models practitioners adjust their practice to their clients' needs and, in turn, help their clients to adjust to clinical psychology methods:

> *So I have to adapt a little bit to their culture so then they'll think: "oh yes, this one will support me". Like one of them, she was from Malaysia, she wanted support too and then she asked me: "Can we do Tai Chi Ch'uan?" And I thought, yeah, we can do that too, because I know that can take your stress away partly, and then they are more open to Cognitive Behavioural Therapy too. Then they want to try new things too, for* them *new things* – Alumnus, the Netherlands.

Combining clinical psychology methods with other techniques opens up the clinical psychology territory to new experiences. Such experiences can form nodes that are more heavily charged – when they are used by more people and become more commonplace – and they may become influential in the clinical psychology territory (see Chapter 4). In the future, Tai Chi Ch'uan may potentially be a technique in clinical psychology as accepted as mindfulness has become in the past few years.

The combined experiences described above indicate that students, academics and alumni purposely negotiate clinical psychology. Clinical psychology's methods are adjusted, critically discussed and accompanied by new perspectives or techniques introduced by clients or practitioners. In this way, students, academics and alumni are potentially opening up the territory of clinical psychology to culturally diverse understandings of mental health and healing – expanding the rhizome (see Chapter 4).

The cultural negotiations described thus far in this chapter are consciously conducted by students, academics, and alumni. However, cultural influences in clinical psychology are sometimes less visible, which lead to actualisations in clinical psychology that are less obviously – or consciously – negotiated. Such subtle cultural influences on learning and practice through words and bodies are described in the next two themes.

Culture in Words

> *I think culture is just the way we do things, and it also relates to how we explain things to the patients as well. How do you explain depression to a patient who is using English and Mandarin, for instance, that will be quite different. It doesn't really map quite as nicely* – Student, Singapore.

Language is an important cultural element of expression. As the quote above indicates, psychological concepts are linguistic constructs, which limits their translation to another language. Relatedly, participants experience multi-linguistic practice as extra challenging because it is difficult to translate expressions of emotions, thoughts, or empathy to another language. Participants' use of language, concepts and verbal expressions of ideas shows how they culturally negotiate clinical psychology.

In order to understand how students, academics and alumni of clinical psychology conceptualise culture and clinical psychology, this research employed the method of free-listing items, along with fieldwork and interviews. The results are summarised in word clouds for each country case study (Figures 9.1 and 9.2). In word clouds, the relative size of each word indicates its frequency – larger fonts indicate that these words were frequently listed by participants. The number of words were limited to 150 for each cloud.

Word clouds of *culture* demonstrate some similarities in how the term is described cross-culturally (see Figure 9.1). In all three countries, the concepts *traditions*, *language*, *ethnicity*, *beliefs* and *values* are commonly associated with the term *culture*. This demonstrates a conceptualisation of culture as long-lasting characteristics of groups of people. Furthermore, the frequency of the words *differences* and *diversity* indicates an understanding of culture as a factor that divides groups of people (see Chapter 2). This suggests that cultural negotiations in clinical psychology practice are informed by notions of enduring differences between groups of people. Such notions of static, homogenous group identities are potentially problematic as they can lead to cultural stereotyping.

There were also differences in how *culture* was described cross-culturally (see Figure 9.1). Compared to Australia and Singapore, *art* and *food* were more frequent in the descriptions of Dutch participants, indicating an emphasis on material culture. Importantly, the word *race* was used by only one Dutch participant and is absent from the word cloud, while it was commonly used in Australia and Singapore, as was *ethnicity* in Australia. The concepts *race* and *ethnicity* rest upon a notion of inherent, innate and stable differences between people. The term *race* is commonly used in Singapore to denote culture, while in the Netherlands it is associated with eugenics and

discrimination. The absence of the word *race* in the Netherlands can be interpreted as a result of a taboo of the concept. However, the additional absence of the term *ethnicity* suggests that culture is considered more fluid and changeable by participants in the Netherlands compared to Australia and Singapore. Hence, cultural negotiations in clinical psychology practice in the Netherlands rely on more nuanced notions of culture and may be more subtle compared to Australia and Singapore.

Cultural categories and binaries are other conceptualisations of *culture* which emerged during fieldwork. The binary categories of 'individualist' versus 'collectivist' culture is used by approximately a third of the interview participants. This distinction is often equated with opposition of romanticised 'eastern' versus 'western' cultures.

> *I think that is a very western idea to pay someone to help you fix your problems. Whereas I feel like in other cultures, it is more of like a less of a focus on the individual, I feel like more you are as part of a unit, so you feel like you would get that help from family members, friends, from their community rather than [to] pay someone to do it for them* – Student, Australia.

The student quoted above describes the common notion of clinical psychology as an expression of 'western' individualism. The opposition of 'paying someone to fix your problems' versus 'getting help from the community' indicates that the student regards collectivist cultures as more caring and inclusive than individualist cultures. At the same time, by stating that consulting a clinical psychologist requires payment, the quote can be understood as a subconscious critique of clinical psychology's individualist ethos and business mode. Such idealised ideas of 'other' cultures make psychologists eager to take clients' perspectives into consideration in clinical psychology practice.

Figure 2. *Cross-Cultural Comparison of Word Clouds of* Culture

2a Netherlands

2b Australia

2c Singapore

Linguistic constructions of cultural binaries of east versus west problematically rely on notions of homogenous history and identity, and ideas of static, contained cultures (Bhabha, 2012; Spivak, 2008). As stated previously, such conceptualisation of contrasting cultural categories may reinforce cultural stereotypes:

> *I tried using a cultural framework once with an Asian client, but I really hated it. I thought well this is a more collective culture and there my framework interfered with me adjusting to the framework of my patient. I was stereotyping the client and making a big mistake. So now I will ask questions. I will ask the patient instead of filling in the blanks myself* – Academic, the Netherlands.

Relatedly, cultural categories based on race or ethnicity may lead to racism. During fieldwork I encountered racist ideas a few times. Some of these encounters shocked me, for example when I was told that a particular racial group would have "*a specific gene for aggression*" – Student, Australia. Some interview participants also shared their encounters with racism during their clinical psychology training and practice – their expressions and body language during these moments revealing their pain or shock. Nevertheless, as the academic quoted above describes, some practitioners focus on understanding each person's unique situation instead of focusing on cultural traits. Such deconstructed notions of cultures may help to counter racism.

Word clouds were also constructed for free-listing of the concept *clinical psychology* to provide insights into how clinical psychologists conceptualise their profession (see Figure 9.2). The clouds show that *mental health*, *therapy* and *treatment* were commonly used concepts, associated with clinical psychology in all three countries, as were *helping* and *empathy*. Cross-cultural differences also emerged. The concepts *assessment* and *formulation* were frequently used in Singapore and Australia but in the Netherlands *therapy* was more frequent, indicating a different emphasis in

clinical psychology practice. Furthermore, the term *evidence-based* was prominent in word clouds for the cases of Australia and Singapore, while in the Netherlands *DSM* (an abbreviation for the Diagnostic and Statistical Manual of Mental Disorders) was prevalent, demonstrating a reliance on scientific discourses and standardisation.

Words and concepts are thus an important way in which culture is negotiated in clinical psychology. Ways of talking about people, groups, culture and differences reveal how psychologists negotiate culture in their training and practice. Next to words and concepts, the use of language as a means of communication is another way in which culture is expressed and negotiated. Communication is an important avenue for cultural influences on training and practice of clinical psychology. After interviewing in Singapore, I reflect in my journal:

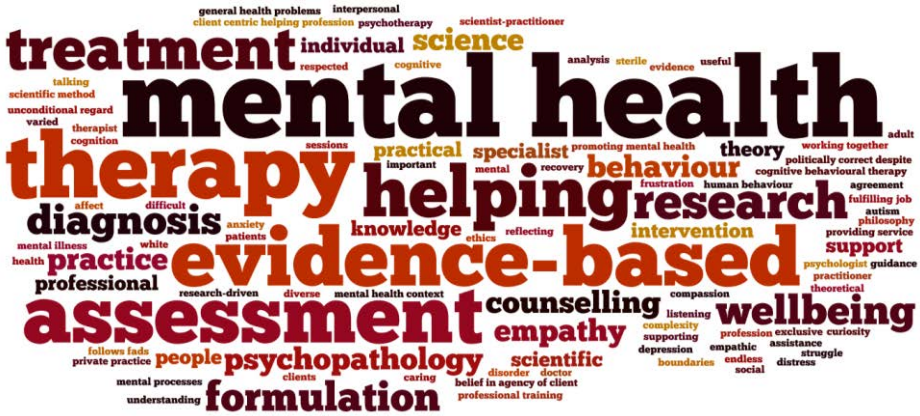
> *When Singaporean interviewees verbally express critique they tend to end with a question or dismissive remark. For example, one interviewee ended all her critical remarks with the phrase: "But I don't know, maybe?"* – Fieldwork journal, May 2014.

Often, apologetic expressions such as the one described above are accompanied by specific body language, such as looking away. Consequently, an analysis solely based on language neglects many other ways of experiencing and communicating, such as through body language and facial expressions. For that reason, phenomenological anthropology also aims to analyse experiences and ideas before they are expressed in words, for example as they are embodied through actions (Jackson, 1996). Therefore, cultural expressions and negotiations through bodies are discussed in the next section.

Figure 3. *Cross-Cultural Comparison of Word Clouds of* Clinical Psychology

3a Netherlands

3b Australia



3c Singapore

Embodied culture

> *And I guess I always think that I feel like I look different to other people. And maybe I do, maybe I don't. But in my mind because it comes into my own thinking that I know that I am from mixed cultural background that is something that comes into my own identity?* – Academic, Australia.

The quote above indicates that bodies exert cultural influence. Skin colour is an important part of the participants' identity, as people respond to the participants' appearance. People automatically respond to cultural bodies, whether or not we see ourselves as *"colour blind"* – a term that is frequently coined by interviewees. In my fieldwork journal, I ask myself the question: *What does it mean when people say that they are colour blind? Are they denying a part of someone's identity?*– Fieldwork Journal, March 2014. Despite the sensitivity around and taboos on colour and cultural appearance in our postcolonial world, these are aspects of cultural identity that clinical psychologists have to work with.

Body language is another way in which culture is expressed and experienced through the body. The amount of eye contact, the use and tone of the voice, the positioning of bodies, the use of facial expressions and hand gestures, and sometimes the use of bodily movements where words fall short – these aspects of culture differed in each interview or social encounter. The omnipresence of embodied culture can create a sense of hyperawareness during cross-cultural practice:

> *I felt like I was more aware of how I was sitting, how I was talking to the client, my tone of voice, whether I was making eye contact. All of these non-verbals that you normally do not think of when you're sitting with a client, but I guess I was more aware, if you can be* – Academic, Australia.

Such experiences indicate how culture permeates each level of human interaction through bodies and language. Cultural experiences are thus always part of clinical psychology training and practice, and are negotiated through both language and bodies.

However, experiences during fieldwork indicate that cultural experiences based on one's cultural presence are highly context-dependent and show that culture is always relational. How one experiences one's own culture is always in relation to ideas of 'other' cultures. For example, as a Dutch person living in Singapore, I am considered to be a cultural insider by Singaporean students in Australia and the Netherlands: *"I'm so happy to speak with someone who understands me!"* – Singaporean Student, Australia. However, I am considered a foreigner by Singaporeans who study in Singapore: *"Sorry if this cultural talk becomes too complicated for you"* – Student, Singapore. The unfamiliar context of Australia and the Netherlands makes participants emphasise our shared Singaporean basis, while in the familiar context in Singapore my foreignness stands out. In other words, although my embodied culture – e.g. white skin, female, particular style of clothes, Dutch accent speaking in English – does not change, it is perceived differently depending on the context. People's appearance is an important factor, but not the sole factor that determines cultural in-group and out-group.

The relationality of culture is central to Bhabha's (2012) description of culture as 'the thing it is not'. This theory of the context-dependency of culture also underlies the notion of culturally appropriate services: the referral of a client to a practitioner with a shared culture. The idea of a shared culture between practitioner and client can only be created in the context of a surrounding culture that is even more foreign.

The cultural context also influences conceptualisations of culture. For example, my cultural presence primes the research participants to think about culture in specific

ways, which are not always predictable. For example, after one interview the participant emailed me:

> *I felt I talked a lot about an East vs West culture as if it was a dichotomy. I think you coming from Singapore primed me to think that way. Of course culture is much more broad and can consider sexual preference, age, child vs adult vs older adult, and whether living in rural/remote vs urban areas* – Student, Australia.

The reflections from the student quoted above demonstrate the relativity of notions and experiences of culture, as well as the participant's explorations of the frameworks and conceptions of culture. The relativity of notions of culture indicate that negotiations in clinical psychology training and practice are not always predictable.

Conclusion

> *I guess... earlier when you were asking me: "What made you decide you want to do this interview," I think in the back of my mind I just want to be helpful. But at the same time, I think that even though it is not like I go around to say: "oh my number one favourite thing to talk about is culture!" I won't say that it is but [my experience of working] here, it made me really think when I saw your research theme it made me think: Yes, maybe if we had more of this in [university] then perhaps I wouldn't face some of the difficulties that I face, in terms of seeing ignorant, stereotypic views of culture in my work setting and, you know, knowing how to be culturally sensitive* – Alumnus, Singapore.

Issues of culture can be an uneasy conversation topic for clinical psychologists as it contrasts with the premise of human universality that supports their discipline. However, this chapter demonstrates that culture is an intrinsic part of clinical

psychology training and practice. Some participants purposely engage with cultural issues during their training and practice. These participants emphasise psychologists' ethical responsibility to provide adequate cross-cultural services and to address discrimination and marginalisation through, and within, their practice. However, cultural messages and ideas are also conveyed in descriptions and categories and are unknowingly communicated and embodied. The diversification of student and client populations show that clinical psychology training and practice is more multicultural than ever before. "*Knowing how to be culturally sensitive*", as the title of this chapter suggests, is a central learning aim in clinical psychology.

10. “This is the World Standard”: An Ethnographic Comparison of Clinical Psychology Training and Practice

This is the second of two anthropological chapters that re-analyse the case studies of clinical psychology in the Netherlands, Australia and Singapore together. Analysis of ethnographic fieldwork and interviews illustrates how the territory of clinical psychology is delineated through engagements with external factors, including learning cultures, discourses of science, and global eduscapes.

This is the second and last chapter to re-analyse the case studies of clinical psychology training and practice in the Netherlands, Australia and Singapore together from a cultural anthropology perspective. Chapter 9 mapped cultural negotiations in transnational knowledge in clinical psychology. It demonstrated that clinical psychology is always culturally negotiated during training and practice, whether purposefully or unknowingly. Chapter 10 takes this conclusion further by highlighting how these negotiations are shaped by cultural contexts, ideas of science, standardisation and global eduscapes. As the title of this chapter suggests, these factors create a notion of clinical psychology as a discipline of world standard. However, these factors can also instil ethnocentrism and even neo-colonialism. These delineating factors thus refer back to the risk of cultural imperialism in present-day higher education, introduced at the beginning of this thesis (see Chapter 1).

As with the previous Chapter 9, this cultural anthropology chapter draws on the theoretical insights provided by interdisciplinary theories of globalisation, deterritorialisation and power/knowledge (see Chapter 4), and utilises ethnographic methods in order to analyse these factors based on the experiences of students,

academics and alumni on the ground. Ethnographic data are derived from three methods: fieldwork, interviews, and free-listing exercises with students, academics and alumni of clinical psychology in the six case universities. These data are (re)analysed from an phenomenological anthropology perspective, described in Chapter 9. Such a perspective reveals seven themes that show how external factors influence participants' lived experiences of clinical psychology. The themes are organised in this chapter to indicate these external factors' increasing scope, beginning with more personal factors and ending with notions of globalisation.

"Does a Fish Know it Swims in Water?"

> *It is really hard to see which aspects we are learning are really exaggerated western components that to someone who is not Caucasian will be "oh my God, that's so western!" To me, I'm not going to be sensitive to that material, so it is hard for me to know how western it is because I* am *western* – Student, Australia.

Participants in Australia and the Netherlands – two countries which can be characterised as culturally diverse but mainly 'western' – express concern about unknowingly holding ethnocentric views of clinical psychology. Participants who identify as culturally western are afraid of being the metaphorical fish which is unaware it swims in water – feeling so at home in 'western' clinical psychology, that they will not notice its western ethnocentrism. This gives rise to their disconcerting feeling of failing to identify and negotiate cultural issues in clinical psychology practice.

During fieldwork in the Netherlands I also experienced how easily influences related to one's own culture are dismissed (I was born and raised in the Netherlands):

For some reason haven't felt the need to write in my research journal for a while. However, I do see many peculiarities in the ways clinical psychology is practiced here, but I guess they just not strike me as much as in Australia or Singapore – Fieldwork journal, May 2014.

Perhaps similarly, participants who identify as culturally mainstream can easily dismiss western cultural influences on clinical psychology. In contrast, people who are immersed in different cultures may consider cultural influences on clinical psychology more obvious and important. In Australia and the Netherlands a relatively large proportion of the people who volunteered for interviews identified as cultural minorities, international students, or of mixed heritage. This suggests that these multicultural individuals considered the research topic more important, hence they were more likely to participate in the research.

This finding implies that it is especially important for majority students, academics and practitioners to become aware of the cultural biases in clinical psychology. In the words of one participant:

I think the answer lies with the people who don't know that they live in a culture. Which is essentially most clinical psychologists in Australia, who live in the dominant culture – Academic, Australia.

These experiences from the Netherlands and Australia suggest that people who are immersed in different cultures are more likely to experience the clinical psychology territory as biased towards western mainstream culture – and more likely to actively culturally negotiate clinical psychology. People who are only familiar with western cultural mainstream Dutch and Australian experiences, for instance, are more likely to consider the clinical psychology territory as universal and internationally applicable (see Chapters 6 & 7). Interestingly, no Indigenous Australians or people with Turkish

or Moroccan heritages – prominent ethnic minority groups in Australia and the Netherlands respectively – volunteered for the interview. It would be worthwhile to explore the representation of these cultural minority groups in clinical psychology training and practice.

"Offering Their Expertise"

> *Because we are such a young country and even today, I don't think we are very grown in this field yet and for that reason I don't think we have enough experience and enough, you know, information generated through research or through clinical practice to resolve what our future direction would be. So because of that I think it is not surprising to hear that we are drawing practices from all these other places where psychology is much more established* – Alumnus, Singapore.

The dependency on foreign resources in clinical psychology in Singapore was demonstrated in Chapter 3. The quote above indicates that this situation is justified by the notion of Singapore as a young country that is constantly improving itself – as the national motto '*Majulah Singapura*' (Onward Singapore) suggests – and with clinical psychology as a new field in the country. This discourse of Singapore's external dependency is powerful and prominent in the country and it has been described as a justification for the government's and university boards' neoliberal and internationally-focused education policies (Sidhu, 2005). In clinical psychology, it justifies a reliance on foreign resources, instead of a focus on developing resources locally.

The adoption of clinical psychology is regarded as modernistic development, or progression of the country's health care system. Singaporean participants were grateful for Australian influences. One participant tells me that Australians *"really want to*

transfer the knowledge and grow the field of psychology outside Australia by offering their expertise" – Student, Singapore. After this conversation I reflect: "*The participant talks about Australia almost in an old Colombo-plan manner: a return to development aid through knowledge sharing?"* – Fieldwork journal, June 2014. This perspective on clinical psychology in Singapore denotes a notion of modernistic development, and suggests that clinical psychology is internationally transferable and universally applicable, and requires little modification in Singapore.

Singaporean students feel they benefit from foreign perspectives in clinical psychology by learning professional skills which were considered essential for clinical psychology practice, but which were regarded as going against cultural norms – such as disclosing emotions or interrupting others. One participant recalls how her foreign supervisor helped her take a more guiding role in therapeutic conversations:

> *So initially I struggled with interrupting patients, because to me that's rude, right, culturally that's rude. But for him it's like: "what's wrong with that? Because the person is rambling on and on and on, therapeutically that's not helpful." So I think that's quite helpful as well and when I actually do it, it is not quite as I feared. They don't take it negatively if you explain why you're doing that. So [it is] not as rude!* – Alumnus, Singapore.

However, while participants value the new practices and cultural norms introduced by clinical psychology, they sometimes experience resistance from clients:

> *I'm trying to set up support groups. But we're getting resistance left, right, centre, and all that. So feedback I've been getting is that some patients even said: "I'm not Caucasian, I don't want to talk about my feelings!" So these are all successful programs that we read about in the literature, that we hear about from overseas. So it doesn't make sense why it wouldn't work in the*

Singaporean context – Alumnus, Singapore.

The above quote indicates that clinical psychology, and especially the practice of disclosing emotions and personal experiences in therapy, can be experienced as western in Singapore (see Chapter 8). The critique expressed by clients that group therapies are "Caucasian" indicates the perception of clinical psychology as foreign and 'white', and reveals the perception of a contrasting, non-western, "Asian" identification of many Singaporeans (Yeo, 1993, p. 29).

Thus, while psychologists in Singapore largely perceive the import of foreign ideas in clinical psychology as beneficial for the mental health care in their country, the quote above indicates that sometimes clients object to 'western' ideas and practices in clinical psychology. This reveals that clients can drive cultural negotiations – by resisting 'western' practices, they force psychologists to adjust their practice.

The next section shows that students and alumni's cultural negotiations of western influences in clinical psychology are especially apparent during training and supervision with foreign academics.

(Post)Colonial Teaching

> *And a lot of the times I say to them that: "I know you wouldn't do this, this is what I would do in my home country. Let me just tell you how I would deal with that back home, because that's my expertise, that's what I'm bringing. And then you tell me how to do it here"*– Academic, Singapore.

As the quote above indicates, foreign academics are aware that they bring western perspectives in clinical psychology to Singapore. These academics , some having had little practice in Singapore, experience limitations of their local cultural knowledge, and in response, they actively try to explore and discuss cultural issues in

supervision. To foreign academics, providing supervision in Singapore can be a valuable two-way learning process. Students and alumni in Singapore recognise the efforts of foreign academics to embed their teachings in the local context. Some even state that "*the non-local academics were more interested in culture than the locals*" – Alumnus, Singapore.

While some aspects of 'western' clinical psychology are welcomed in Singapore, other aspects are considered less beneficial. Supervision between local students and foreign academics sometimes provides unwelcome western cultural influences. Most students and alumni are reluctant to critique academics. My fieldwork journal describes several occasions where I stopped the audio-tape to end the interview, at which point participants started to open up about difficult experiences with foreign supervisors. For example, students receive advice from their supervisors on their clients' therapy that they consider inappropriate. Often, such advice can be *"repackaged"* in the delivery to clients, but other times it is not useful at all. Thus, some western ideas presented by supervisors were culturally negotiated, others were ignored.

In addition, perceived power differentials and (post)colonial relations influence academic-student relations:

> *Sometimes […] after a session or after the lessons, we will talk and kind of say like: "oh our lecturer wasn't behaving very appropriately. He didn't seem to have the cultural context of how he spoke of things without thinking that: 'oh I'm a white person, coming from a country that used to rule this country!'"* – Alumnus, Singapore.

The quote above shows how critique from foreign academics on practices in Singapore, such as hiding emotions or spanking children, can be experienced as a

continuation of colonial repression of culture. Students and alumni do not openly challenge foreign academics or supervisors, but discuss their academics' *"inappropriate remarks"* with their peers. This means that western cultural knowledge in clinical psychology is mainly negotiated outside the classroom.

In addition to (post)colonial power differentials, students and alumni perceive an unevenness in cultural knowledge: they feel that they know a lot about western cultures, but academics from western countries do not know a lot about Asian or Singaporean cultures. This shows that western culture is still dominant – 'others' can benefit from knowledge from the west, but not the other way around. There is no need for people from the west to learn about 'others' and their knowledges. Such a (post)colonial unevenness in knowledge valuation currently takes place in clinical psychology education as Australian universities define the norms for clinical psychology training in Singapore (see Chapter 3).

This (post)colonial situation is not unique to Singapore. In the Netherlands, international students from Asia and other regions are invited into Dutch universities for clinical psychology training. These international students are discouraged from practicing in the Netherlands as clinical psychologists, as academics tell them that the country only needs psychologists who are Dutch. So, the potentially valuable perspectives brought by international students and alumni are disregarded, while Dutch perspectives are considered useful in international students' home countries. This indicates a colonial continuation of the prioritisation of some cultures and perspectives and dismissal of other perspectives.

Learning Cultures

> *We expect students to be independent, to ask questions whenever they have a question and to come to you if they have a problem. And I don't expect to be right, you can tell me if I'm wrong. […] And this is too much of a culture change for international students, so now every time I have an international student, I start by explaining this* – Academic, the Netherlands.

Many academics in the Netherlands, Australia and Singapore prefer to teach clinical psychology in ways that promote independent learning. Instead of positioning themselves as experts who instruct their students, academics aim to help students find solutions and answers independently. This type of independent problem solving is a central tenet in therapy. Therapist-academics help client-students think and fend for themselves. Individuality and independence is promoted in both clinical psychology therapy and training.

The relation between independent learning and individuality made some participants in Singapore consider this non-hierarchical learning style 'western' teaching, as opposed to a more 'eastern' teaching styles based on apprenticeship. Students in Singapore, but also international students in the Netherlands and Australia, often struggle to adjust to non-hierarchical learning cultures. This difficulty can create a false sense of openness and equality in teaching relations in which students continue to experience power differentials while academics are trying to bridge hierarchies:

> *At the end of the day as trainees, I don't think that we have a very active voice, especially [as] we feel like we don't have avenues to talk about these things because... […] can you do it in a safe environment in which you feel like it won't affect your grades, so it won't affect the relationship? I'm not sure* – Alumnus, Singapore.

Social hierarchies and perceived power differentials may thus interfere in two-way learning processes between students and academics. Students refrain from introducing cultural ideas into clinical psychology training, or from challenging their lecturers' or supervisors' suggestions. As a result of social hierarchies, academics' views are prioritised, and clinical psychology territories are left uncontested.

Informal learning networks are an important way in which clinical psychology is taught and learned outside the social hierarchies (see Chapters 6 – 8). Convening with peers, sharing tips and articles with a colleague, attending a workshop with friends – these are important and influential ways in which clinical psychology is also taught and learned. It also shows that training in cultural sensitivity is not dependent solely on official clinical psychology training: *"There's heaps of people, like the Indigenous chief [sic] I mentioned, she knows a lot and she's very well-respected in the Indigenous community as well as outside. So you've got all those resources!"* – Student, Australia. These informal networks have the potential to open up learning cultures in clinical psychology, while formal training opportunities – discussed in the next themes – are becoming more and more standardised.

Standardisation: Closing the Territory

> *Our program is more or less dictated by the post-master training programs. They have entry requirements and we have to make sure that our students when they graduate fulfil those entry requirements and that dictates to a certain extent the kind of courses we give them* – Academic, the Netherlands.

In the Netherlands, master's training in clinical psychology is generally regarded as a preparation for post-master programs (see Chapter 6). As the quote indicates, standardisation of master's degrees into one year programs and the strict

entry requirements for post-master education are sometimes experienced as a straightjacket for academics involved in clinical psychology training. Academics feel there are no options to teach clinical psychology in alternative ways.

As a result of standardisation, academics are time-pressured to teach their students the necessary baseline skills. Importantly, these baseline skills do not include any cultural topics or cultural sensitivity training: "*Of course I think it would be very important to make people sensitive to cultural differences. But […] there is no time" –* Academic, the Netherlands. Standardised clinical psychology programs thus neglect cultural issues. Standardisation is implemented to manage change in academic programs, the experiences from the ground indicate that it prevents cultural negotiation.

In Australia, clinical psychology degrees are standardised and accredited by the Australian Psychological Accreditation Council (APAC; see Chapter 3):

> *So the postgraduate program was designed to comply with APAC, I'm not sure what that stands for... So it was designed to be complied with those guidelines that are set to ensure that there is a good standard of training of postgraduate clinical psychologists* – Academic, Australia.

The quote above shows that accreditation is important to Australia's clinical psychologists as an assurance for quality of their degrees. However, as the guidelines are taken for granted – even the full name of the accrediting body is taken for granted and is unknown – a reliance on standardisation may prevent critical scrutiny of the relevance of accredited degrees (see Chapter 7). As a result, curricula were not improved with insights regarding the experiences and needs of students, academics and alumni on the ground.

In contrast, in Singapore the *lack* of standardisation influences the perception of clinical psychology in the country as underdeveloped. The absence of standardisation

and accreditation are important reasons for aspiring clinical psychologists from Singapore to study abroad:

> *I thought it didn't make sense for me to go with a very young, unrecognised program when I can be in a more recognised program and sort of gain some steps towards actually being registered with a board because in Singapore there isn't a board for clinical psychologists. Accreditation gets me up to a better position to practice more globalised* – Singaporean international student.

To Singaporeans, an accredited degree in clinical psychology means being recognised internationally, and achieving a higher quality and more prestigious education (see Chapter 8). As Australian degrees are accredited by APAC, clinical psychology programs provided by this regional neighbour are a preferred choice for international students from Singapore.

The situation in which Singaporeans seek Australian accredited degrees depends on the notion of clinical psychology as internationally transferable and universally applicable. However, actual experiences from training and practice can create friction with this notion of universality:

> *Well, I thought that my training was all western. But one of the things one of my Australian lecturers said was like stuck in my head until now. She said that no matter what culture you're from, the same principles apply and the same treatment has been found to be effective. I thought that even if I come back to Singapore and there will be Malays, Chinese and Indians, it should work with them. [LG: And does it?] Not really, no* – Alumnus, Singapore.

The quote above shows the problem of ethnocentrism in standardised and accredited clinical psychology degrees. Standardisation is a specific actualisation of

clinical psychology and a way through which organisations and universities exert cultural influence on the discipline. Standardised curricula are thus always influenced by culture; however, accreditation provides the newly standardised territory with a notion of universal applicability (see Chapter 4). APAC exerts such a cultural influence on clinical psychology programs in Australia and Singapore (see Chapter 3), while post-master programs play the same role in the Netherlands.

"We're Teaching Science Here!"

> *How to deal with cultural difference in therapy is not that structurally addressed in the program because if you want to give lectures about it you need to have a good theoretical and research-driven framework. […] We try to teach them evidence-based psychology. Not hugging with trees* – Academic, the Netherlands.

The scientific basis of standardised clinical psychology education supports the notion of clinical psychology as a rational, scientific discipline. According to the academic quoted above, evidence-based therapies are the opposite to *"tree hugging"* – denoting practices which are considered irrational or emotive, the domain of shamans or spiritual healers, in contrast to the clinical psychology profession.

However, the evidence-based approach is not unanimously considered beneficial among all interview and fieldwork participants because clinical psychology's knowledge base is influenced by culture. Students in the Netherlands point out that it is important to understand *who* constructs clinical psychology knowledge, and with what methods (see Chapter 6):

> *If you look at the big names in psychology: a lot of old men with beards! You cannot find any Black people or any Asian people or whatever. I'm sure*

there are but we just don't know enough about them here, even women, there aren't a lot of female big names in psychology, a least not in its history – Student, the Netherlands.

The quote above indicates that some students regard scientific knowledge in clinical psychology as problematically cultural. Knowledge production in clinical psychology largely depends upon American and European research. Consequently, clinical psychology is considered to be slanted towards working with western client populations, which is especially problematic in Singapore:

All the textbooks we had and all the articles we read, it is just really quite written on the US and the European populations. Sometimes when you want to do research and you search for articles it is really hard to find articles relating to how to treat a Chinese or a Malay – Student, Singapore.

The quote above shows that knowledge in clinical psychology is not necessarily regarded as universal and cross-culturally transferable. The cultural underpinnings of knowledge are also recognised by interview participants. However, scientific clinical psychology knowledge is presented to the students as if it is universal. This reveals the power/knowledge effects of science (see Chapter 4).

Power/knowledge effects of psychological science prioritise some values, experiences and knowledges, and subjugate others. One participant summarises how the scientific bias subjugates cultural minority perspectives: *"we have a good view on health, and cultural minorities need to learn our view. You could summarize it as an imperialistic idea"* – Alumnus, the Netherlands. Thus the idea of an evidence-based and universally applicable clinical psychology potentially makes practice ethnocentric: *There are a lot of practitioners who come in and say: "so that's the world standard. You've got to go from where you are to here"* – Academic, Singapore.

Due to power/knowledge effects clinical psychology is sometimes experienced as prescriptive. For example, slamming her fist on the table, one student recalls the frustration she felt in response to the absolutist norms presented during training: *"It's that there! That! That! We don't do that! It's always like that!*" – Student, the Netherlands. The student also recollects experiences of volunteering alternative cultural perspectives on mental health and therapy during classes, to which the tutor responded: *"'No, this is the way we're supposed to do it'. And the way he said it was a very like: this, this, this, this is the truth!".* These experiences illustrate power dynamics in classrooms, in this example with a gender aspect. Due to power/knowledge effects of scientific discourses, people who are considered clinical psychology 'experts' subjugate ideas and perspectives of people who they consider less knowledgeable of clinical psychology.

Discourses of science restrict the territory of clinical psychology. Ethnographic data and contemporary literature indicate that criteria for science are often problematically defined as knowledge that is based on 'western' experiences and research methods (Appadurai, 2006; Ng, 2012b; Yang, 2006). Evidence-based clinical psychology is biased towards experiences and ideas of Caucasian males in western countries (Arnett, 2008; Haque, 2008; Henrich et al., 2010; Ng, 2012a), even though power/knowledge effects reinforce the notion of clinical psychology as a universal truth. This limits psychologists options for cultural negotiation.

"We Bring You The World"

I'm reading university brochures. They proclaim: "We are Asian and global" and "We bring you the world," and show pictures of cityscapes, people in white coats and business outfits, and world maps. It must be great to explore

'the world' as a student or academic of this prestigious university. But I wonder: how can you make sure you are prepared for serving the needs in your neighbourhood? – Fieldwork journal, March 2014.

Fieldwork experiences such as the one described above illustrate how eduscapes emphasise globalisation of education and the workplace. Chapter 4 described eduscapes as social imaginaries of the globalisation of education, which take shape through representations and enactments of international reach by intellectuals, policy makers, lecturers and students. On websites and in brochures and advertisements of the case study universities, I read phrases such as "top 100 universities," "leading international university," and "global impact" on nearly every page. Universities thus engage in a discourse of internationality that is related to eduscapes of globalised higher education.

The context of global eduscapes creates a notion of shared, international standards and norms in clinical psychology. The availability of external resources is an especially important way in which globalisation of education is experienced. It inspires the idea that clinical psychologists are part of a global community:

I think [clinical psychology] would be classed as internationally relevant because really, we're drawing on textbooks and resources and online resources from Canada, and the United Kingdom and North America, like the United States. So I would say it is very much international – Academic, Australia.

In addition, global eduscapes reinforce a notion of clinical psychology as a globally relevant business:

If we really want to be an international hub in Singapore for clinical psychology, I think that definitely we need to learn from people from the Middle East. Clinical psychology is also a business, so that means that there will

ultimately be a need to work with individuals from that country – Student, Singapore.

The 'hub' thinking in the quote above characterises ideas about fast economic development and progress in Singapore and in other parts of the Malay Archipelago and the world – the frantic development of global education hubs, creative hubs, technology hubs, and meetings, incentives, conferences and exhibitions (MICE) hubs, are just a few examples of processes of hub development for economic gains (Ford, 2008; Knight, 2011). In the quote above, the imaginary of creating a hub for clinical psychology in Singapore portrays the profession as a business profession that aims to attract opening markets of clients.

Relatedly, clinical psychologists in all three countries express the perceived need to prepare for increasing globalisation and internationalisation of their profession. Universities are answering this perceived need by internationalising education. For example, English language is adopted in clinical psychology training in universities in the Netherlands (see Chapter 6), and Australian universities initiate collaborations with Singaporean ones to expand their impact (see Chapters 7 & 8). Internationalisation of university education is an important trend as universities are encouraged by governments to participate in neoliberal globalisation (Sidhu, 2005).

The ethnography shows that people 'on the ground' can experience internationalisation and globalisation as a top-down process initiated in government settings or university boardrooms. This could lead to resistance:

Not all teachers wanted to participate [in internationalisation]. Nobody asked them if they wanted to do it. But gradually we got used to it, all the classes were designed anew and now we have a large amount of international students – Academic, the Netherlands.

The academic quoted above seems to suggest that globalisation is an unstoppable process, as the internationalisation of clinical psychology education went ahead even without academics' efforts.

These data show that by engaging in discourses of global eduscapes, hub thinking and internationalisation, students, academics, and alumni of clinical psychology programs in the Netherlands, Australia and Singapore create and reinforce a notion of a globally applicably and relevant clinical psychology, which is reinforced by notions of universal scientific evidence (see previous theme). Furthermore, the training and practice becomes embedded in broader ideas of economic development through globalisation, which creates a notion of clinical psychology as a health care business. Such ideas provide an important rationale for the standardisation of clinical psychology education, a theme described above.

Conclusion

> *We [students] just look at each other. Like what's there to say, I guess. Sometimes we might speak up [to our lecturers], but at the same time you think: do I really want to speak up? […] So a lot of it is just, well you know, you just give your friends knowing looks and just....* – Alumnus, Singapore

This chapter demonstrates that cultural negotiations in clinical psychology are restricted and shaped by the power/knowledge effects wielded by the territory of clinical psychology. As people engage with clinical psychology, they sometimes experience the discipline as universally applicable, but at other times as prescriptive and neo-colonial. The latter experience invokes a feeling of powerlessness, as the quote above shows. Psychologists' cultural negotiations and appropriations are restricted by factors delineating the discipline: (post)colonial power differentials, discourses of

modernistic development, standardisation, discourses of science, and global eduscapes. However, referring back to the quote above, the *"just..."* is when and where the cultural negotiation takes place: not in the classroom, but in informal learning networks; not in the standardised diagnoses, but in shared understandings between practitioners and clients; not audio-taped, but off the record. Thus, while holding up the ideal of a single, universal clinical psychology, psychologists actively create and work with numerous and intertwined territories of clinical psychology – each of which are always in becoming stasis and flow.

11. Conclusion: Cartographies of Cultural Negotiations in Transnational Knowledge

This Master of Philosophy thesis has mapped cultural negotiations in transnational knowledge through cases of clinical psychology in the Malay Archipelago and beyond. The study of transnational knowledge is of central importance in today's globalised higher education landscape as academic disciplines can become vehicles for cultural imperialism – spreading knowledges, epistemologies and world views that dominate alternative views within and across countries and cultures (Rizvi, 2007; Yang, 2013). The thesis answers to the critical need to understand how transnational knowledges can be culturally negotiated by identifying factors that enable (post)colonial one-way flows of knowledge as well as opportunities to counter such processes through training and professional practices.

Clinical psychology in the Malay Archipelago and beyond is an especially relevant case study of transnational knowledge. Clinical psychology was introduced into the Malay Archipelago and Australia during the colonial period and continues to regard knowledge that is based on 'western' experiences as universally applicable. Critical literature has called for the necessary evaluation of the cross-cultural applicability of American-based knowledge in clinical psychology (Arnett, 2009; Chang, 2012; Davidson, 1993; Henrich et al., 2010; Ng, 2012a). In response to this call, this thesis provides a comprehensive investigation of transnational knowledge in clinical psychology through multidisciplinary, multinational and multi-sited case studies. The case studies of Singapore, Australia and the Netherlands present a glimpse of the tension between (post)colonial dependency on western knowledge and cultural negotiation in transnational knowledge in the Malay Archipelago, Australia, and

Europe. This research has utilised Singapore as a case study for the Malay Archipelago, cultural negotiations may be different in other countries in the Archipelago, such as Indonesia and Malaysia. It is hoped that this research will be taken up and furthered by future case studies.

Cultural Negotiations in Transnational Knowledge

Four conclusions regarding cultural negotiation in transnational knowledge are derived from the case studies.

A first conclusion is that transnational knowledge forms a territory that is negotiated from 'above' (professional organisations, education institutions) as well as from 'below' (students, academics, practitioners). 'Above' and 'below' are not binaries but a continuum that distinguishes power differentials influencing the territory. The case studies demonstrate that individuals in, for example, professional organisations provide powerful interpretations of the discipline, which are solidified in fixed spaces of enclosure – such as protocols – and valued as universally applicable. Through spaces of enclosure, professional organisations delineate the clinical psychology territory. The 'ground up' cultural negotiations of clinical psychology conducted by students or academics are not likely to have a similarly powerful impact on the territory, unless – through more people – they form nodes that become more heavily charged. This emphasises the importance of power differentials in cultural negotiations in transnational knowledge.

Secondly, the prioritisation of particular territories of transnational knowledge highlights the risk of a (post)colonial repression of non-western knowledges in contemporary research and education. The case studies of clinical psychology in Singapore, Australia and the Netherlands demonstrated that cultural negotiations in line

with ‘western’ culture are most powerful in the territory of transnational clinical psychology knowledge. Western interpretations provide norms for clinical psychology; while alternative negotiations, such as perspectives of Asian scholars, remain on the fringes of psychological science. This situation demonstrates a problematic (post)colonial continuation of the prioritisation of ‘western’ cultural negotiations in research and education. Thus, problematic (post)colonial one-way flows of knowledge may be reinforced through the prioritisation of some, and the devaluation of other, cultural negotiations of transnational knowledge.

A third conclusion derived from the case studies is that cultural negotiations from ‘below’ can have diversifying as well as delineating effects on territories of transnational knowledge. Students, academics and alumni apply knowledge based on their perceptions of the knowledge territory in relation to the perceived needs of the country, community, colleagues or clients. If psychologists consider the knowledge territory inappropriate for providing adequate mental health services locally, then cultural negotiations are more likely to open up the territory. In this case, students, academics and alumni potentially diversify transnational knowledge with new perspectives, practices or theories. However, simultaneously, by engaging in discourses of science, globalisation and standardisation, students, academics and alumni reinforce certain delineations of transnational knowledge territories. Thus, cultural negotiations from ‘below’ do not necessarily open up knowledges; they may also reinforce the closing of knowledge territories. Cultural negotiation and cultural imperialism are not opposites, but are in interrelation.

Relatedly, a fourth and final conclusion is that perceptions of knowledge territories can be a barrier for contesting neo-colonialism through cultural negotiation. The case studies of clinical psychology showed that students, academics and alumni

were more likely to reinforce delineations and standardisations of the discipline when the territory of clinical psychology was considered universally applicable, scientific and globally relevant. In contrast, when the knowledge territory was perceived to be culturally western, cultural negotiations were more likely to contest (post)colonial tendencies. In other words, discourses of science and globalisation, eduscapes and notions of standardisations can be barriers for contesting imperialist tendencies in higher education, research and practice.

Theoretical Implications

Four theoretical implications are derived from this research. They relate to the analysis of cultural negotiation in transnational knowledge.

Firstly, this thesis demonstrates that research on cultural impacts on transnational knowledge may benefit from using de-essentialised notions of culture. While cultural contexts differed in the three case countries of the Netherlands, Australia and Singapore, some contextual factors extended beyond country borders or varied within countries or regions, such as learning cultures. Thus, a cultural context is not delineated or defined by a country border; rather cultural negotiations are fluid and unpredictable. Therefore, an analysis of cultural influences on academic disciplines that focuses on negotiations at country level, as is often the case in clinical psychology research, fails to understand the nuance of cultural influences and the interrelation of knowledges, cultural contexts and personal interpretations. Instead, analyses that focus on the *application* of knowledge deconstruct notions of a single 'western' or 'Asian' cultural interpretation, or ideas from 'the' Malay Archipelago, or uniform Singaporean, Australian or Dutch knowledges. Through a focus on application of transnational

knowledge, research may better understand the interrelated and subtle cultural negotiations in knowledge.

A second implication is that research aiming to raise awareness of cultural biases in academic disciplines or knowledges may benefit from a contextual perspective that takes into account discourses of transnational knowledge. This thesis shows how discourses of science and globalisation, eduscapes and notions of standardisation can be barriers for cultural negotiation. For example, a more culturally relevant interpretation of a particular theory in clinical psychology can be easily dismissed by the argument that clinical psychology is scientific and therefore universal. In other words, an understanding of the effects of discourses supporting cultural imperialist tendencies in transnational education is important to deconstruct the argument for universality of transnational knowledges, and to support cultural negotiation to open up knowledges.

A third implication is that the study of transnational knowledge may benefit from further development of an interdisciplinary social science perspective. Most research of higher education focuses on educational policy in the context of cross-border expansion of neoliberal education. The research conducted for this thesis highlights the value of a cultural anthropology perspective in understanding the experiences of transnational education from 'below' (i.e. the students, academics and alumni), and the interrelation of practices from 'below' with those from 'above' (i.e. education institutes, professional organisations). Thus, an anthropological focus returns attention to the actual practices of transnational higher education, the experiences of educational activities, and the impacts of these experiences on people's professional and personal lives. This thesis represents an effort to contribute these valuable perspectives to the study of transnational higher education.

Finally, from a more practical perspective, this thesis highlights the need for culturally specific knowledge. The case studies of clinical psychology demonstrate that models that have been developed in one cultural context, such as MCC, do not necessarily suit another context. Therefore, a model attempting to address cultural issues in transnational knowledge should be developed to suit a particular cultural context. Empirical evidence demonstrated that students, academics and alumni felt the need for locally relevant knowledge and skills. Thus, cultural considerations in clinical psychology training, as with other professional and academic training programs, would benefit from being more specific and focusing on applications of transnational knowledge in the local context – while recognising diversity. Taken together, this indicates that culturally specific knowledge remains relevant and necessary, perhaps even more so in times of globalisation. Therefore, future research into clinical psychology training and practice could expand on culturally relevant knowledge, which refrains from cultural essentialism, by including more case studies from the Malay Archipelago and beyond.

Cartography

Transnational knowledge is always in becoming stasis and becoming flow – becoming universal and becoming cultural. Mapping plays an important part in the negotiation of transnational knowledge territories in the present globalised world. Students, academics, researchers, practitioners, and others map alternative perspectives that, without totalising or overriding 'other's' voices, create a space for explorations of the diversity of perspectives that are subjugated in transnational education, research and globalised practice. Discussing and writing about disciplinary knowledges, cultural imperialism, local knowledges, or pioneering philosophies are essential tools for

cultural influence from 'below' – new cartographies for thought, critique, or inspiration are elaborated. The disciplinarian delineations of clinical psychology were mapped and contested in this thesis through conducting interdisciplinary research (see Chapter 2). Thus, this multidisciplinary and multinational thesis in itself is a cultural negotiation of transnational knowledge.

In the elegant words of Deleuze (1988, p. 44): *"From this we can get the triple definition of writing: to write is to struggle and resist; to write is to become; to write is to draw a map: I am a cartographer."*

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Appendix I: Details of Publications

The table below lists the publications and anticipated publications that have informed the chapters in this thesis, and the intellectual input of each author.

Chapter no.	Details of (anticipated) publications on which chapter is based	Nature and extent of the intellectual input of each author, including the candidate
3	**Geerlings, L.R.C**., Thompson, C., & Lundberg, A. (2014). Culture and psychology: Exploring clinical psychology in Australia and the Malay Archipelago. *Journal of Tropical Psychology, 4*(4), 1-12. **Geerlings, L.R.C**., Lundberg, A., & Thompson, C. (2013). Transnational psychology: A case study of South East Asia. In P. Mandal (Ed.), Proceedings of the International Conference on Managing the Asian Century (pp. 73-79). Singapore: Springer. doi:10.1007/978-981-4560-61-0_9 **Geerlings, L.R.C**., Thompson, C., & Lundberg, A. (2013). Borderless psychology in South East Asia: History, current state and future directions. In P. Mandal (Ed.), *Proceedings of the International Conference on Managing the Asian Century* (pp. 353-362). Singapore: Springer. doi:10.1007/978-981-4560-61-0_40	These three papers followed identical procedures. The authors co-developed the research questions. Ms Geerlings reviewed the literature and wrote the first drafts of the papers, which were revised with editorial input from Dr Lundberg and Assoc. Prof Thompson. Ms Geerlings developed the tables and figures.
4	**Geerlings, L.R.C**., & Lundberg, A. (2014). Globalisation and deterritorialisation: An example of	The authors co-developed the research question. Dr Lundberg directed Ms Geerlings to relevant

	an academic discipline in the Malay Archipelago. In A. Kwam, E. Wong, T. Kwong, P. Lau & A. Goody (Eds.), *Research and Development in Higher Education: Higher Education in a Globalized World*, 37 (pp. 137-146). Hong Kong, 7-10 July 2014	theory. Ms Geerlings reviewed the literature and discussed this with Dr Lundberg to further develop her ideas. Ms Geerlings wrote the first draft, which was revised with editorial input from Dr Lundberg.
	Geerlings, L.R.C., & Lundberg, A. (in review). Global discourses and power/knowledge: Theoretical reflections on futures of higher education in the Asian Century. *Asia-Pacific Journal of Education, Special Issue on Exploring Leadership and Learning Theories in Asia.*	The authors co-developed the research question. Ms Geerlings reviewed the literature and wrote the first draft, which was revised with editorial input from Dr Lundberg.
5	**Geerlings, L.R.C.**, & Thompson, C. (ready to submit). Cross-cultural explorations of multicultural counselling competencies: A review of the literature from Australia, Singapore and the Netherlands. *Anticipated submission to a psychology journal.*	The authors co-developed the research question. Ms Geerlings reviewed the literature and wrote the first draft, which was revised with editorial input from Assoc. Prof Thompson.
6	**Geerlings, L.R.C.,** Thompson, C.L., Kraaij, V., & Keijsers, G.P.J. (ready for submission). Preparing for multicultural clinical psychology practice in the Netherlands: A survey and interview study on multicultural counselling competency in two universities. *Anticipated submission to a psychology journal.*	Ms Geerlings, Dr Lundberg and Assoc. Prof Thompson co-developed the research question. Ms Geerlings collected and analysed the data, and wrote the first draft. Assoc. Prof Thompson provided feedback on the analyses and on the first draft. Ms Geerlings wrote the second draft which was revised with editorial input from Dr Kraaij and Prof Keijsers.
7	**Geerlings, L.R.C.**, Thompson, C.L., Bouma, R., Hawkins, R. (ready for submission). Preparing for multicultural practice: An exploratory study of multicultural counselling competency in two	Ms Geerlings, Dr Lundberg and Assoc. Prof Thompson co-developed the research question. Ms Geerlings collected and analysed the data, and wrote the first draft. Assoc. Prof Thompson provided feedback on the

	Queensland universities, Australia. *Anticipated submission to the Australian Psychologist.*	analyses and on the first draft. Ms Geerlings wrote the second draft which was revised with editorial input from Dr Bouma and Prof Hawkins.
8	**Geerlings, L.R.C.**, Thompson, C.L., & Tan, G. (ready for submission). Preparing for multicultural clinical psychology practice in Singapore: A mixed-methods survey and qualitative study of multicultural counselling competency. *Anticipated submission to a regional psychology journal*	Ms Geerlings, Dr Lundberg and Assoc. Prof Thompson co-developed the research question. Ms Geerlings collected and analysed the data, and wrote the first draft. Assoc. Prof Thompson provided feedback on the analyses and on the first draft. Ms Geerlings wrote the second draft which was revised with editorial input from Assoc. Prof Tan.

Appendix II: Informed Consent Form

INFORMATION SHEET

PROJECT TITLE: Cultural impacts on training and practice of clinical psychology

You are invited to take part in a research project about **the cultural influences on training, teaching and practice of clinical psychology**. The study is being conducted by **Lennie Geerlings** and will contribute to the degree of Master of Philosophy (MPhil) at James Cook University.

If you agree to be involved in the study, you will be invited to be interviewed. The interview, with your consent, will be audio-taped, and should only take up to 30 minutes of your time. The interview will be conducted at your university, or at a venue of your choice.

Taking part in this study is completely **voluntary** and you can stop taking part in the study at any time without explanation or prejudice.

Your responses and contact details will be strictly **confidential**. The data from the study will be used in research publications and reports. You will not be identified in any way in these publications.

If you have any questions about the research, please contact Lennie Geerlings, Assoc. Prof Claire Thompson or Dr Anita Lundberg.

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If you have any concerns regarding the ethical conduct of the study, please contact:
Human Ethics, Research Office
James Cook University, Townsville, Qld, 4811
Phone: (07) 4781 5011 (ethics@jcu.edu.au)

INFORMED CONSENT FORM

PRINCIPAL INVESTIGATOR: Lennie Geerlings

PROJECT TITLE: Cultural impacts on training and practice of clinical psychology

SCHOOL: School of Arts and Social Sciences, James Cook University

I understand the aim of this research study is **to understand how culture influences training and practice of clinical psychology**. I consent to participate in this project, the details of which have been explained to me, and I have been provided with an information sheet to keep.

I understand that my participation will involve an **interview** and I agree that the researcher may use the results as described in the information sheet.

I acknowledge that:

- taking part in this study is voluntary and I am aware that I can stop taking part in it at any time without explanation or prejudice and to withdraw any unprocessed data I have provided;
- that any information I give will be kept strictly confidential and that no names will be used to identify me with this study without my approval;

	(Please tick to indicate consent)			
I consent to be interviewed		**Yes**		**No**
I consent for the interview to be audio-taped		**Yes**		**No**

Name:

Signature: **Date:**

Appendix III: Interview Outline

Demographic background

Alias…….

Age:…….

Gender:……

Nationality:……..

Cultural identification:……

Program details

University:……

Program:…….

student/staff/graduate

If student: which year:…….

If staff: where did you do your postgraduate training?.....

Questions

1. Was there any specific reason for you to participate in the interview? Which?
2. What can you tell me about the origins of your curriculum or program?
3. How much consideration for cultural issues is there in your training program?
4. How do you think students can best be prepared for multicultural practice?
5. This research explores the critique that clinical psychology is western. What do you think of this critique? Why?
6. Are/were there any cultural or alternative models of psychology taught at your university?

7. Is there any course, or specific knowledge or skill that you are being taught (or: teach) at your university that is specific for your culture or country?
8. Can you tell me about a multicultural practice situation you encountered? How was that?
9. Are clinical psychology models currently taught in your university an adequate preparation for multicultural practice in your society? Why (not)? Examples?
10. Do you have any ideas on how to culturally tailor your clinical psychology training to fit your cultural context?
11. Do you have any advice for foreign universities who wish to teach clinical psychology here (or: in your country)?
12. Is there anything you wish to add, or highlight that relates to the topic of this interview?