

Decolonising Clinical Psychology Training in Singapore:

Trainee and Recently Qualified Psychologist views about diversifying therapeutic models

Caleb H.Q. Wong

Student Number: 18057965

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Content

Abstract.....	8
Aim	8
Method.....	8
Results	8
Implications	9
Chapter 1. Introduction.....	10
1.1. Ontology and Epistemology.....	12
1.2. A Note on Language	13
1.2.1. Indigenous	13
1.2.2. Decolonisation.....	14
1.2.3. Culture and Ethnicity	15
1.2.4. Cultural Competence and Cultural Humility	15
1.2.5. On Mental Health Conditions.....	16
1.2.6. ‘Us’ and ‘Them’.....	16
1.3. Setting the Context	17
1.3.1. Singapore’s History	17
1.3.2. Singapore’s culture	18
1.3.3. Development of Clinical Psychology in Singapore	23
1.4. Western Psychology and Singapore	24
1.4.1. Current Research in Cultural Adaptations.....	26
1.4.2. Limitations	26
1.5. Indigenous therapies and Spiritual healing	27
1.6. Systematic Review: What do Singaporean MHPs think?	28
1.6.1. Search Strategy.....	28
1.6.2. Overview.....	32
1.6.3. Synthesis.....	32
1.6.4. Universal factors.....	33
1.6.5. Adapting Western Models.....	33
1.6.6. Unpacking ‘Western’ Models.....	40
1.6.7. Acceptance of IT/SH.....	44
1.6.8. The Wider Context of Practice	46
1.7. Discussion	46
1.9. Research Rationale and Aims	49
Chapter 2. Methodology	52
2.1. Overview	52
2.2. Qualitative Research	52
2.3. Epistemological Position	53
2.4. Thematic Analysis	54
2.5. Research Rigour	55
2.5.1. Reflexive Research Journal and Supervision	55

2.5.2. Ecological Validity.....	55
2.5.3. Member-checking.....	56
2.5.4. Triangulation	56
2.6. Research Design	56
2.6.1. Video Interviews.....	56
2.6.2. Project Consultants.....	57
2.6.3. Participant Selection	57
2.6.4. Recruitment.....	59
2.6.5. Group Dynamics	62
2.6.6. Focus Group Planning.....	64
2.6.7. Ethics, Consent, and Data Management	66
2.7. Data Analysis	67
2.7.1. Analysing the Interviews.....	67
2.7.2. Analysing the Interview Activity.....	68
Chapter 3. Analysis.....	69
3.1. Overview	69
3.2. Is that culture or personal bias?	70
3.3. CBT is suitable but not sufficient for Singapore	72
3.3.1. Culture as an external factor.....	72
3.3.2. CBT fits most Singaporeans' mindsets but may not gel with cultural explanations	73
3.3.3. CBT can be further adapted to fit Singapore	76
3.3.4. CBT as the 'first line' intervention.....	78
3.4. Modalities are tools in our toolbox	79
3.4.1 Many factors affect which models we use.....	79
3.4.2. Borrowing ideas but using CBT as a base.....	84
3.4.3. Other models may be more aligned with our culture.....	87
3.5. Improving cultural relevance of CP training.....	91
3.5.1. Mixed views on the current level of training on culture	92
3.5.2. Non-academic components can also be more culturally relevant	95
3.6. Interview Activity Data.....	96
Chapter 4. Discussion	102
4.1. Overview	102
4.2. Summary	102
4.3. The Study in Context	103
4.3.1. Is the focus on CBT suitable for working within Singapore?	103
4.3.2. What other models of therapy might be culturally relevant for Singapore?	104
4.3.3. How prepared do Singaporean CPs feel for culturally relevant practice after training locally?	105
4.4. The Wider Context	106
4.4.1. What is culture and decolonisation in therapy?.....	107
4.4.2. What is the value of evidence base?	109
4.4.3. What are the processes of change in therapy	110
4.6. Strengths and Limitations.....	113
4.5. Clinical implications	114

4.5.1. Implications for Individual Therapists.....	114
4.5.2. Implications for Training Courses	115
4.5.3. Implications for Professional Bodies.....	117
4.7. Recommendation for Future Research	118
4.8. Conclusion	119
References	120
Appendix A – Search Strings Used for the Systematic Literature Review.....	142
Appendix B – Summary of Research in the Systematic Literature Review.....	144
Appendix C – Quality Appraisal for Papers in the Systematic Literature Review.....	157
Appendix D – Excerpts from Reflexive Research Journal	186
Appendix E – Recruitment Poster.....	189
Appendix F – Recruitment Blurb.....	190
Appendix G – Interview Schedule.....	191
Appendix H – Pre-interview Activity.....	195
Appendix I – Example of Interview Activity (Part One)	198
Appendix J – Example of Interview Activity (Part two)	199
Appendix K – Participant Debrief Sheet	200
Appendix L – Ethics Approval.....	202
Appendix M – Example of Transcript Coding	204
Appendix N – Example of Consent Form.....	208
Appendix O – Example of Transcript Coding.....	210
Appendix P – Initial Thematic Diagram	212

List of Tables

Table 1 – Singaporean and Confucian Values	20
Table 2 – Milestones in the Development of Clinical Psychology in Singapore	23
Table 3 – Search Parameters for the SLR	29
Table 4 – Summary of Adaptations from the SLR	39
Table 5 – Participant Demographics	61
Table 6 – The Six-Phase Approach to TA	67
Table 7 – Cultural Relevance of Mindfulness-Based Approaches	88
Table 8 – Participants’ ECA	97
Table 9 – Participants’ ICA	98
Table 10 – Changes Between Participants’ ICA and ECA	99

List of Figures

Figure 1 – Cultural Values in Singapore and Confucian Societies	21
Figure 2 – Prisma 2020 Flow Diagram	31
Figure 3 – Thematic Map.....	70

Abstract

Aim

Despite literature suggesting that Western psychology and models might not be as culturally appropriate in other cultures (e.g. Henrich et al., 2010; Llewelyn & Shimoyama, 2012), clinical psychology courses in Singapore continue to follow a mainly Western curricula (Geerlings et al., 2014; Lange et al., 2015). Geerlings et al. (2017) found that these courses focused heavily on Cognitive Behavioural Therapy (CBT), and suggested that courses expand their curriculum to include other models. However, they did not propose any suitable models. The current study aims to address this gap by answering the following research questions based on interviews with clinical psychologists (CPs) from these programmes:

- 1) Is a focus on CBT suitable for working within Singaporean culture?
- 2) What other models of therapy might be culturally relevant for Singapore?
- 3) How prepared do Singaporean CPs feel for culturally relevant practice after training locally?
 - Which models of therapy would they have liked to learn more about before graduating and what else would have added to their preparedness to provide culturally relevant therapy?

Method

Nine recent graduates and five final-year trainees from both clinical psychology courses in Singapore were interviewed across four online focus groups (FGs). The interviews were analysed using thematic analysis (TA) and member-checking was used to confirm the preliminary themes. Findings from the interview activities completed during the FGs are also reported.

Results

Participants felt that CBT was suitably relevant but could be further adapted for Singapore. They shared about how they used an integrative approach in incorporating other more culturally

relevant models at times. Participants referred to an assumption about the need to follow 'evidence base' when deciding which models to use.

Implications

Some implications for Singapore CPs, training courses, and professional bodies are discussed, including better cultural training, more reflective spaces on evidence and culture, the inclusion of more culturally appropriate models in CPs' practices, and increasing the diversity of CP trainees. Some areas for future research are discussed.

Chapter 1. Introduction

All this is not a warning or complaint about how unfair life will be for you. After all, you will not be unhappy; or if you are, you will not really notice. You will learn things, make friends, and acquire 'social polish', a confidence in speaking, the tools to make yourself heard.

These are all good things. They are the things that you went to Britain to acquire. But I am writing to you to make you see what you will be at pains not to see: that as you acquire them, there will also be parts of you that are lost. And I am writing to tell you that your gains are not innocent—that they come with the baggage of coloniality.

– To my Eighteen-Year-Old Self, on your Departure for Cambridge

By Singaporean Michelle K. (2013, pp.29-30)

The universality of psychology has in recent years become the subject of renewed scrutiny – it has been pointed out that no theory or therapy is ever constructed in a social vacuum (Laungani, 2004), and therefore all psychological constructs are culture-bound (B.O. Lee & Foo, 2019). Most of what we claim to know about psychology is drawn from studies with WEIRD (Western, European, Industrialized, Rich, Democratic) populations who represent only 12% of the world (Henrich et al., 2010). That being the case, just as there exist studies in Black, Chinese, and other indigenous psychologies, what is typically taught in Singaporean universities as 'psychology' should be considered 'Western indigenous psychology' (B.O. Lee, 2018). This thesis aims to explore how applicable Western psychological models of mental health are to Singapore's context.

It was conceived from my own experiences of being a cultural 'outsider', living and training in the United Kingdom (UK). It took shape as I reflected about how clients in Singapore might be different from those I saw in the UK, discussed ideas with Singaporean friends and colleagues, and explored a growing awareness of decolonial literature which paralleled a growing interest in epistemology. As I reckoned with questions about my own identity and coloniality, I started to

examine my own epistemology and mental health views more closely. All of this inevitably came full-circle when I finally asked myself whether these new thoughts indeed represented a journey in decolonisation or, being 'revelations' gathered through a western training, were in fact fine examples of continued colonisation. As such, the logical conclusion was to seek the views of fellow Singaporeans on such topics.

The structure of this thesis is outlined below:

Chapter 1. Introduction

I begin with an exploration of epistemology and culture, focusing on the differences between 'Western' and 'Asian' views, and how they impact on mental health and psychological interventions. I zoom in on the context of Singapore, before presenting a systematic literature review (SLR) examining the cultural adaptations for psychological interventions in Singapore from the perspective of local mental health professionals (MHPs).

Chapter 2. Methodology

Following the systematic review, which points to a dearth in the literature on the cultural relevance of different psychotherapeutic models for Singaporean populations, I proceed to describe the research which was conducted to address this gap.

Chapter 3. Analysis

Results of focus groups (FGs) are presented along with the constructed themes.

Chapter 4. Discussion

The themes from the research are discussed in relation to extant literature. Recommendations are provided for clinical practice and training in Singapore, and it is suggested that other multicultural societies could potentially (and cautiously) benefit from these findings.

Further areas for research are also suggested before I conclude with my final reflections on the process.

1.1. Ontology and Epistemology

The research takes a social constructivist epistemology with a critical realist ontology. That is, it assumes the existence of an 'objective' external world, but that it is noumenal, and that knowledge about it is socially constructed (Raskin, 2002). This means that as knowers, we may only ever know how well our knowledge 'fits' the world around us, rather than how 'accurate' it is. Von Glasersfeld (1981) likened knowledge to a key that 'fits' the lock of the external world. Where multiple keys may 'fit' and open the same lock, we still do not know the lock in its entirety. He suggests that we abandon the belief that knowledge is an "iconic representation of ontological reality" (p.8). According to Raskin (2002), this view fits with the category of constructivism called epistemological constructivism, with von Glasersfeld's radical constructivism being one such example.

Another important aspect of this position is that it views knowledge as an active process, which means that no knower can be a passive recipient (von Glasersfeld, 1984). However, while language and social interaction play an important role in shaping knowledge, we "ultimately remain cognitively isolated" (p.11), with each arriving at our own subjective meanings.

It is important to note that many experimental methods are based on Western values and traditions (Gergen, 2001), and that research itself can colonize the other (Smith L. T., 1999). Whereas Western sciences focus on conquering and "disenchanted" nature, Chinese traditions, for example, strove to live in "universal harmony" with nature (Harding, 1994; pp.315-316). As a result, Chinese epistemology was relational and viewed the world as a dynamic network of relations (Rošker, 2021).

This being a thesis focused on decolonisation, it might seem inconsistent if more Asian epistemologies were not mentioned. Namely, I wanted to spotlight egalitarian epistemology, which was based on Daoist beliefs (Rošker, 2021). Similar to social constructivists, Zhuangzi (a philosopher

in 4th century BC China) saw knowers as limited in our capacity to gain true knowledge due to the limits of our comprehension and our senses. However, one possible difference is that Zhuangzi espoused introspection as a method of comprehension, as compared to social constructivists, who seem to place more emphasis on social processes.

Unfortunately, I am not versed in any research methodologies based on such epistemologies (if there are any). I am reminded of Collins' (1990) inspirational work in writing about an Afrocentric feminist epistemology from the ground-up. She explained that she chose to rely on her own experiences and the voices of African-American women and made a conscious decision to cite few statistics in order not to violate the basic epistemological framework on her paper.

Recognizing that often "the individual scientist is deemed rational only if he or she adopts the codes of discourse common to his or her particular community of science" (Gergen, 2001, p.805), and lacking Collins' courage to make a similar choice for an academic article, however, this thesis will stick with a radical constructivist epistemology, as outlined previously. Unfortunately, as Scheurich and Young (1997) lamented, scholars of colour need to become accomplished in Western epistemologies which might be exclusionary or even hostile to alternative race-based epistemologies because of the assumed neutrality of Western epistemologies. Such hostility has been given names like 'epistemic injustice' (Fricker, 2007) and 'epistemological racism' (Scheurich & Young, 1997).

1.2. A Note on Language

Given the importance of language and social interaction in our epistemology, it would be prudent for us to clarify some of the language that will be used in this thesis.

1.2.1. Indigenous

Broadly speaking, the Cambridge Online Dictionary (n.d.-b) provides two definitions for the term 'indigenous'. The first refers to things (people, animals, plants) which originally or naturally live in a place, and did not come from somewhere else. The Singapore government recognizes the Malays as the indigenous population of Singapore (Section 152 of the Constitution of the Republic of

Singapore), since the native population of Singapore before the British arrived mainly comprised of Malays (see Section 1.3.2.). However, scholars have noted that the Malays in Singapore are made up of different ethnic groups from the region, some of whom migrated from countries like Indonesia (and therefore may not adhere to a *strict* definition of 'indigeneity' (Clammer, 1981; Tham, 1993).

The second definition refers to things which are 'not foreign' or 'from outside areas' (Cambridge Online Dictionary, n.d.-b). While quite similar, this definition-by-exclusion is broader and circumvents the question of how to determine if something is 'originally' from the place. Arguably, this definition allows for 'indigeneity' to be applied to all Singaporean things, whether they 'originated' from here or not – which includes our food, culture, and people. This is the definition that will be used in this thesis. As such, cultures, knowledges, and beliefs from all Singaporeans (not just the Malays) will be considered 'indigenous'. While not uncontentious, this is in line with existing research on this topic (e.g., B.O. Lee, 2002a, 2018).

1.2.2. Decolonisation

'Decolonisation' can have many different definitions, aims, and strategies. The discussion on the complexities involved in considering what is 'indigenous' to Singapore also gives rise to questions about what 'decolonisation' means in Singapore. At its core, Bhabra and colleagues (2018) highlight two main points: 1) it is a worldview which examines colonialism and its impact on the modern world, and 2) it offers other ways of reimagining and understanding the world. In particular, Bhabra et al. (2018) described decolonising education as an effort to "question the epistemological authority assigned uniquely to Western university as the privileged site of knowledge production and to contribute to the broader project of decolonising through a discussion of strategies and interventions emanating from within imperial metropolises" (p.3). In trying to privilege 'indigenous' knowledge in Singapore, we run into our earlier dilemma of which definition of 'indigeneity' to use (and therefore whether some knowledge should be preferentially highlighted over others). Consistently with that discussion, I will follow Bhabra et al.'s (2018) definition which does not

seem to differentiate between non-Western knowledges. In this thesis, I will use terms like 'Western', 'Asian', 'Non-western', or 'Indigenous' as a shorthand for these discussions. It is important to recognize that these broad categories risk doing its members a disservice by implying homogeneity. Rather than homogeneity, I use these categories merely to indicate commonality in some respects (e.g., geographical location, historical context).

Decolonisation has taken the form of protests (e.g., Rhodes Must Fall), educational campaigns (e.g., Why is My Curriculum White?), and academic writing (e.g., studies on indigenous psychologies), among other things. While some efforts aim to replace the current Eurocentric ways of thinking, this thesis adopts a pluralistic approach which respects the right of those traditions to sustain its own existence, but also hopes to give voice to alternative traditions (Gergen, 2001). As such, both indigenous theories and adaptations of Western theories will be considered attempts at decolonisation.

1.2.3. Culture and Ethnicity

Culture, as defined by the Cambridge Online Dictionary (n.d.-a), refers to "the attitudes, behaviour, opinions, etc. of a particular group of people within society". This means that there are as many cultures and sub-cultures as there are groups of people. In this thesis, I will mainly focus on culture at a national level and at the level of ethnicity. In turn, ethnicity will be defined by the four major groups recognized by Singapore's CMIO model: Chinese, Malay, Indian, and 'Others'. While this model is a holdover from Singapore's colonial past (Hirschman, 1987) and is far from unproblematic (Kathiravelu, 2017), it is currently the most common and straightforward way to understand Singapore's 'multiracial' and 'multicultural' society.

1.2.4. Cultural Competence and Cultural Humility

Although the concept of cultural competence has a wider following (Greene-Moton & Minkler, 2019), some argue that the concept of cultural humility is more useful, particularly in a multicultural society (Tervalon & Murray-García, 1998). Where cultural competence focuses on

understanding different cultures, beliefs, and practices, cultural humility emphasizes self-reflection and an awareness of one's own biases. While there has been some controversy around these distinctions (e.g., Danso, 2018), some have suggested the need for both (Greene-Moton & Minkler, 2019).

I will mainly use the term 'cultural competence' in this paper to reflect what is more common in the literature. It is perhaps more appropriate for discussions about 'skills' and 'techniques'. However, it is necessary to acknowledge an important critique – that 'competence' suggests a binary where we can be either 'incompetent' or '(fully) competent'/'experts'. This is not what I intend to imply, and I echo Tervalon and Murray-García's (1998) assertion that knowledge of other cultures needs to be accompanied by lifelong learning and self-reflection.

1.2.5. On Mental Health Conditions

There is a potential disconnect between an effort to decolonize clinical psychology and the continued use of Western diagnoses that should be acknowledged as well. While I prefer to use the terms 'mental health difficulties' and 'distress', they do not always accurately reflect what some of the literature are referring to (i.e., a specific group of symptoms and presentations that has been recognized in Western psychology as a 'condition'/'illness'). As such, I will often use the term 'mental health condition' as a shorthand for this (in favour of the more stigmatizing 'illness'), and to provide a shared language for coherent discussion.

1.2.6. 'Us' and 'Them'

Inspired by Collins (1990), I will often use the pronoun 'us' instead of 'them' when referring to Singaporeans, and will also embed my own experiences throughout the discussions. Like Collins, this is a decision to situate myself within the culture that I am studying, instead of following traditional research norms of distancing myself from it. I felt that this was important to avoid the trap of benevolently trying to 'help' the Other, thereby inadvertently replicating the "civilizing mission of colonialism" (Blackmore, 2010, p.51). The use of personal reflections would also be in line

with Chinese epistemologies which recognize introspection and intuition as sources of knowledge (Gao & Wang, 2014; Rošker, 2021).

1.3. Setting the Context

Before diving too far into the applicability of Western psychology and how it can be adapted or decolonised in Singapore, it is important to first know the context we are entering.

1.3.1. Singapore's History

Singapore is an island-state in Southeast Asia, with a total land area of 728.3 square kilometres in 2020 (Singapore Land Authority, 2021). While Singapore's history may stretch back as far as 1299 and more efforts have been made in recent years to recognize this, the typical national narrative was that 'modern' Singapore was 'founded' in 1819 by Sir Stamford Raffles (Sa'at, Joraimi, & Sai, 2021), who established Singapore as a trading post for the British Empire. The British invited settlers to Singapore's free port, and as Singapore flourished, more arrived from the region around (Lepoer, 1989).

Singapore remained a British colony until 1942, when during World War II, the British surrendered Singapore to the Japanese. After the war ended in 1945, the British returned to Singapore. However, the local population had lost faith in the British (Lepoer, 1989), and it soon became an independent Crown Colony in 1946. After a brief merger with neighbouring Malaya (now Malaysia) in 1963, Singapore finally gained independence in 1965.

However, even after independence, remnants of our colonial past can still be seen in our political, legal, and education systems. English has been adopted as the main language of administration, even though other 'local' languages (Chinese, Malay, and Tamil) are also recognized as national languages. As an independent Republic, Singapore's first Prime Minister (often considered our founding father) was Lee Kuan Yew. It is perhaps notable that he received his law education in Cambridge, and maintained close links with the UK. However, he often reflected not

only on what he could adopt from the UK, but also the differences between Western and Asian cultures (Eyal, 2015).

1.3.2. Singapore's culture

Singapore's history of migration during the colonial era has irrevocably shaped our cultural landscape (B.O. Lee & Foo, 2019; Kathiravelu, 2017). In 1819, Turnbull (2009) estimated that Singapore's population of about 1000 consisted mainly of indigenous Malays and only about 20 to 30 Chinese. By 1826, a census showed that the Chinese population was almost equal to the number of Malays, Bugis, and Javanese combined (Arnold & Cartwright, 1908). In 2021, out of Singapore's 3,986,842 residents, 74.2% are Chinese, 13.7% are Malay, 8.9% are Indian, and 3.2% are 'Others' (Singapore Department of Statistics, 2021b). This means that Singapore is now the only majority Chinese country outside of China, Hong Kong, and Taiwan (New World Encyclopedia contributors, 2019; Poston & Yu, 1990). Being located in the Malay archipelago in Southeast Asia, an area which has seen anti-Chinese violence and ethnic politics (BBC News, 1998; The Economist, 2005; Wongsurawat, 2016; Smith B. , 2018), this has resulted in tensions, and was "at the heart" of the separation of Singapore and Malaysia (HistorySG, 2014b, para.4).

Singapore now prides itself as being multiracial, multireligious, and multicultural – although the precise meaning of this is debated (Kathiravelu, 2017; Lai, 2017). A 2020 census reported that among residents above 15, 20% identified as non-religious, 31.1% as Buddhist, 8.8% as Taoist, 15.6% as Muslim, 5% as Hindu, 0.3% as Sikh, 7% as Catholic, 11.9% as 'Other Christians', and 0.3% as 'Other Religions' (Singapore Department of Statistics, 2021a). Our diversity can be seen in the variety of cultural foods, traditional costumes, religious practices and holidays, and the many hybrids thereof – for example, with food as a 'national pastime' it is not uncommon for us to enjoy food which have influences from the multiple cultures in Singapore (Koh, 2017). However, as Lai (2017) points out, this diversity comes with its set of challenges, which includes finding a common shared identity and culture.

Even so, I will briefly try to highlight some values and beliefs which might be common to us Singaporeans. Han (2017) describes how the government tries to use 'citizenship education' to create a shared identity for our young nation by imparting some common values. She tracks these changes across the years, with some early values including 'politeness', 'honesty', 'perseverance', 'kindness', and 'right conduct'. It later evolved to include 'a love for their country and its people' and 'loyalty'. In a 1979 report, Lee Kuan Yew laid out several other desirable qualities of Singaporeans, including: "loyal and patriotic", able to "contend and co-operate in a civilized way", "filial, respectful to elders, law-abiding, humane, and responsible", "a good neighbour and a trustworthy friend", "tolerant of Singaporeans of different races and religions", "clean, neat, punctual, and well-mannered", and "a good soldier, ready to defend his country, and so protect his wife and children, and his fellow citizens" (pp.8-9). In setting these values, Lee Kuan Yew used pragmatism (another often-mentioned value) as his compass:

The best of the East and West must be blended to advantage in the Singaporean. Confucianist ethics, Malay traditions, and the Hindu ethos must be combined with sceptical Western methods of scientific inquiry, the open discussion methods in the search for truth. We have to discard obscuranist (*sic*) and the superstitious beliefs and practices of the East, as we have to reject the passing fads of the West. Particularly important are intra-family relationships. We must reinforce these traditional family ties found in all Asian societies (K.Y. Lee, 1979, p.9)

However, as Gao and Wang (2012) pointed out, "modernization is often a synonym of westernization" (p.227) – a sentiment echoed by Laungani (2004). In 1991, the government recognized that being "exposed to Western lifestyles and values" came at the risk of the "erosion of [our] Asian values" (HistorySG, 2014a, para.2). To "uphold certain common values which capture the essence of being a Singaporean" (para.3), a set of five 'Shared Values' were drafted. They were: 1) Nation before community and society above self; 2) Family as the basic unity of society, 3) Regard

and community support for the individual, 4) Consensus instead of contention, and 5) Racial and religious harmony. During the 1990s, Lee Kuan Yew also started promoting the concept of 'Asian values' (which were inspired by Asian philosophy and history), and in particular what he called 'Confucian values' – including 'hard work', 'strong family ties', 'sacrifice for the future', 'respect for education, learning, and entrepreneurial spirit', 'filial piety', 'respect for elders', and 'freedom in an orderly society' (Han, 2014).

Table 1 summarizes several other values which literature has highlighted as relevant in Singapore and other societies based on Confucian values (for details see Foo et al., 2006; Hall et al., 2011; Huang & Zane, 2016; Ma et al., 2019; Ow, 1998).

Table 1

Singaporean and Confucian Values

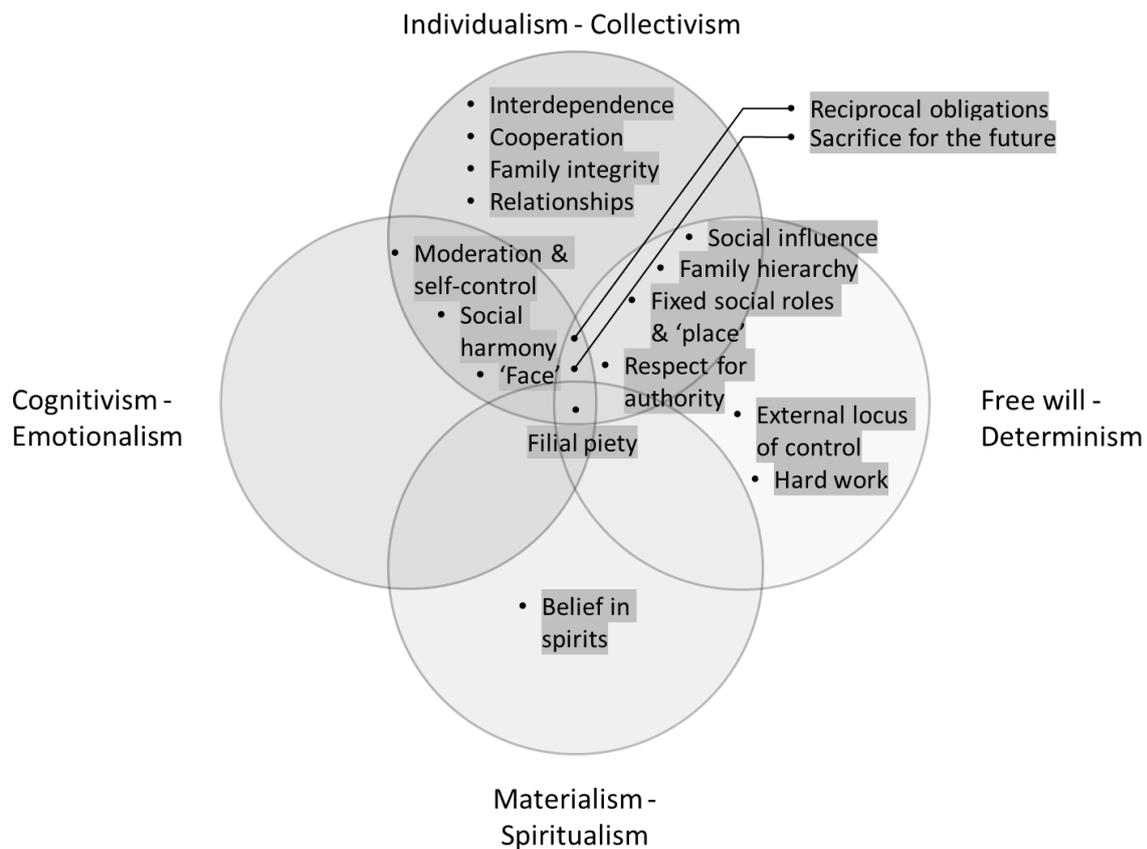
Value	Brief description
Social harmony	Conflict is avoided; a particularly important value which underpins many other values
Interdependence	Where individualism emphasizes independence from groups, collectivism embraces greater connections between people
Cooperation	Cooperation is valued over competition, so that sometimes personal goals are subordinate to in-group goals
Family integrity	Close links are valued, as exemplified by children who remain close to and are expected to make regular visits to their family of origin in adulthood; family traditions and goals are prioritized
Relationships	Relationships may even be considered more important than laws for the social safety and influence they provide
Family hierarchy	Family members have fixed roles and norms defined by age, gender, etc.
Fixed social roles and 'place'	Individuals' roles extend beyond the family as well
Respect for authority	As part of a fixed role, respect for authority is expected
Social influence	The view that human development is driven more by social forces than psychological factors
External locus of control	Individuals tend to attribute causes to external factors such as fate
Reciprocal obligations	Individuals have mutual obligations to one another (e.g., obligations to

	respect parents is met by their obligation to protect children)
Moderation and self-control	Compromise is seen as an important part of maintaining interpersonal and intrapsychic harmony
'Face'	A person's feelings about their own social character, integrity, self-esteem, and family's name; it is related to feelings of shame if 'face' is 'lost'
Filial piety	Respect for, loyalty, and obedience to parents and ancestors
Belief in spirits	Spirit and ancestral worship is seen as important and spiritual forces may be seen as causing illness

Laungani (2004) described several differences between 'Western' and 'Eastern' values, which Naeem et al., (2021) grouped into four dimensions: individualism-communalism, cognitivism-emotionalism, free will-determinism, and materialism-spiritualism. To organize the values above, I tried to fit them into these dimensions (Figure 1). While most of the previously discussed values may be mapped onto those in Table 1 (e.g., 'politeness' onto 'social harmony', 'respect for education' onto 'respect for authority'), I have added 'hard work', and 'sacrifice for the future' because I felt they contributed something more. The term 'collectivism' is used interchangeably with 'communalism' as they share similar values (Jagers & Mock, 1995).

Figure 1

Cultural Values in Singapore and Confucian Societies



It is this tenuous mix of values which led Foo et al. (2006) to describe Singapore as “essentially an Asian state with features of collectivism, interdependence, familism, hierarchy, and holistic worldview...a complex metropolitan state embracing a mix of Eastern and Westernized values, attitudes, and lifestyles” (p.273).

Reflecting on these values, many of them resonate with me on a personal level. I am reminded of a story which I read as part of my Mandarin lessons in Primary school:

孔融让梨 (*Kǒng Róng Ràng Lí*) is the story of 孔融 (*Kǒng Róng*), a would-be scholar, who was the sixth of seven sons. When his father brought home some pears for the family and offered him the largest, he declined and took the smallest, stating that the older brothers should have the bigger pears. When asked about his younger brother, 孔融 replied that as

the elder brother, he needed to take care of his younger brother and so also gave him a bigger pear (an example of this story can be found at eChineseLearning, 2015).

The moral of the story, we were told, is about the importance of respect for your elders, and looking after your family, even at the cost of personal sacrifice. It is a story which has deeply entrenched itself into my worldview.

Whether these were values passed down through the generations in my family or indoctrinated into me through the education system (or most likely a combination of the two), is a question I am unable to answer.

1.3.3. Development of Clinical Psychology in Singapore

Having some context of Singapore, we can now focus on the development of clinical psychology here. Some of its major milestones described by Geerlings et al. (2014) and B.O. Lee and Foo (2019) are listed in Table 2.

Table 2

Milestones in the Development of Clinical Psychology in Singapore

1841	A mental asylum was established by the British in Singapore
1979	The Singapore Psychology Society (SPS) was formed
1986	First undergraduate psychology programme established at the National University of Singapore (NUS); in 2014 a total of seven universities offered such programmes
1998	First clinical psychology training programme (a Masters programme) established at NUS; its curriculum was modelled on those of British universities
2004	James Cook University (JCU), which is an Australian University, started offering clinical psychology Masters and Doctoral training programmes in Singapore
2009	NUS started a joint, Australian Psychology Accreditation Council (APAC)-accredited clinical psychology training programme with another Australian University, the University of Melbourne

Geerlings et al. (2014) observed that clinical psychology in Australia and the Malay Archipelago was an Euro-American import. They found that most of the regional courses continued

to pay little attention to the cultural background of Western psychology and did not include 'non-Western' models in their coursework. Singapore was no exception: Clinical psychology education had clear colonial influences since its inception, with a dependence of foreign texts, resources, and lecturers who were trained abroad (Geerlings et al., 2014; Lange et al., 2015; B.O. Lee & Foo, 2019). Geerlings et al. (2014) further highlighted that unlike Australia, Indonesia, and Malaysia where some programmes have made attempts to integrate local culture and religion, the training programmes in Singapore still do not make specific mention of adapting clinical psychology for our culture. Finally, they noted how this pattern was being repeated by more recent 'flows of knowledge' from Australia to Singapore.

Interestingly, B.O. Lee and Foo (2019) highlighted that before the psychology programme in NUS had their own department, the course was offered as part of the Department of Social Work, which suggested a recognition of the need to draw expertise from both disciplines to address local issues. They also noted the increasing popularity of psychology as an academic subject in recent years.

1.4. Western Psychology and Singapore

Because the psychology curriculum in Singapore is highly Westernized, its expansion is not entirely unproblematic. While some psychological processes might be universal (especially from a biological perspective), this should not imply homogeneity as distinctions may arise from cultural and contextual differences (Chowdhary, et al., 2014; Neuberg & Schaller, 2015). Where clinical psychology has historically been blind to cultural differences, we should be considering if these Western psychological constructs are applicable to our local context (B.O. Lee & Foo, 2019). For example, in a study in India, 87.1% of psychology students reported feeling cognitive approaches (rational-emotive therapy and cognitive therapy) conflicted with their own values and beliefs, with 46.8% saying it clashed with cultural and family values, and 40.3% saying it clashed with religious beliefs (Scorzelli & Reinke-Scorzelli, 1994). Geerlings et al. (2014) argued that Western psychology

was not a great fit for the region either, and felt that clinical psychology in the Malay Archipelago has imposed Western norms of behaviour on Asian and Indigenous societies which might have conflicting views about dealing with distress.

Laungani (2004) cautioned that because the West had the power to set 'gold standards' for therapies, other countries would aspire to those standards and eventually become homogenized/westernized. These anxieties about colonisation and cultural clashes are neither unique nor trivial – Guowei Wang, who was a pioneer in introducing Western psychology in China, was "tormented by the cultural anxiety and uncertainty of China's fate" and eventually drowned himself in 1927 (Gao & Wang, 2014, p.224).

In Singapore, the introduction of psychology was similarly received with some trepidation. Among Christian circles, psychology was seen as tending to the physical but ignoring the spiritual aspects of life (Yeo, 2002). As noted before, only 20% of Singaporeans identify as non-religious, and it would not be surprising if members of other religions had similar concerns, since clinical psychology has been criticized for neglecting spiritual dimensions of wellbeing (e.g., Naeem et al., 2009; Scorzelli & Reinke-Scorzelli, 1994). Increasingly, calls have been made for culturally sensitive therapies to adopt a biopsychosocial-spiritual model of illness (Naeem, et al., 2021).

Looking at a 2009-2010 community survey, Chong et al. (2012) found that out of 874 persons with mental health conditions, only 15.7% sought help from MHPs, while 7.6% consulted religious or spiritual healers (and this was not correlated with education level). Meanwhile, 12.7% sought help from social support professionals (social workers, counsellors) and 9.1% from other medical health professionals. In their study of the same data set, Picco et al. (2013) estimated that 6.6% of Singaporeans who had mental health conditions (and 1.5% of the general public) consulted religious and spiritual advisors. They added that of those who did so in the past 12 months, 84.6% were satisfied with the help they received, and 63.9% reported that it helped "a lot". Similarly, Kua et al. (1993) reported that 36% of Chinese patients seeking help from a Singaporean psychiatric

hospital consulted a traditional healer prior to going to the hospital. These statistics suggest a relatively low rate of acceptability of western MHPs, and a continued acceptance of religious or spiritual healers despite increased globalization/westernization. It also suggests that Singaporeans may hold different beliefs about the causes of mental health conditions than MHPs. B.O. Lee and Bishop (2001) showed that compared to MHPs, the general public had higher endorsements of indigenous and 'other' (organic, socioeconomic, and 'naïve') beliefs about aetiology and treatments for psychological distress.

Along with the challenges which come along with Singapore's complex ethnocultural mix however, comes unique opportunities – Sternberg (2002) asserted that Singapore would likely play a key role in the development of multicultural therapy.

1.4.1. Current Research in Cultural Adaptations

Despite the likelihood of Western psychology not being directly applicable to Singapore, much of that influence remains strong today. It is therefore clear that psychology in Singapore needs to be decolonised and that we need to find therapies which are culturally relevant and acceptable. Globally, researchers have started to pay more attention to this in recent years, and a number of systematic reviews have provided evidence that culturally adapted therapies can be effective, and even more so than their non-adapted counterparts (e.g., Benish et al., 2011; Chowdhary et al., 2014).

The efficacy of cultural adaptations is also backed by qualitative data from a study among psychologists in Pakistan, where psychologists felt that therapy works for those who stay in therapy, but that the number who stay is so small that no systematic evidence could be collected (Naeem et al., 2009).

1.4.2. Limitations

At this point, a useful distinction should be made between efficacy and acceptability. As seen from Naeem et al.'s (2009) study, just because an intervention is effective does not mean that it is acceptable (i.e., clients may drop out of therapy before experiencing its full benefits). In fact,

Chowdhary et al. (2014) reported that most of the authors in their systematic review cited the need to increase acceptability of the therapy as the primary reason for cultural adaptations, and recognized acceptability and patient satisfaction as important mechanisms to improve the efficacy of therapy.

Another limitation is that despite the increase in studies of culturally adapted therapies, many do not adequately describe the process or nature of their adaptations (Chowdhary, et al., 2014). This limits the practical applications of such research as practitioners are left with vague guidelines and suggestions (Geerlings et al., 2017; Huang & Zane, 2016). In this regard, Chowdhary et al. (2014) made a significant contribution by highlighting the adaptations they found in their systematic review (pp.1140-1141).

However, since this research was not done in Singapore, caution should be applied when considering their findings – homogeneity among ‘non-Western’ cultures should never be assumed. Even among Asian cultures, there are often significant differences – which should be no surprise given that besides Southeast Asia, ‘Asia’ also includes parts of the Arab world, Russia, India, China, etc. Differences have even been found between Singaporeans and people from other Confucian countries like China, Taiwan, Japan, and Korea (Foo et al., 2006; B.O. Lee & Foo, 2019). Based on a brief scoping search, little research has been conducted on culturally adapted therapy in Singapore.

1.5. Indigenous therapies and Spiritual healing

While adapting Western psychology to fit the local culture could be one way to arrive at decolonised and culturally relevant interventions, some Singaporeans have called for a more emic ‘inside-out’ approach which gives voice to marginalized and indigenous psychological constructs and does not depend on examining the fit of western models (B.O. Lee & Foo, 2019). Lyddon (1995) highlights that all therapies are underpinned by a set of epistemic assumptions – as such, any attempt to decolonize therapy should seriously consider therapies based on non-Western epistemologies.

Indigenous therapies and spiritual healing (IT/SH) are therefore suggested as alternatives. B.O. Lee and colleagues (e.g., B.O. Lee, 2002a, 2002b; B.O. Lee & Foo, 2019; B.O. Lee & Kirmayer, 2020) have written much about different types of IT/SH in Singapore, specifically about traditional Chinese medicine (TCM; a holistic approach integrating mind and body, focusing on both inter- and intra-personal balance and harmony), dang-ki healing (童乩; a form of shamanism), and feng-shui (风水; a type of divination based on fate and living in harmony with the physical environment). They suggested that these therapies would be more acceptable to some locals who held such beliefs about mental health. Laungani (2004) pointed out that the line between 'sacred' and 'secular' is more blurred in Eastern cultures, while Lim and Bishop (2000) reported that Chinese Singaporeans who visited both sinsehs (TCM practitioners) and Western doctors felt that sinsehs listened to them more and were more concerned about their wellbeing.

Gergen (2001) suggested that besides being beneficial to the cultures they were born in, Western therapies may have much to learn from Indigenous psychologies.

1.6. Systematic Review: What do Singaporean MHPs think?

The literature examined so far supports the need for Singaporean MHPs to employ acceptable, culturally relevant therapies. However, the question remains about what MHPs here think and what this looks like practically, given the limitations and lack of clear guidelines.

To my knowledge, no study has systematically reviewed the extant literature in this area. The following systematic review aims to fill this gap by addressing the question: 'What are Singaporean MHPs' views and experiences of cultural adaptations or indigenous therapies in Singapore?'

1.6.1. Search Strategy

An electronic search was carried out in four databases: Medline, PsycArticles, PubMed, and Scopus. These databases were chosen in consultation with the university's Information Manager for the Department of Life and Medical Sciences, based on the understanding that most psychological

papers would be covered within these databases. While the use of Google Scholar was also discussed as a possible way to include grey literature, it was decided against due to an excess of irrelevant search results. Search terms were developed following the SPICE mnemonic (Setting, Perspective, Intervention, Comparison, Evaluation; Booth, 2004, 2006), and were identified in consultation with consultation team, relevant literature, and Visuwords and PsycNet thesauruses (see Table 3;). Search terms for professionals were not limited to clinical psychologists and/or psychiatrists, based on the recognition that many other professions were involved in the delivery of mental health care. The terms were applied to titles and abstracts, and included all articles up until 25 March 2022. Only articles in English were included (see Appendix A for search strings).

Table 3

Search Parameters for the SLR

Setting	AND	Perspective	AND	Intervention	AND	Comparison	AND	Evaluation
Singapore		Decolon*		Psycholog*		Profession*		Experience*
		Local*		Mental health		Worker*		View*
		Indigen*		Psychotherap*		Nurse*		Belief*
		Cultur*		Counsel*		Therapist*		Philosophy
		Adapt*		Well?being		Psychotherapist*		Opinion*
		Race*		Psychiatr*		Psychiatrist*		
		Racial*		Therap*		Psychologist*		
		Ethn*				Practitioner*		
		Minori*				Counselor*		
		Religio*				Psychoanal*		
		Spirit*						
Exclusion criteria:		<ul style="list-style-type: none"> • Singapore culture was not examined separately from other cultures (e.g., if it was grouped together with other cultures) • Local adaptations and/or clear links to cultural differences were not discussed • Views were exclusively sought from foreign therapists in Singapore • Study uses the same data set as another included study without any significant additional contribution • Studies only examining adaptations to service provision and structures (rather than interventions per se) were excluded 						

The initial search returned 260 articles. After removing duplicates, 136 articles remained.

The titles and abstracts of the remaining 144 articles were screened. From this, 12 articles were

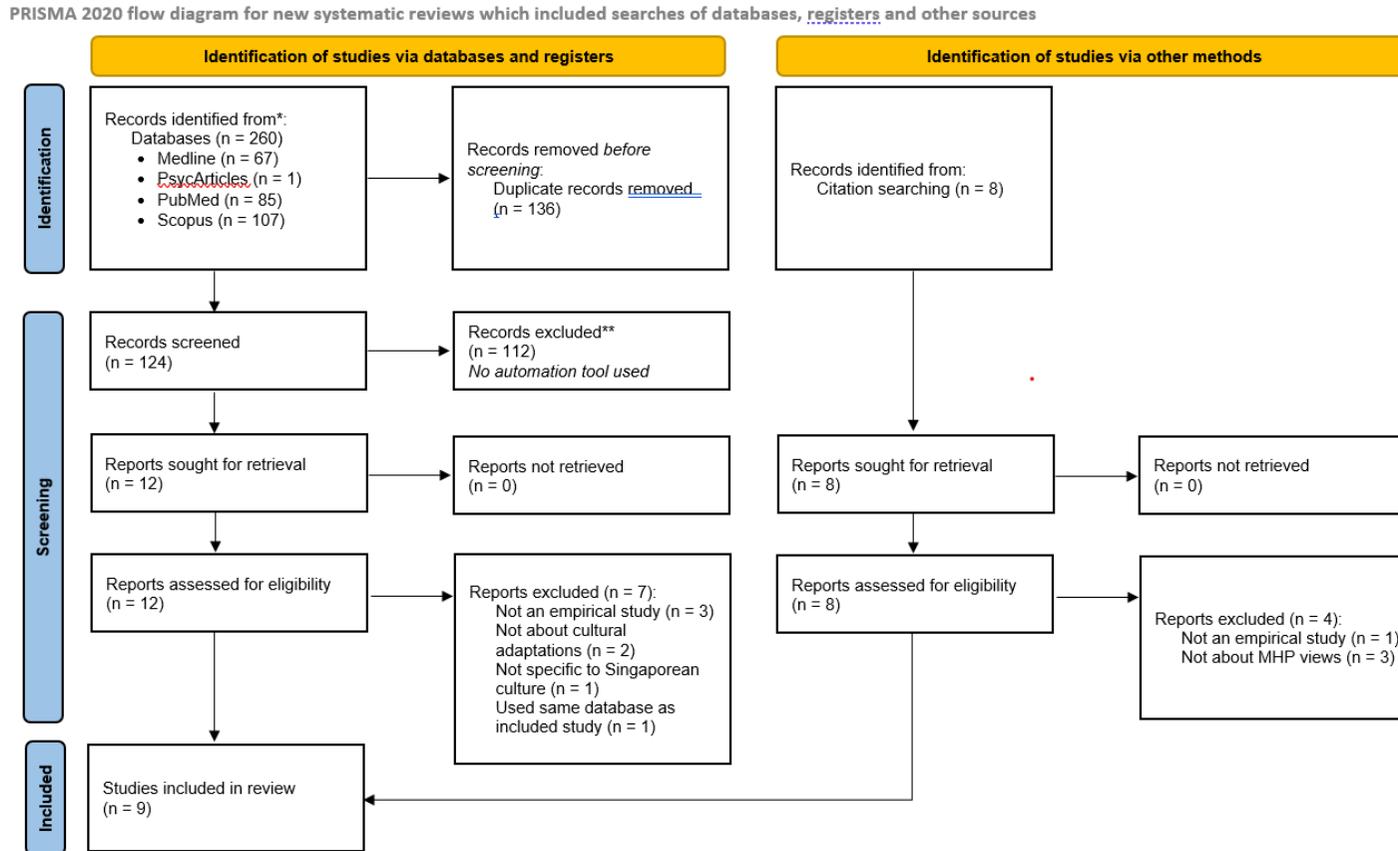
selected, to which eight handsearched articles were added, resulting in a total of 20 articles which were selected for a reading of their full text. Subsequently, 11 articles were excluded. In total, nine papers were included for the systematic review (Figure 2).

Articles were included only if they used empirical (quantitative or qualitative) studies – an exception was made for Yeo (2002)'s paper on pastoral care and counselling in Singapore. This was to allow for representation in this area of IT/SH, especially since among the religions in Singapore, Christians were the most likely to seek help from spiritual advisors (Picco, et al., 2013). In the United States (US), Weaver (1995) called clergy people "frontline community mental health workers" (p.129), citing the large proportion of time they spent providing pastoral care. The exception was also based on the understanding that because IT/SH practitioners likely subscribed to a different epistemology than Western MHPs, they might place less emphasis on conducting empirical studies and reporting them in journals in the same way as Western MHPs.

Review articles were excluded, but the reviewed studies were considered for inclusion. Reference lists from these papers were also screened for relevant articles. Other exclusion criteria included are shown in Table 3.

Figure 2

Prisma 2020 Flow Diagram (Page, et al., 2021)



*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).

**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: <http://www.prisma-statement.org/>

1.6.2. Overview

Of the nine selected articles, four were qualitative, two were quantitative, and two employed mixed methods. Three qualitative papers examined local MHPs' experiences of cultural issues in therapy, both quantitative papers surveyed MHPs about their views on various interventions (including IT/SHs), and one mixed methods paper did both. The final mixed methods study sought feedback from MHPs about a culturally-adapted intervention that was being developed, and the final qualitative paper was a case study describing the impact of culture in the treatment of a culture-bound syndrome (frigophobia). Yeo's (2002) paper was an opinion article on pastoral care and counselling in Singapore, written as a pioneer in both Christian and secular counselling since their inception in Singapore (Yeo, 2002) who had achieved "near legendary status within the local counselling community" (Mathews, 2007, p.565). A summary of the studies and their key findings can be found in Appendix B.

The quality of the papers were evaluated using the Mixed Methods Appraisal Tool (MMAT; version 2018) tool (Hong, et al., 2018; see Appendix C). Most were found to be of good quality, with the exception of the case study (observations were presented without any substantiating data), one mixed method study (data analyses methods were not specified), and the aforementioned non-empirical paper (expected, since the MMAT was only designed to appraise empirical studies). However, as Hong et al. (2008) suggested, no studies were dropped based on 'low methodological quality'.

1.6.3. Synthesis

Relevant points were extracted from each paper and coded. The codes were subsequently grouped into themes, and four recurring themes were identified: 1) Universal factors, 2) Adapting Western Models, 3) Unpacking 'Western' models, and 4) Acceptance of IT/SH.

1.6.4. Universal factors

MHPs in all nine papers felt that (with appropriate adaptations) Western interventions could still be effective for Singaporeans. Foo and Merrick (2004) reported that 67.1% of local MHPs felt culturally adapted therapies were relevant for more than half their clientele. Parker et al. (1999) reported that across three mental health conditions (depression, schizophrenia, and mania), local MHPs consistently felt that psychiatrists would be the best source of help. Similarly, all participant groups (clients, non-clients, and MHPs) in B.O. Lee and Bishop (2001)'s study had higher endorsements of psychological models (psychodynamic, behavioural, humanistic, and cognitive therapies) than indigenous models (Chinese medicine, dang-ki, and feng-shui) for both aetiology and treatment beliefs.

Many articles referred to some form of 'universality' among Western therapies, which Geerlings et al. (2017) suggested to mean that clinical psychology could be adapted for practice in Singapore, rather than "completely discarded for cultural insensitivity" (p.7). Their participants experienced clinical psychology as having both universal and Western aspects, with the 'core' of the models and skills being universal, while the theories, tools, and therapies were seen as Western. This 'core' included 'basic therapeutic skills' and therapeutic relationship factors, which were also mentioned by Jennings et al. (2008) and Loh et al. (2020).

However, it is worth noting that both Jennings et al. (2008) and Loh et al. (2021) felt that there were cultural differences even within the universal importance of establishing of a good therapeutic relationship.

1.6.5. Adapting Western Models

As seen above, there may be overlaps between what is considered 'universal' and what needs adaptation. Eight of the reviewed papers discussed some form of adaptation, with the exception being Parker et al. (1999). Here, I have grouped the adaptations into seven broad

categories based on the cultural differences they addressed: 1) Language, 2) Self-expression, 3) Respect for authority, 4) Family values, 5) *Kampung* spirit, 6) Multiculturalism, and 7) Health beliefs.

MHPs' challenges are discussed, and to avoid providing only vague suggestions, a summary of concrete adaptations discussed by MHPs for each category is presented in Table 4.

1.6.5.1. Language. Perhaps the most straightforward adaptations are the ones involving the need for direct translations of Western concepts and resources (e.g., test kits, psychoeducational materials). MHPs from three papers (Foo & Merrick, 2004; Geerlings et al., 2017; Loh et al., 2021) noted this adaptation, and those in Foo and Merrick (2004) also highlighted the importance of using cultural metaphors, while others noted the use of Singlish (local colloquial English-based creole language) in sessions (Geerlings et al., 2017).

As a counterpoint, when describing a need for more focus on 'basic' counselling skills (e.g., gentleness and tact), some MHPs were quoted saying that such skills come more naturally to Western therapists since it is their 'natural language', whereas this manner of talking is not 'normal' for Singaporean MHPs (Jennings et al., 2008). As such, there appears to be a balance between picking up Western ways of communicating gentleness and tact, and simultaneously adapting it to be familiar to local clients.

1.6.5.2. Self-expression. Linked to the use of language in therapy, MHPs in five papers (Foo & Merrick, 2004; Geerlings et al., 2017; Loh et al., 2021; Sim, 2012; Yeo 2002) noted challenges related to differences in Singaporeans' levels of self-expression in therapy. While some MHPs spoke about barriers to the overt expression of emotions (Geerlings et al., 2017; Sim, 2012), others described it more broadly in terms of a hesitation to self-disclose about their personal history (Foo & Merrick, 2004), and in group settings (Loh et al, 2021).

Some MHPs felt that the emphasis on self-expression was a Western value which did not apply to Singaporeans (Geerlings et al., 2017). Such differences might account for why the families

who took part in Loh et al.'s (2021) multi-family therapy suggested to reduce the discussion time in the multi-family context.

1.6.5.3. Respect for Authority. MHPs noted that hierarchies were prevalent in families, training, and therapeutic relationships (Geerlings et al., 2017; Sim 2012), and clients often expected therapists to be experts who gave directive advice and solutions (Foo & Merrick, 2004; Geerlings et al., 2017; Loh et al., 2021; Sim, 2012).

On the other hand, some MHPs also highlighted that sometimes the hierarchy is more complex in that the father of a family might not fully respect the position of some MHPs (e.g., a female family therapists) as much, and therefore not engage with the intervention (Sim, 2012).

This preference for expert therapists might explain why families in Loh et al.'s (2021) study suggested that interventions should incorporate success stories of previous families, as this might reinforce therapists' 'expert' credentials.

While some academics in Geerlings et al.'s (2017) study similarly felt it was better to accept similar hierarchies in trainee-academic relationships and work within it, others found it useful to invest effort into establishing more egalitarian relationships with their trainees. However, whether this translated to their therapeutic practice was not explored.

1.6.5.4. Family Values. Besides family hierarchies, other cultural differences related to family values were noted in four studies (Jennings et al., 2008; Loh et al., 2021; Sim, 2012; Yeo, 2002).

MHPs noted the importance of respecting the hierarchy and family structure of Asian families (Jennings et al., 2008; Sim, 2012; Yeo, 2002). Some elaborated that whereas most therapists were trained in individualistic interventions (which promote Western values like autonomy and assertiveness), Singaporeans had a relational view of their selves (Jennings et al., 2008). Accordingly, MHPs warned against imposing such Western values onto Singaporean families (Jennings et al., 2008; Sim, 2012).

Other MHPs discussed a different challenge, where families tended to perceive the client as the 'problem' (Loh et al., 2021). It is unclear whether this is a challenge unique to Singaporeans, as Western psychology itself has been criticized for doing the same thing of situating the problem in the individual, thereby ignoring the wider systems around them (Bloch et al., 1991; Bronfenbrenner, 1979; Minuchin, 1985). However, my personal reflections with other Singaporeans have highlighted the possibility that such challenges might indeed be more common in societies like ours where 'social harmony' and 'family integrity' are valued above the individuals within it. Here, it might be less stigmatizing to have a 'problem' member than a 'problematic' family dynamic, with the latter resulting in a greater loss of 'face'.

1.6.5.5. *Kampung Spirit.* *Kampung* (Malay for 'village') spirit refers to "a sense of community and solidarity" (National Archives Singapore, 2018, para.1), and invokes images of life in Singapore as recently as the 1970s and 80s (Rahman, 2014; Remember Singapore, 2012) – including neighbours who readily offered food, help, and support to each other.

In contrast to our earlier discussion on clients who expected directive, expert therapists, Yeo (2002) reflected that sometimes a clinical approach might be considered offensive. Noting that Singaporeans prefer casual and personal relationships due to our communal orientation, he observed that Singaporeans might prefer to have informal consultations (e.g., at home). He felt that Singaporeans might have less boundaries and expect ready access to pastoral staff whenever, due to a 'village mind-set' wherein village elders were readily available and would inquire into the welfare of community members. Accordingly, Yeo (2002) recommended that counselling should be done through therapeutic conversations and relationships without formal, structured problem solving, and without imposing particular (Western) counselling strategies or techniques.

It should be noted that while Yeo (2002) was writing about counselling practices, it was through the lens of pastoral care. As such, one possible explanation for the difference between our earlier discussion and Yeo's (2002) observation is that the setting the MHP is located (e.g., church

versus hospital) or the type of professional being seen (e.g., pastor versus psychiatrist) might affect the expectations clients come with. All three studies in the earlier discussion (Foo & Merrick, 2004; Loh et al., 2021; Sim, 2012) had been done in hospitals and/or included medical professionals (e.g., psychiatrists, clinical psychologists [CPs]).

Regardless, non-pastoral MHPs should also be aware of the possibility of such client expectations, as without further research it is unclear which set of expectations (or even a combination) clients might bring into sessions. Even within settings and professionals, some might fall into 'grey' areas (e.g., family service centres, counselling psychologists). From a decolonising lens, although it is outside the scope of this review, the fact that Singaporeans might have adjusted their expectations for Western, medicalized institutions and professions is also worth reflecting on.

1.6.5.6. Multiculturalism. Four studies (Geerlings et al., 2017; Jennings et al., 2008; Loh et al., 2021; Sim 2012) discussed the importance of adaptations to work 'within a multicultural context'. Jennings et al. (2008) noted in that when comparing themes from master therapists in Singapore and America, this was one of four unique themes in Singapore.

MHPs spoke about the importance of noting differences even within the similar (Sim, 2012). They described how adaptations needed to be made at multiple levels: Asians, Singaporeans, members of specific groups in Singapore, and at client level (Geerlings et al., 2017). This might be especially important in Singapore, with its aforementioned mix of Asian and Western values, as the 'blend' will look different across families and individuals, with differences in degrees of Westernization (Foo et al., 2006).

Some studies made rather vague references to MHPs using 'intuition', 'wisdom', or 'clinical and professional judgement' in adapting Western therapies, or about how culture was 'automatically' integrated based on therapists' understanding of their clients' cultural needs (Geerlings et al., 2017; Sim, 2012). While such suggestions were sensible and could reflect the complex and enigmatic nature of multicultural practice, they also suggested some level of

esotericism accessible only to ‘culturally competent’ practitioners – how do therapists develop such intuition?

Geerlings et al. (2017) pointed out that while some MHPs believed that all Singaporeans possessed a ‘basic capacity’ for cultural sensitivity due to extensive cross-cultural interactions since young, others challenged this belief as ‘ignorant’. MHPs highlighted the importance of cultural awareness (Geerlings et al., 2017; Jennings et al., 2008), which to many involved being ‘curious’, ‘respectful’, and adopting a ‘cultural relativist stance’. This involved recognizing that Western ideas and therapies are not always appropriate (Geerlings et al., 2017; Jennings et al., 2008; Loh et al., 2021; Sim 2012), and being able to work with multiple explanatory models simultaneously, including cultural models (Geerlings et al., 2017)

1.6.5.7. Health Beliefs. Five papers discussed the impacts of Singaporeans’ health beliefs on therapy (Foo & Merrick, 2004; Geerlings et al., 2017; Jennings et al., 2008; B.O. Lee & Bishop, 2001; Ng, 1998).

Ng’s (1998) described how his client’s cultural beliefs (that the loss of 气[qi], or vitality, had caused an imbalance of 阴[yin] and 阳[yang] resulting in illness) led to a particular presentation of symptoms consistent with those beliefs (i.e., a fear and avoidance of ‘cold’, including food which is traditionally seen as being of a ‘cold’ [yin] nature). These beliefs impacted on which professionals she trusted for advice and chose to consult (e.g., TCM practitioners), and which interventions she chose to abstain from (e.g., blood investigations, as blood is seen as linked to qi).

Ng’s (1998) observations are supported by B.O. Lee and Bishop’s (2001) study which found that clients’ aetiology beliefs were correlated with their treatment beliefs, with indigenous belief models having the strongest correlation (compared to psychological and ‘other’ belief models). This suggests that clients who hold causal beliefs about their difficulties which are consistent with IT/SH models are more likely to seek help from IT/SH practitioners than from Western MHPs.

MHPs noted that both clients and MHPs may hold cultural and spiritual explanatory models which contradict psychological ones (Geerlings et al., 2017; Jennings et al., 2008), and that IT/SH can supplement Western psychotherapy (Foo & Merrick, 2004).

Table 4

Summary of Adaptations from the SLR

Cultural difference	Examples of adaptation	Discussed in
Language	Direct translations of Western concepts and resources (e.g., test kits, psychoeducational materials)	Foo & Merrick (2004) Geerlings et al. (2017) Loh et al. (2021)
	Using cultural metaphors	Foo & Merrick (2004)
	Using Singlish (colloquial Singaporean English)	Geerlings et al. (2017)
	Learning from Western ways of communicating gentleness and tact to clients	Jennings et al. (2008)
Self-expression	Allowing couples to talk to each other through the therapist first before doing so directly	Sim (2012)
	Using more rapport-building sessions	Foo and Merrick (2004)
	Beginning sessions by focusing on practical concerns	Loh et al. (2021)
	Acknowledging the vulnerability of self-disclosure	Loh et al. (2021)
	Using more personal self-disclosure from MHPs	Foo and Merrick (2004)
Respecting clients' decisions not to speak about feelings and personal issues	Yeo (2002); Geerlings et al. (2017)	
Respect for authority	Teaming up with MHPs of higher 'status' (e.g., male psychiatrists) to facilitate engagement of more senior family members	Sim (2012)
	Using more directive and active techniques which aim to provide more input and concrete, practical suggestions (e.g., Strategic therapy)	Loh et al. (2021) Sim (2012)
	Avoid being too reflective and 'insight-oriented'	Loh et al. (2021) Sim (2012)
	Sharing positive feedback about therapy from previous clients	Loh et al. (2021)
	Consider investing more effort to foster a more egalitarian relationship	Geerlings et al. (2017)
Family values	Avoid disrupting family structures	Jennings et al. (2008) Sim (2012) Yeo (2002)
	Children might get into trouble for embarrassing parents – avoid asking younger members to express negative opinions about senior members	Sim (2012) Yeo (2002)
	Asking senior members for permission to allow younger members to speak freely	Jennings et al. (2008)
	Spending more time to psychoeducate families about the relational impacts of mental health difficulties	Loh et al. (2021)

<i>Kampung spirit*</i> *Mainly based on a pastoral care context	Being aware that Singaporeans might prefer more informal consultations	Yeo (2002)
	Using therapeutic conversations and relationships, with less emphasis on formal Western strategies and techniques	Yeo (2002)
Multiculturalism	Identifying differences even within similarities – adaptations need to be made at multiple levels: Asians, Singaporeans, members of specific groups, client	Geerlings et al. (2017) Sim (2012)
	Exercising ‘intuition’ and ‘professional judgement’ in adapting therapy	Geerlings et al. (2017) Sim (2012)
	Remaining ‘open-minded’ and ‘curious’, and adopting a ‘cultural relativist stance’	Geerlings et al. (2017) Loh et al. (2021) Sim (2012)
	Recognizing that Western ideas, values, and therapies are not always appropriate for Singapore	Geerlings et al. (2017) Jennings et al. (2008) Loh et al. (2021) Sim (2012)
	Being able to work with multiple models simultaneously, including cultural models	Geerlings et al. (2017)
	Incorporating systemic thinking into our work	Jennings et al. (2008) Sim (2012)
Health beliefs	Understanding cultural differences in the expressions of distress	Ng (1998)
	Respect clients’ beliefs about their mental health difficulties and avoid antagonizing them	Ng (1998)
	Negotiating a shared explanation of the symptoms to help clients see the links with psychosocial stressors	Ng (1998)
	Being comfortable with addressing spirituality within therapy, or even exercising our own spirituality (e.g., praying privately or with them)	Foo & Merrick, 2004 Jennings et al. (2008)
	Reframe concepts to fit clients’ beliefs	Foo & Merrick (2004)
	Adopting a flexible therapeutic stance towards therapy, and working with alternative explanatory models which are more congruent with clients’ beliefs	Jennings et al. (2008) Geerlings et al. (2017)
	Allowing IT/SH to complement our sessions	Foo and Merrick (2004)

1.6.6. Unpacking ‘Western’ Models

Up until this point, we have mainly spoken about ‘Western’ psychology as a homogenous group. As acknowledged earlier, this way of categorizing often does its constituents a disservice. For example, concerns that Western psychology has traditionally been too individualistic have frequently been raised by proponents of systemic therapy (e.g., Bloch et al., 1991, Bronfenbrenner, 1979, Minuchin, 1985).

Singapore MHPs' calls for us to adopt a flexible therapeutic stance which might incorporate other explanatory models (Jennings et al., 2008; Geerlings et al., 2017) prompt us to take a closer look at the different models of therapy under this umbrella of 'Western' therapy.

1.6.6.1. Western Medication. While not a model of psychotherapy per se, Western medication is included here briefly as a Western aetiology belief of mental health.

MHPs in Parker et al.'s (1999) study consistently saw psychiatrists as the 'best help' for various mental health conditions (depression, mania, and schizophrenia). This is notable as other options included a self-awareness of the 'problem', and seeking social support. Similarly, B.O. Lee and Bishop (2001) showed that Singaporeans (clients, non-clients, and therapists) endorsed organic aetiology and treatment beliefs alongside psychological models, which suggested the importance of incorporating biological approaches in treatment. Finally, Ng (1998) also wrote that a combination of Western medication, reassurance, psychoeducation, and marital therapy had resulted in early symptom improvement and stabilized his client's condition, increasing subsequent engagement in therapy. These reports reflect the confidence that many MHPs have in Western medication as an intervention, whether as the primary intervention ('best help') or to complement other interventions.

1.6.6.2. Cognitive and Behavioural Therapies. In their study, Foo and Merrick (2004) found that three of the four most common therapy models used by practitioners in Singapore were behavioural management, cognitive therapy, and CBT. Additionally, B.O. Lee and Bishop (2001) reported that MHPs endorsed psychological aetiology and treatment beliefs (including psychodynamic, humanistic, behaviour, and cognitive therapies) more so than they did indigenous and 'other' models.

Interestingly, B.O. Lee and Bishop (2001) found that Singapore clients and non-clients exhibited a similar pattern of endorsement of psychological models over indigenous and 'other' models. However, both Ng (1998) and Geerlings et al. (2017) reported that CBT was not always

helpful for their clients. Some MHPs specifically named CBT as an example of therapies which hold Western values (e.g., open emotional expression and linear relationships) that did not fit with Singapore's culture (Geerlings et al., 2017).

1.6.6.3. Marital and Family Therapy. Marital therapy was the last of the four most common therapy models reported by Foo and Merrick (2004). It was also credited by Ng (1998) as one of the interventions which was helpful at providing early symptom improvements in his client. Beyond marital therapy, MHPs also found that it was helpful to include their clients' families in their sessions (Foo & Merrick, 2004).

Marital and family therapy, however, may be an ambiguous term as it could be underpinned by CBT theories (e.g., Epstein & Baucom, 1989), systemic theories (e.g., Stanton & Welsh, 2012), both (e.g., Dattilio & Nichols, 2011), or even other modalities. Without knowing more about the specific form of therapy described in the above studies, it is difficult to comment further on its cultural appropriateness.

1.6.6.4. Systemic Therapy. MHPs in four articles discussed to varying extents the usefulness of systemic interventions, which included understanding clients' contexts, recognizing Asians' relational view of the self, and taking multiple perspectives to see multiple truths (Jennings et al., 2008; Loh et al., 2021; Sim, 2012; Yeo, 2002). Two other articles also discussed principles intrinsic to systemic therapy without explicitly naming it (Geerlings et al., 2017; B.O. Lee & Bishop, 2001). MHPs in Geerlings et al. (2017)'s study spoke about how therapy with Singaporeans needed to consider the relational self, while B.O. Lee and Bishop (2001) advocated for an ecological approach to therapy (rather than a purely psychological or biological one), noting that besides organic and psychological beliefs, Singaporeans (clients, non-clients, and therapists) also endorsed socioeconomic aetiology and treatment beliefs.

Such systemic principles and approaches were seen by MHPs as a better fit for Singapore's culture than the individualistic therapies they were trained in (Geerlings et al., 2017; Jennings et al.,

2008). Family therapists in Sim's (2012) study also cited a "handicap" and lack of tools in working with their patients and families as a driving force behind their pursuit of family therapy training.

From the clients' perspective, Loh et al. (2021) reported that on average their families had good experiences and rated the structure, content, and effects of their multi-family therapy based on systemic principles positively.

Taken together, these articles suggest that the cultural relevance of systemic therapy is widely recognized by many MHPs and clients in Singapore. However, MHPs cautioned that as a Western model, adaptations were still required to avoid causing harm to our clients (Loh et al., 2021; Sim, 2012).

1.6.6.5. Empowerment/Strength-based Approaches. The last 'model' which MHPs in two papers spoke about were those which highlight clients' strengths and empower clients to elicit change (Jennings et al., 2008; Yeo, 2002). They believed that this way of interacting with clients would empower and motivate them, and help to validate and normalize their feelings.

It should be noted that while strength-based approaches may constitute their own models (e.g., positive psychotherapy; Seligman et al., 2006), they can also be integrated into other models (e.g., strengths-based CBT; Padesky & Mooney, 2012). Additionally, Constantine and Sue (2006) point out that while positive psychology can be helpful when working with people of colour, therapists need to remember that values often associated with a 'good life' and 'optimal human functioning' (e.g., hope, happiness, self-determination) are Western culture-bound and may not apply to other communities. Specifically, they note that the Buddhist belief that 'life is suffering' may not fit with an emphasis on optimism. As such, even when applying empowerment/strength-based approaches, we may need to be careful not to overemphasize the importance of being happy or hopeful.

1.6.6.6. Flexibility. Finally, it is important to note that four papers advocated for some flexibility in our approach to therapy, and to match our interventions to our clients' beliefs (Geerlings et al., 2017; Jennings et al., 2008; B.O. Lee & Bishop, 2001; Yeo, 2002). Many MHPs did not advocate for any singular model, but instead advocated for the ability to work with different explanatory models simultaneously (Geerlings et al., 2017; Jennings et al., 2008). MHPs recommended that we should not fixate on particular strategies or techniques, so that we can recognize when a model we are using is incompatible with our clients' beliefs (Jennings et al., 2008; Yeo, 2002). Instead, we should pay more attention to foundational skills (Jennings et al., 2008), and match our interventions to our clients' beliefs (B.O. Lee & Bishop, 2001).

In advocating for flexibility, B.O. Lee and Bishop (2001) go further to say that MHPs should not classify beliefs into Asian or Western, and that culturally relevant treatments should integrate both indigenous and Western approaches.

1.6.7. Acceptance of IT/SH

MHPs had mixed views about the usefulness of IT/SH treatments. Foo and Merrick (2004) reported that 65.8% of their MHPs accepted clients' use of IT/SH alongside therapy, and MHPs generally agreed that IT/SH can supplement Western therapies. However, MHPs preferred IT/SH to be conducted outside of their sessions – 67.1% of MHPs said that they would consent to discuss religious topics but would refer them on.

In contrast, Parker et al. (1999) reported that across all studied conditions, all professions agreed that most (if not all) IT/SH interventions would not be helpful. This included traditional or spiritual healers, Chinese medicine hall or Malay medicine shop, tonic or herbal medicines, acupuncture, and religious leaders. Similarly, B.O. Lee and Bishop (2001) found that MHPs in their study endorsed psychological beliefs more than they did indigenous and 'other' beliefs.

One possible reason for their different findings could be the settings from which their participants were recruited. Whereas Foo and Merrick (2004) recruited from National registries and

directories across Singapore and included counsellors, psychiatrists, psychologists, psychotherapists and social workers, Parker et al. (1999) only recruited from one psychiatric hospital. It could be hypothesized that MHPs in hospitals may see more severe mental health difficulties due to the nature of their setting, and so their views may reflect a perceived limit to the helpfulness of IT/SH – namely that IT/SHs may only be helpful for less severe difficulties.

Another possible reason is that sampling biases may have occurred: 1) Many of the staff surveyed by Parker et al. (1999) came from more medicalized professions (e.g., psychiatrists, nurses, occupational therapists), and 2) Regardless of profession, it is likely that hospital staff adopt a more medicalized approach towards mental health. These findings may reflect the unfavourable view that Western medicine has historically had towards ‘folk medicine’.

Given these conflicting results, it is unclear how receptive MHPs are to IT/SH. What *is* consistent, however, is that MHPs see IT/SH as separate from their practice.

Despite these findings, B.O. Lee and Bishop (2001) suggested that local MHPs should ‘integrate’ IT/SH (specifically TCM) with Western psychotherapy, based on their findings that there was still some endorsement for these models among non-MHPs (clients and non-clients). However, they acknowledged that detailing how to do so required its own study. Yeo (2002) recommended that for pastoral staff, counselling skills should be employed within the context of pastoral care (which may be seen as a form of IT/SH). He argued that pastoral care, which has a wider focus on caring and building up rather than problem-solving, was a better fit for the *kampung* spirit Singaporeans possessed.

Notably, Foo and Merrick (2004) also found, through their interviews, that an indigenous therapy model existed in Singapore but was not fully developed (PADI; Yeo, 1993, as cited by Foo & Merrick, 2004). Yeo is also the author of the pastoral care paper included in our review, but unfortunately information about PADI therapy was not readily available and so cannot be discussed here.

1.6.8. *The Wider Context of Practice*

The papers reviewed here also speak to some cultural challenges in the wider context of their practice including: lack of therapy and supervision opportunities for MHPs (Jennings et al., 2008); organizational structures being unsupportive of family therapy (Sim, 2012), training courses being Westernized and mainly focusing on CBT (Geerlings et al., 2017; Sim, 2012); high proportions of MHPs being trained overseas (Foo & Merrick, 2004); and a high reliance on Western tools, standards, resources, and academics (Foo & Merrick, 2004; Geerlings et al., 2017; Parker et al. 1999). While these are all important factors to consider and have direct impacts on the way we work, they are outside the scope of this review and will not be discussed at length.

1.7. Discussion

Going back to the original research question, what are Singaporean MHPs' views and experiences of cultural adaptations or indigenous therapies in Singapore? These papers suggest that MHPs overwhelmingly felt that Western therapies are viable in Singapore's context, but require adaptations (Foo & Merrick, 2004; Geerlings et al., 2017; Jennings et al., 2008; B.O. Lee & Bishop, 2001; Loh et al., 2021; Ng, 1998; Sim, 2012; Yeo, 2002). Generally, these adaptations revolved around meeting certain cultural differences: 1) Language, 2) Self-expression, 3) Respect for authority, 4) Family values, 5) Kampung spirit, 6) Multiculturalism, and 7) Health beliefs. MHPs provided some concrete suggestions from their own experience, but equally, many continued to advocate the importance of remaining 'curious' and adopting a cultural relativist stance (Geerlings et al., 2017; Jennings et al., 2008; Loh et al., 2021; Sim 2012). Many of the areas of adaptation were similar to those highlighted by Chowdhary et al. (2014; e.g., language adaptations, including families in therapy, incorporating local practices and remedies). These papers also added adaptations specific to Chinese cultural values (e.g., using more personal self-disclosure, respecting family hierarchies) and multicultural societies (e.g., adopting a cultural relativist stance, using multiple models simultaneously).

MHPs spoke about different models of therapy, but many pointed out the shortcomings of CBT and other individualistic approaches while advocating for a systemic approach (Geerlings et al., 2017; Jennings et al., 2008; B.O. Lee & Bishop, 2001; Loh et al., 2021; Sim, 2012; Yeo, 2002). However, rather than becoming focused on one particular model, MHPs felt that flexibility and the ability to work with different models simultaneously was an important skill in working with multicultural populations (Geerlings et al., 2017; Jennings et al., 2008; B.O. Lee & Bishop, 2001; Yeo, 2002). It should be noted here that a possible reason for the strong support for systemic therapies is a sort of self-selection bias – whereas CBT and individualistic therapies might view culture as an ‘external’ factor which needs to be accounted for, culture and context are an intrinsic part of systemic therapies. As such, it is unsurprising that more systemic therapists would be interested in reflecting and writing about cultural differences.

Additionally, many MHPs saw the incorporation of spirituality into their work as an important adaptation (Foo & Merrick, 2004; Jennings et al., 2008; Yeo, 2002), but saw IT/SH as separate from their work (Foo & Merrick, 2004; Parker et al., 1999). However, some MHPs still felt that integrating IT/SH with our work in some way was still important, for example by accepting the use of IT/SH in supplementing their interventions (Foo & Merrick, 2004; B.O. Lee & Bishop, 2001). It is also interesting to note that in Parker et al.’s (1999) study, MHPs endorsed ‘attending courses on relaxation, stress management, meditation, yoga, tai-chi or chi-gong’ much more so than they did IT/SH, despite many of these having their roots in Asian traditions and philosophies as well. Perhaps one explanation for this is those practices have now gained recognition and following in the West, which somehow lent them more credibility in the eyes of MHPs.

It is important to acknowledge that there were a number of limitations in the papers reviewed here. While there were other limitations within each paper (see Appendices B and C), I wanted to highlight a few overarching ones. Firstly, there was a lack of diversity in many of the papers. Most of the paper did not include data about age, ethnicity, gender, and/or religious beliefs

of their MHPs (Loh et al., 2021; Ng, 1998; Parker et al., 1999; Sim, 2012, Yeo, 2002). Where such information could be gathered, the MHPs were mostly adults below 40 (Foo & Merrick, 2004; Geerlings et al., 2017; B.O. Lee & Bishop, 2001), Chinese (Foo & Merrick, 2004; Jennings et al., 2008; B.O. Lee & Bishop, 2001; Ng, 1998; Yeo, 2002), female (Geerlings et al., 2017; Foo & Merrick, 2004; B.O. Lee & Bishop, 2001), and Christian (Foo & Merrick, 2004; B.O. Lee & Bishop, 2001; Yeo, 2002). These demographics are important to consider as members of different groups might have different opinions. For example, B.O. Lee and Bishop (2001) found that Buddhists and Taoists clients were more likely to endorse indigenous therapies than Christians or non-religious clients. This makes sense because the indigenous therapies they studied shared cultural origins with Buddhism.

This leads into the next limitation discussed here, which is the lack of representation of other indigenous therapies in the papers. While I had tried to include papers about different IT/SH in Singapore (e.g., Yeo, 2002), I was only able to find studies on Chinese IT/SHs and Christian pastoral care – besides Parker et al. (1999) who also included options like *Jamus* (Malay medicine shop dispensers) and *Bomohs* (Malay shamans and traditional healers). While I have come across (few) academic papers about Malay IT/SH, I was unaware of any literature on MHPs' views of Malay, Indian, or any other IT/SH in Singapore. This is a major limitation in the literature, as it potentially excludes the indigenous wisdom of a large group of Singaporeans, including the Malays, who might rightfully be considered the 'natives' of Singapore (Sa'at, Joraimi, & Sai, 2021).

Clinically, the present review suggests that the use of Western therapies with Singapore clients can still be effective. Indeed, MHPs' faith in culturally adapted Western interventions is supported by local studies which have demonstrated that they can be effective here (e.g., Drmic et al., 2017; Ooi et al., 2007). However, as previously explained, acceptability is just as important as efficacy, and I am not aware of any studies which have examined this (despite Drmic et al.'s [2017] title, they only discussed feasibility and not acceptability). MHPs need to be aware of the cultural roots of Western therapies and our clients' own beliefs, so that we employ models which match

their beliefs, and can make the appropriate cultural adaptations. Even then, we need to be constantly reflective and curious, to notice the differences even within our similarities as Singaporeans.

On a structural level, MHPs felt that local training programmes are not doing enough to prepare MHPs for practicing in Singapore. MHPs felt that the cultural training they received on their courses was 'ambiguous' and insufficient, with most of their learning being done through informal networks on the job (Geerlings et al., 2017). Some MHPs suggested that trainings need to focus more on foundational skills instead of techniques (Jennings et al., 2008). Others felt that more formal local training courses were needed which would be more sensitive to the local culture (Sim, 2012). B.O. Lee and Bishop (2001) argued that MHP training should include teaching about the major religions in Singapore (e.g., Buddhism, Christianity, Islam). Similarly, MHPs had suggestions for clinical psychology programmes in particular (Geerlings et al., 2017): 1) Increasing teaching on cultural content (e.g., including literature on Asian clients, learning about different cultures in Singapore and their history, training in specific cultural adaptations); 2) Decreasing foreign dependency (in terms of curricula and resources); 3) Encouraging and facilitating reflective spaces and cross-cultural engagement on courses and on placements; and 4) Supporting academics in developing cultural knowledge (since academics sometimes believed themselves more culturally competent than their students did).

1.9. Research Rationale and Aims

In summary, our SLR suggests that MHPs believed that Western therapies can be adapted for Singapore, but also that some modalities might be more appropriate than others. However, this finding was limited by the fact that none of those papers directly asked MHPs to compare various models. The closest attempt at this was made by B.O. Lee and Bishop (2001), who asked MHPs about their endorsement of aetiology and treatment beliefs based on a few psychological models (psychodynamic, humanistic, behavioural, and cognitive therapies). However, as their main interest

was in IT/SH beliefs, they did not report or compare the ratings for each of the psychological 'sub-models'. Additionally, while there were conflicting findings about MHPs' views of the usefulness of IT/SH, most agreed that it should be kept separate from their therapy. These findings, along with the fact that an indigenous counselling model (PADI) existed but was not fully developed (and had no resources readily available) suggests that MHPs in general had a "strong allegiance to a Western medical and psychiatric model" (Parker et al., 1999, p. 562).

Another finding from the review was that there were insufficient local training courses in Singapore, and that the existing ones were not adequately preparing their trainees for culturally relevant practice in Singapore. Interestingly, only three papers reported the training background (in terms of country) of their MHP participants (Foo & Merrick, 2004; Geerlings et al., 2017, Jennings et al., 2008). Foo and Merrick (2004), who recruited broadly from national registries and directories, found that only 35.6% of their participants were trained locally. This was reflected in Jennings et al. (2008), in which only one out of nine 'master therapists' trained locally. The exception was Geerlings et al. (2017), and this was due to the fact that they specifically recruited from local courses – even then, they reported that most of the academics in those schools were not local, but did not consider the views of locally trained MHPs separately. Given prevalent attitudes and 'knowledge flows' (Geerlings et al., 2014) in Singapore, it would not be surprising if a large proportion of the remaining 64.4% trained in Western countries (much like I did). It is perhaps apt then to question whether an education in Western countries would be more likely to bias MHPs toward Western interventions and/or against IT/SH practices.

I also noticed that most of the papers which included CPs did not distinguish between their views and those of other MHP professions, with the exception of Geerlings et al. (2017) who only recruited CPs. Given our discussion on the contrasting findings between Foo and Merrick (2004) and Parker et al. (1999), it is perhaps also useful to find out more about the views of CPs in particular. In this regard, Geerlings et al. (2017) reported that while there was disagreement between CPs in their

study, some held a belief that scientific and 'objective' evidence meant that Western therapy was in fact universal.

The systematic review highlights a gap in the literature on the cultural relevance of various models for Singaporean populations. The research described in the next chapter was designed to address this gap, with a particular focus on the views of Singaporean CPs who trained locally. Specifically, the study aimed to find their views about the following research questions:

- 1) Is a focus on CBT suitable for working within Singapore culture?
- 2) What other models of therapy might be culturally relevant for Singapore?
- 3) How prepared do Singaporean CPs feel for culturally relevant practice after training locally?
 - Which models of therapy would they have liked to learn more about before graduating and what else would have added to their preparedness to provide culturally relevant therapy?

Chapter 2. Methodology

You study moral philosophy: Aristotle, Cicero, Locke, and Kant. You learn to read them with blinkers on, mining them for the things that matter. You learn to write the way they do assertive, arrogant, to-the-point. Men do better in exams, you are told, because they write this way. You must be confident. You must write like a man.

– To my Eighteen-Year-Old Self, on your Departure for Cambridge

By Singaporean Michelle K. (2013, p.28)

2.1. Overview

The present study adopted a Thematic Analysis (TA) approach. This chapter will describe this methodology and the key considerations that went into designing the study. It begins with providing the rationale for a qualitative approach to exploring the views of Singaporean MHPs on clinical psychology training in Singapore. This will be followed by a discussion of how my epistemological position impacted on study. Efforts to maintain methodological rigour are then discussed before the research design is described in detail.

2.2. Qualitative Research

With little research currently available on these research questions, an exploratory qualitative approach seems appropriate for this study. Rather than simply answering the ‘what’ questions (e.g., what models are culturally relevant), we are also seeking to answer the implicit ‘why’ questions (e.g., why are these models culturally relevant).

Quantitative research is concerned with hypothesis testing and finding generalizable and objective truths about the world. It generally follows an objectivist epistemology which assumes a reality independent from the mind and discoverable through empirical means (Moon & Blackman, 2014). However, it has been argued that such views ignore the importance of culture and society. As

Gergen (2001) notes, “to presume the local to be universal not only is arrogant but also sets the stage for conflict and a deathly silencing” (p.806).

Qualitative traditions, on the other hand, seek to understand human experience and sense-making in a way that is deep and rich (Lincoln, 2010), and avoids obscuring the variability and uniqueness inherent to human experiences by quantifying them (Henwood & Pidgeon, 1992). Social processes are recognized, and individual experiences are privileged.

Since I am interested in culture, personal experiences, and the exploration of a less-researched area, a qualitative methodology was suitable to allow in-depth descriptions of the topic. Specifically, interviews were chosen as the most direct and open-ended way to explore participants’ views.

2.3. Epistemological Position

As previously described, this research adopts a radical constructivist epistemology. The sense-making approach of qualitative methods therefore fits well with the epistemological position of this paper, which denies our ability as researchers to verify the ‘accuracy’ of our analysis (Von Glasersfeld, 1981). Indeed, the ‘passionate analysis’ of culture and society are desirable under postmodern epistemologies (Gergen, 2001).

However, this epistemological position has further implications. Gergen (1985) writes that “knowledge is not something people possess somewhere in their heads, but rather, something people do together” (p.270). The immediate implication of this was that as a researcher interviewing the participants, I needed to be aware of my involvement in the sense-making process during both the interview and data analysis. This highlighted the importance of a reflexive research journal (more details in Section 2.5).

I also considered what Gergen’s statement would mean for an area of study which I expected my participants to have had little opportunities to have prior discussions about (Geerlings

et al., 2017). I reasoned that participants would be learning more about their own views through the interview process. However, I also wanted to limit my impact (as an 'outsider') on this process. As such, I decided to use focus groups (FGs) for the data collection to facilitate more organic conversations (Wellings et al., 2000). It has been argued that FGs are ideal for exploring shared and contested social meanings (Braun et al., 2016; Wilkinson, 1998).

Radical constructivism also views individuals as cognitively isolated knowers, which means that eventually each of us have our own constructions of our realities. As such, it was epistemologically coherent not to seek a consensus from each of the groups. Instead, in addition to data from the FGs, each participant was asked to complete an individual activity at the end of each group (more details in Section 2.6.6.2.). However, neither interview nor activity data was privileged. Rather, they were seen as providing multiple perspectives to the same topic.

2.4. Thematic Analysis

TA, or more specifically reflexive TA (Braun & Clarke, 2019), was chosen for the data analysis. TA is a flexible analytic method which looks to identify, analyse, and interpret relevant themes and patterns of meaning from qualitative data (Clarke & Braun, 2016). As an exploratory study, it was used inductively to generate themes from the bottom up without applying pre-existing theories (Braun & Clarke, 2012). However, TA also recognizes that the researcher's own biases and knowledge will impact on the process regardless. This fits with our earlier discussion about epistemology and the researcher's involvement in knowledge generation, and once again highlights the importance of reflexivity during the entire process.

Another benefit to using TA over other qualitative methods was that it is more accessible to audiences and is therefore particularly suited to incorporating participatory approaches, wherein participants can be consulted about the themes that they helped to generate (Braun & Clarke, 2013). This allowed me to stay closer to my belief that research should follow the motto of "nothing about us without us", a line that has strong roots in activism (e.g., Shah, 2012).

Content Analysis (CA; e.g., Wilkinson, 1998) was also considered as an equally accessible alternative to TA due to the allure of numbers as one way to make sense of potentially conflicting opinions between participants. However, it was rejected due to the aforementioned underlying belief that imposing quantification on the data would result in losing the richness of variability and difference which qualitative studies seek to capture (Henwood & Pidgeon, 1992). As such, CA was felt to be inconsistent with the epistemology and goals of this study. Other methods such as Interpretative Phenomenological Analysis (IPA) was also deemed inappropriate for an exploratory study using FGs due to their idiographic philosophy (Tomkins & Eatough, 2010).

2.5. Research Rigour

While there are difficulties in translating the typical criteria for the quality of quantitative studies to qualitative studies, robust ways to evaluate qualitative research have also been developed (Braun & Clarke, 2013).

2.5.1. Reflexive Research Journal and Supervision

Firstly, because constructivists believe that the research process is subjective and that researchers cannot be separated from their research, it becomes imperative that we as researchers practice reflexivity. Braun and Clarke (2013) describe it “as part of ‘quality control’ in qualitative research” (p.37), and suggest the use of reflexive research journals to record our thoughts, feelings, and reflections about the research process. Discussions with my supervisory team have also been very helpful in guiding this reflexive process (for examples, see Appendix D).

2.5.2. Ecological Validity

Braun and Clarke (2013) write about the importance of ecological validity as the most relevant aspect of validity to qualitative research. I also conceptualized this in terms of careful selection of data collection methods and participants. For example, FGs can help by providing insight into more ‘naturally occurring data’ in more naturalistic contexts (Kitzinger, 1994). More details are given in Section 2.6.

2.5.3. Member-checking

In terms of 'reliability', member-checking was used as a way to ensure that my interpretation of participants' experiences fit with their own (Braun & Clarke, 2013; Lincoln & Guba, 1985). While the practice of member-checking is consistent with a critical realist ontology (Braun & Clarke, 2013), it should be highlighted that such efforts do not reflect an attempt to 'verify' my themes, but merely to check its 'fit'. Participants who indicated an interest in member-checking were contacted with the preliminary themes once they were generated. Their feedback was incorporated into the final analysis where appropriate.

2.5.4. Triangulation

Finally, the study attempted to triangulate the data by using two different data collection approaches. Alongside the interview, participants were asked to complete an interview activity (more details in Section 2.6.6.2.). As argued in Section 2.3, this was consistent with a radical constructivist epistemology, and allowed me to obtain multiple perspectives on the topic (rather than getting closer to the 'truth').

2.6. Research Design

Many factors were considered in the research design. As discussed in Section 2.5.2, such considerations are important to ensure the ecological validity of the study.

2.6.1. Video Interviews

The study was conducted virtually via video conference calls because I wanted to interview participants from Singapore while I was still in the United Kingdom. Asynchronous methods of data collection (e.g., e-mails, social media) were rejected as rapport is harder to establish through these mediums (Archibald et al., 2019) and they are unable to produce the depth of discussion I desired (Biedermann, 2018).

Zoom was chosen as the platform due to its increased popularity in Singapore during the Covid-19 pandemic, and its functions, user-friendliness, and security (Archibald et al., 2019). A

growing body of research supports the use of videoconferencing platforms for research (for a discussion see Falter et al., 2022), and Archibald et al. (2019) reported that 69% of their participants preferred Zoom interviews compared to in-person or telephone interviews.

This medium also suited this pandemic climate as it reduced the risks of infection from face-to-face contact, especially given the use of FGs and the unpredictable nature of the pandemic which sometimes came with restrictions on face-to-face group activities.

2.6.2. Project Consultants

I decided early in the research planning to consult those with insider knowledge of the research area in as many aspects of the planning as possible. This was important to me because of my aforementioned belief in the motto of “nothing about us without us”.

A year two trainee CP in Singapore (consultant Andy, not his real name) was recruited as a consultant for the project. His participation was particularly valued as someone who was not only a CP trainee, but also had lived experience of receiving therapy from CPs for mental health difficulties. This meant that he was in a unique position to comment on what models he felt resonated as both a therapist and a client. He also agreed to participate in a pilot interview as he was unable to participate in the actual FGs. Three further consultants, who were part of the target group for the study and whom I was personally familiar with, also offered consultation.

2.6.3. Participant Selection

In this section, I will discuss the inclusion criteria before explaining the exclusion criteria for participant selection.

2.6.3.1. Courses. As outlined in Chapter 1, there are currently two courses in Singapore which provide CP training locally: NUS and JCU (see Table 2). It was important for the research to include participants from both courses to get a rounded view of CP training in Singapore. This had an impact on subsequent criteria.

2.6.3.2. Academic Training. To get an account of the experience of local training programmes in their entirety, I only recruited participants who had been through all the academic teaching on their respective programmes. At the same time, I wanted to get an account of current CP training, recognizing that training programmes can change over time. As such, I recruited: 1) trainees who were in their final placements (i.e., they had completed the academic portion of their training), and 2) graduates from local CP training programmes who had ‘recently’ graduated. Whereas ‘recently’ was initially operationalized as ‘within the last three years’,

I eventually had to relax this definition as I was unable to recruit any participants from JCU. After consulting with my supervisory team, we agreed that the first criterion (recruiting from both courses) outweighed the second (recruiting recent graduates). As such, we relaxed the second criterion to include graduates from the past five years.

2.6.3.3. Work Experience. I only recruited participants who had at least one year of experience working therapeutically with clients in Singapore, including placement experience. I felt that having at least one year of experience would be important for participants to be able to comment on how well local CP training courses prepared them for practicing in Singapore.

2.6.3.4. Nationality. The final inclusion criterion was that participants needed to be Singaporeans. This was based on the understanding that culture is difficult to define. It would be useful for participants to have a good, immersive understanding of Singapore culture in order to comment on issues of cultural relevance. While it is recognized that this was not the only way to gauge and assess participants’ understanding of our culture (and on hindsight perhaps not even the best way), it was decided upon as the simplest way to do so. I hoped to recruit a sample which was representative of the diversity seen in Singapore (e.g., multi-ethnic, multi-religious).

2.6.3.5. Exclusion Criteria. No exclusion criteria were specified, and participants were only excluded if they did not meet the inclusion criteria. Language was not considered as an exclusion

criterion as both courses were conducted in English, and all candidates were expected to be conversant in English.

2.6.4. Recruitment

Due to the small pool of potential participants the study could draw from (each cohort of trainees had approximately 12 to 15 graduates every year), two approaches were used to advertise the study: 1) snowball sampling starting with personal contacts, and 2) purposive sampling with the help of university administrators. A recruitment poster (Appendix E) was sent out along with a blurb (Appendix F). While the snowball sampling method was by far the most effective way to recruit eligible participants, it came with a set of ethical considerations.

2.6.4.1. Familiarity with Participants. An immediate consequence of the snowballing method was that I was familiar with and had a pre-existing relationship with a few participants. These were ex-colleagues with whom I had maintained varying degrees of contact with over the years. The impact of this was reflected on at different points over the course of the study (for examples, see Appendix D). While there were worries that this might result in participants giving responses which they thought I wanted to hear, it was eventually decided that including these participants was not only practical, but epistemologically consistent. It was felt that excluding these participants would reflect an effort to isolate a 'true' response 'unbiased' by the influence of the researcher, which according to radical constructivism would not be possible. It could similarly be argued that a lack of familiarity with the researcher would influence responses if participants felt less comfortable. In fact, research has suggested that people in East Asian and other collectivistic societies are less comfortable fully expressing themselves to strangers in FGs, preferring to give short answers instead (J.J. Lee. & K.P. Lee, 2009).

2.6.4.2. Insider/Outsider Perspectives. A related consideration was how all of this positioned me as the researcher. Dwyer and Buckle (2009) write about the pros and cons of insider research in qualitative studies, which brings with it access, acceptance, and open sharing, but may

also raise questions about unspoken assumptions, biases, and role confusion (even though the focus of much qualitative research has shifted away from finding ‘objective’ data). They argue against the dichotomy of insider-outsider researchers, proposing instead that most researchers occupy ‘the space between’, the hyphen of insider-outsider. They describe this as a dialectical space holding both similarities and differences which L. Breen (2007) felt “maximized the advantages of each [side] while minimizing the potential for disadvantages” (p.171).

In the context of this study, I occupied this ‘space between’. In many respects I was an insider: I was a Singaporean CP trainee and was known to some of the participants. At the same time, I was an ‘outsider’ who had not trained locally and had been living in a different country for the past three years. Through a decolonial lens, I also wondered about the impact of my Western training; it would be problematic (and ironic) for my research if I was seen as another proxy of Western society swooping in to critique local practices. To maximize this ‘space between’ position, I ensured that I held it in mind reflexively throughout the research, and was transparent with participants about my positioning (e.g., see self-introduction in Appendix G).

2.6.4.3. Participant Demographics. In total, 13 participants joined the FGs after one participant withdrew due to contracting Covid-19. Relevant participant demographics were collected prior to the groups and are presented in Table 5.

Interestingly, as I was creating pseudonyms for my participants, I noticed that I automatically chose English names for all my participants – even those who had used Chinese names. I recognized this as a symptom of the colonisation of research and of my own mind, and the use of Chinese pseudonyms for participants who had used Chinese names was an intentional and reflexive decision.

As seen in Table 5, I was unfortunately only able to recruit Chinese participants for the study. This was something I had noted during the recruitment process, but participants informed me that there were very few non-Chinese trainees on their courses, and therefore this was in fact representative of the courses. Given the earlier discussion about the complexities involved in

defining 'decolonisation' and 'indigeneity' in Singapore's context, the lack of diversity, and particularly the lack of Malay participants, was disappointing and posed a limitation of the interpretation of results (see Section 4.6).

Table 5*Participant Demographics*

Pseudonym	Age	Ethnicity	Gender	Religiosity	Training Course	Career stage
Amelia	27	Chinese	Female	None	NUS Masters	Graduated ≤ three years
Ben	30	Chinese	Male	Agnostic	NUS Masters	Graduated ≤ three years
Chende	32	Chinese	Male	Buddhism	NUS Masters	Graduated ≤ three years
Diane	31	Chinese	Female	Christianity	JCU Masters	Graduated ≤ five years
Ella	34	Chinese	Female	Agnostic	NUS Masters	Graduated ≤ three years
Felicia	30	Chinese	Female	Christianity	NUS Masters	Second year trainee
Guanjie	33	Chinese	Male	Buddhism	NUS Masters	Second year trainee
Huaqin	29	Chinese	Female	Taoism	NUS Masters	Second year trainee
Yibin	31	Chinese	Male	Buddhism	NUS Masters	Second year trainee
Jiaqi	29	Chinese	Female	None	NUS Masters	Second year trainee
Kristy	29	Chinese	Female	Christianity	NUS Masters	Graduated ≤ three years
Lexin	27	Chinese	Female	None	NUS Masters	Graduated ≤ three years
Megan	34	Chinese	Female	None	JCU Masters	Graduated ≤ five years

2.6.5. Group Dynamics

Beyond participant recruitment, many practical and ethical considerations also shaped planning of the FGs. One important aspect which warranted careful deliberation was group dynamics, which included many factors besides the impact of a 'space between' researcher.

2.6.5.1. A Sensitive Topic. I considered that the topic might be a sensitive one as participants would be asked to take a critical lens to not only their training courses, but by extension to their own training and potentially their own practice. Encouragingly, Braun and Clarke (2013) pointed out that speaking as a collective rather than as an individual can sometimes help participants to feel more comfortable discussing sensitive topics. One step taken to balance this was to keep group sizes small. It was hoped that this arrangement would not only allow for more depth in exploring the topics, but also allow participants to feel less vulnerable in their sharing.

When considering how small to keep the groups, I aimed to have three to six (ideally five) participants in each of four FGs. This was based on Braun and Clarke's (2013) recommendations of three to eight participants and two to four groups to keep groups manageable. This decision was also supported by a study which reported that more than 80% of all themes in a study were discoverable within two to three FGs, 90% within three to six FGs, and the most prevalent within only three FGs (Guest, Namey, & McKenna, 2016). However, after the first group of five, I decided to use smaller groups (two to three participants) as I reflected that there was insufficient depth, perhaps due to the 'awkward' conversational flows involved in video FGs (Falter et al., 2022); see Appendix D).

2.6.5.2. Familiarity Between Participants. Due to the nature of the target population and the snowball sampling used, it was inevitable that some of the participants would have pre-existing relationships outside of the FGs (e.g., [ex-]coursemates, friends, colleagues). Similar to the discussion about some participants' familiarity with the researcher, it was felt that while familiarity between participants could lead to biases and socially desirable responses, the openness that the

familiarity engendered (J.J. Lee & K.P. Lee, 2009) would benefit the study, particularly given the sensitivity of the topic. FGs with pre-existing relationships can also allow us to better tap into the natural settings in which these topics are discussed and decisions are made (Kitzinger, 1994).

2.6.5.3. 'Rivalry' Between Courses. Comparisons between the courses are inevitable given that they are the only two options for CPs to train locally. I considered the impact this might have on a group with participants from both courses. On one hand, participants might hesitate to speak too harshly about their course in front of 'outsiders' or trainees from another course. This was something I felt strongly about, based on my own reflections as an alumnus of other schools and groups in general (at least those I felt some loyalty towards).

On the other hand, hearing from both courses together might add to the richness of the data, and my presence alone might already fill the role of an 'outsider' regardless. Being aware of my own personal bias, I brought this reflection to my project consultants. The consensus was that a mixed grouping would not complicate things too much, especially for the graduates who would probably have less strong affiliations with the courses. As such, the decision was to have mixed groups for graduates, but separate groups for trainees.

2.6.5.4. Power Differences. When reflecting on the group dynamics, I considered issues about power. The first layer was in relation to me. In some respects, I might be perceived as having more power in relation to some participants: as the researcher, as a doctoral candidate, and as an older male. In some respects, less: as a trainee, and as someone with less experience practicing in Singapore. To encourage participants to speak their minds openly, I highlighted the latter aspects in my self-introduction at the start of each FG.

The second layer of power was between participants. I considered that trainees might feel less confident sharing their opinions in the presence of qualified CPs, especially if those opinions happened to differ. Reflecting on this with my project consultants suggested that this was indeed something to be wary of, and led to the decision to split graduate and trainee participants.

2.6.5.5. Cultural Adaptations. In their study on cultural differences in FG interactions between individualistic/low-context cultures (Netherlands) and collectivistic/high-context cultures (South Korea), J.J. Lee and K.P. Lee (2009) pointed out that the participants from the latter cultures gave shorter and more direct answers and relied more heavily on the facilitator instead of discussing among themselves. They experimented with several tools and proposed tips for facilitating FGs in East Asia. I adopted several, including incorporating icebreakers (longer introductions and giving a PIA [more details in Section 2.6.6.1]) and placing critique tasks at the end of the FG. Additionally, I adopted a slightly more involved stance and made efforts to open up the conversation again if participants did not build on each other's sharing (e.g., "What about for others? Any similar or different thoughts?").

2.6.6. Focus Group Planning

The FG consisted of three components: 1) a PIA, 2) the FG interview, and 3) an interview activity. Each focus group lasted for two hours. Here I will describe each component and the rationale for including them. The use of consultants at this level of planning was limited to consultant Andy, as I wanted to avoid foreknowledge of the FG details that may bias the two participant-consultants.

2.6.6.1. Pre-interview Activity (PIA). The PIA was included for two reasons. J.J. Lee and K.P. Lee (2009) suggested that pre-interview activities could open dialogues during the FG as participants could start by sharing about their experiences completing the PIA. The second function of the PIA was to introduce a few therapeutic models, as based on conversations with the consultants, I was unsure which models participants would be familiar with. It would be difficult to have a conversation about alternative models if participants were only exposed to a couple of them. As such, the PIA was designed to stimulate participants' thinking by providing them with short descriptions of the theoretical underpinnings of several models of therapy and asking them to reflect on which statements resonated with them and/or their clients (see Appendix H; citations added). These

models were drawn from a combination of literature on models which might be culturally relevant for East Asian societies (e.g., B.O. Lee & Foo, 2019; Llewelyn & Shimoyama, 2012) and discussions with consultant Andy.

2.6.6.2. Interview Activity. Materials and activities can make focus groups more engaging and enjoyable, facilitate discussions about sensitive topics, and provide alternative ways to gather data (Colucci, 2008; Kitzinger, 1994). The interview activity was included for these reasons, and to allow triangulation of the data from the interview schedule. It sought to shed light on which models of therapy were culturally relevant for Singapore, and which they would like to have learned more about before graduating. The activity consisted of two parts: 1) estimate how much academic time their course spent on different models of therapy (experienced course allocation [ECA]; e.g., Appendix I), and 2) illustrate how their ideal course would split its focus among the different models to prepare students for culturally relevant practice in Singapore (ideal course allocation [ICA]; e.g., Appendix J). Part one was completed near the start of the FG, while part two was completed at the end. This was done to punctuate the monotony of the interview, stimulate participants' thinking about their courses, and allow for the group to shape its members' beliefs before completing part two. Feedback from some of the participants post-interview was that this arrangement was helpful in allowing them to consolidate their reflections after our discussion.

2.6.6.3. Interview Schedule. The interview followed a semi-structured schedule (Appendix G), which was used flexibly to ensure that we covered the information that we wanted, while also allowing the group to guide the conversation. The structure and questions were formulated following guidelines from Krueger (2002) and R. Breen (2006).

The interview began with a self-introduction to position myself in the group. I offered to stay back after the group to answer any questions or share my own opinions if participants wished. I then moved on to introduce the topic and went through ground rules and ethics (e.g., recording, confidentiality) before beginning the discussion.

The discussion began with reflections about the PIA, followed by sharing of personal experiences with therapeutic models to break the ice. Participants were then asked to complete part one of the interview activity to frame the rest of the conversation. We then explored the cultural relevance of their training and different therapy models. We ended off by broadening the discussion to other suggestions for improving the cultural relevance of CP training. The main discussion points were then summarized to check my general understanding of the discussions with the group, and participants were invited to bring in other important points we might have missed. Finally, participants were asked to complete part two of the interview activity.

Participants were then debriefed. They were asked to fill out a form to indicate their interest in member-checking, updates about my analyses, and/or updates about the research progress (e.g., publication). A debrief sheet (Appendix K) was sent out to participants via email, along with an offer to share resources for further reading.

2.6.6.4. Pilot Interview. The entire interview (including PIA and interview activity) was piloted with consultant Andy, who provided useful feedback on the way the activities were worded, the models which were included, and the depth of the discussion. This feedback and subsequent feedback from each group helped to shape subsequent runs of the groups.

2.6.7. Ethics, Consent, and Data Management

This study was approved by the University of Hertfordshire Health, Science, Engineering & Technology Ethics Committee with Delegated Authority (UH Protocol number: LMS/PGT/UH/04737; Appendix L).

Participants were provided with an information sheet (Appendix M) and asked to sign a consent form (Appendix N). The information sheet covered general ethical issues such as study background, inclusion and exclusion criteria, confidentiality, potential risks, and data management. This included descriptions about how data would be stored securely and anonymously, with

pseudonyms being used in transcripts, and how the data will be deleted after five years (to allow for secondary analyses).

Additionally, Braun and Clarke (2013) highlighted further ethical issues specific to FGs. Special attention was paid to inform participants that they may encounter people they are familiar with in the groups, and to ensure that they agreed to maintain the anonymity of other members as well. As a researcher, I felt some reassurance from knowing that as CPs, my participants would be aware of the importance of maintaining confidentiality. In a separate email prior to each FG, participants were asked to either find a private space to join our groups, or to use earphones to maintain our privacy. Finally, at the start of each interview, participants were informed that while they could withdraw from the study at any point during the group, the nature of FGs meant that we would not be able to extricate their sharing from the group's data (in accordance with the ethics approval).

2.7. Data Analysis

Two sets of data were generated: the interview and the interview activity. While TA was used to analyse the interviews, descriptive data were generated for the interview activity.

2.7.1. Analysing the Interviews

I followed the six-phase approach to TA as described by Braun and Clarke (2012) to analyse the interviews. A brief summary of this approach and the steps I took in each phase is shown in Table 6.

Table 6

The Six-Phase Approach to TA (Braun & Clarke, 2012)

Phase	Brief description of process
Familiarizing with the data	Transcribing the data by myself helped me to familiarize with the data as I 're-lived' each interview line by line Immersing in the data by repeatedly reading through the transcripts I made notes within the transcript when it piqued my curiosity; these notes guided some of my initial codes

Generating initial codes	The data was systematically analysed and codes were generated from the data (see Appendix O for an example) Both semantic (descriptive) codes and latent (interpretive) codes were generated using nVivo As I coded, I reflected that some latent codes were perhaps a bit 'overly' interpretive, and efforts were made to re-code lines where I had made bigger assumptions about latent meanings
Searching for themes	Codes were clustered into themes These themes were in turn grouped together in order to form bigger themes to loosely fit the research questions An initial thematic map was drawn at the end of this process (Appendix P)
Reviewing potential themes	The themes were checked against the entire data set to ensure coherence Member-checking was also done at this stage, with three members responding and discussing their feedback via email and text messaging During this step, some themes were merged while others were renamed so that the themes would tell a coherent story together
Defining and naming themes	Theme names were further refined, particularly for names which did not informative Extracts were also selected to represent each theme to ensure that they were taken from across the data set
Producing the report	This step mainly involved the writing up of the results of my analysis However, as Braun and Clarke (2012) noted, writing did not only begin in the final phase but is interwoven throughout in the notes and memos kept, which also influenced the final report

2.7.2. Analysing the Interview Activity

No statistical analyses were used on the data collected via the interview activity. This was in part due to a small sample size, but mainly because the activity was intended to help triangulate data from the interview. While the use of quantitative methodologies might not be incompatible with social constructionist epistemologies (including social constructivism; Gergen, 1985), I felt it was inconsistent with my exploratory approach as I had not set out to test any hypotheses. Instead, only descriptive data will be presented and interpreted in relation to the interview data.

Chapter 3. Analysis

But coloniality didn't end in 1963, when the British let your country go. It is not just the business of unfortunate Third Worlders in distant lands, still floundering in corruption and poverty because they lacked the vision and the statecraft of a Lee Kuan Yew. Coloniality continues, in fact, whenever bright young men and women from all over the world decide to cap off their educations by going on pilgrimage to the pinnacles of Western civilisation; when they dedicate themselves to the Western canon and walk in the shadows of imperial facades, and learn that this is the good life.

– To my Eighteen-Year-Old Self, on your Departure for Cambridge

By Singaporean Michelle K. (2013, p.30)

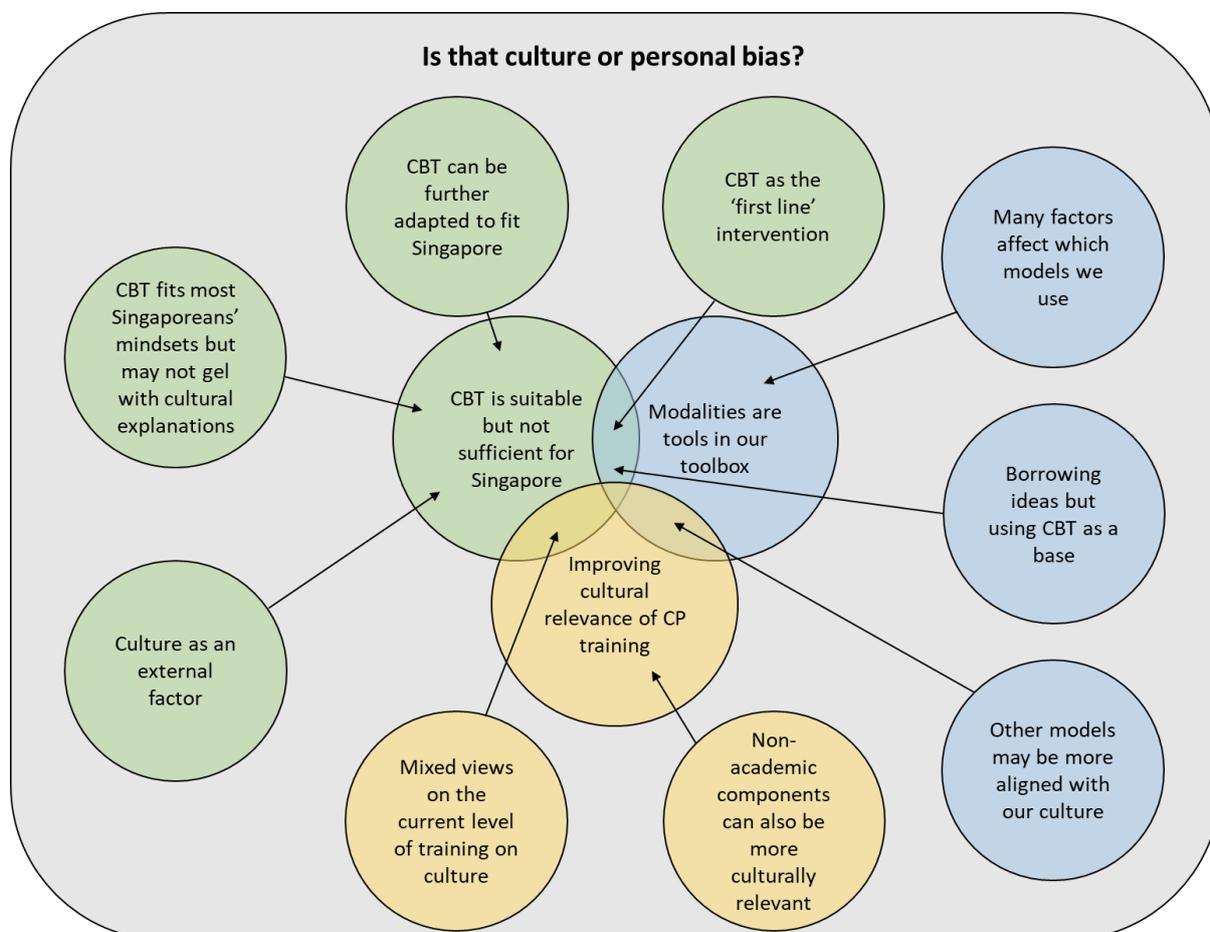
3.1. Overview

This chapter describes the themes and subthemes I generated from the data, following input from the member-checking process. It is acknowledged that these were only 'findings' insofar as the search was an active process, and the themes did not spontaneously 'emerge' from the data (Braun & Clarke, 2019). Three partially overlapping themes corresponding to my main research questions were constructed, which comprised of nine subthemes in total. Additionally, an overarching theme was generated which framed the interpretation of all the other themes (Figure 3). Data from the interview activity is also reported after the themes.

Interview extracts are quoted to substantiate the themes and to tell a vivid and compelling narrative (Braun & Clarke, 2013). To better represent the interactional data from the FGs, I have included extracts which give a flavour of the interactions between participants (Kitzinger, 1994; Wilkinson, 1998). In re-presenting participants' contributions, I have also chosen to keep *some* local Singlish words (e.g., 'lah', 'lor') and sentence structures (while maintaining readability for non-native Singlish speakers), to better situate our conversations within the wider culture.

Figure 3

Thematic Map



3.2. Is that culture or personal bias?

This study required participants to reflect on the cultural appropriateness of therapeutic models, and therefore to be able to take a meta-position and consider Singaporean culture and the cultural values and assumptions embedded in different therapeutic approaches. The first overarching theme describes the uncertainty that participants had in identifying culture and therefore cultural relevance. Almost all the participants spoke hesitantly, using lots of *maybe's*, *don't know's*, and *not sure's* (most removed from extracts for readability). They sometimes second-guessed themselves and some expressed doubts about not knowing whether their observation was a “personal bias” (Ben) or “(over-)generalization” (Megan).

Some participants pointed to the broad nature of the term as a source of this uncertainty:

Actually[...]even the term 'culture' itself, I think there's many different understandings to it. So off the top of (my) head, it's like race, religion, that kind of thing, but there's also like those subcultures or things like family culture. I mean, it's a very broad term[...] (Lexin)

In trying to make sense of our shared culture, some participants tried to check their understanding with other group members:

I don't know whether (Huaqin) and (Felicia) would share this, but my own experience is that even though we may be born here, brought up here, the understanding of culture may not be to a level where we might find it's competent with working with a very diverse population. And I think that's also because there's just so much diversity in our own culture[...]And I think the challenge with being culturally competent is that sometimes you don't know what you don't know. And that can be a very challenging space to navigate[...] (Guanjie)

Others tried to understand our culture by comparing it against other cultures:

And there's a bit of that sense, so I'm not sure whether that's also a bit relevant? For some clients that aspect (of family) may come out a bit more. I'm not sure whether it's a bit different in Western cultures[...] (Felicia)

This general sense of uncertainty pervaded all the FGs. As such, this theme frames the rest of our discussion, and the rest of the discussion must be understood through this lens.

3.3. CBT is suitable but not sufficient for Singapore

Most participants felt that CBT was effective for Singapore's context. In this theme, participants discussed parts of CBT that fit with Singapore's culture, and parts which did not. They also reflected on how they have tried to manage CBT's limitations by adapting it, or by using a trial-and-error approach to bring in other models.

3.3.1. Culture as an external factor

Although this was not a particularly 'thick' theme (Braun & Clarke, 2012), it felt important to note that some participants spoke of culture as something which could fit into CBT, but was a separate, distinct part which might sometimes "interfere" (Guanjie):

The thought that crossed my mind was more of how the interpretations of like bible verses, or even perspectives of the tradition, or like whatever it is about the religion is actually subjective[...]If I were the therapist (I'd be) trying, like (Yibin) lor, (to) bring it back to the model[...]I think these are some of the things I have in mind before dwelling too much on the religion part. Because after all, that might not be the core of the treatment. So then what's the function of having that conversation lor. Is there something that could be more helpful lah. Because religion is just one part. Unless that's the core of their condition or something lah. (Jiaqi)

In this way, these participants, drawing on a CBT framework, saw culture as just one type of thought or perspective.

3.3.2. CBT fits most Singaporeans' mindsets but may not gel with cultural explanations

Regardless, most participants felt that CBT was generally a good fit for Singapore. There was some agreement that CBT matched Singaporeans' expectations of therapy providing practical, goal-directed "fixes":

I think, I think there's something very goal-oriented, homework/objective-based about CBT that is so exciting for people. It's like, come in, give me homework, and fix me. I mean as much as we enter therapy with the idea that we don't want it to be like a cave where you come in and get assignments and solve your problems. But when some of the clients culturally have a broad overall idea, "I'm coming here to see a professional who's supposed to give me answers to my life", that seems to like work?[...] So I think there's something about CBT that is very helpful. (Ben)

Participants also noted that "Singapore(ans) tend to be more cognitive and not so much in tune with the emotions part" (Megan). Here, the suitability of CBT was not always clear. While CBT might fit with such predispositions, participants noted that it might sometimes be important to balance it with emotion-focused work, which CBT tended to "neglect" (Yibin):

Ben: *I do find that[...]there is something about the culture that tells you not to express (emotions) – just to make these emotions go away, and then you can get on with your life. That idea of restructuring your thoughts is very seductive, that you don't really have to think about the emotions. Just change your thoughts and life will be good. I think that idea is very seductive. It may work very well for very subclinical symptoms, but when it doesn't go so well, when a lot of these unexpressed emotions are brought up to the surface, I think that's where other modalities like*

ACT, or even Schema, psychodynamic work comes into play. But if say the client is otherwise functioning quite okay, sometimes they don't see why we need to talk about emotions[...]*

Ella: *[...]Some set of Singaporeans not really expressing their emotions – (that) is quite true. I'm not emotion-focused trained but I have friends who actually go for therapy. And they say that they generally are not very in touch with their emotions, so when they go for things like emotion-focused therapy, (it's) kind of life-changing for them[...]And it's actually very helpful for them, compared to something more traditional like CBT.*

*Acceptance and Commitment Therapy (ACT)

Participants also discussed the changing nature of culture. They observed that CBT worked better for younger generations who were described as more “*educated in terms of mental health issues*” (Chende), and “*more aware of their thoughts, or how past experiences might continue to affect the lenses we see the world (with)*” (Huaqin), which made CBT a good fit. In contrast, older generations were felt to be more “*traditional and not as psychologically-minded*” (Chende) and “*a lot more religious*” (Amelia).

In this respect, while some participants felt that the structure of CBT allowed for some exploration of cultural issues, they also felt that it was not always the best model for this:

For example, CBT when you start to ask them what are their thoughts right? And then that's when they might share certain thoughts – maybe they think that this is karma, or this is because of something they did in the past. So that might help you to tease out (that) there might be some spiritual aspect to it, or they might be influenced by their religious beliefs. So,

the initial start may be helpful, that framework. But I guess subsequently if it's really very deeply rooted and you really need to tease it apart and go deeper into it, then I'm not sure whether (the) CBT model may help me to go deeper into it lah. But maybe as a start (laughs).

(Felicia)

They also felt that CBT did not fit some cultural values such as respect for elders (Kristy), and may even contradict some cultural values and explanations of distress, which could be about religious beliefs:

Guanjie: *Partly the social roles are not well accounted for in existing models[...]And also I think some areas that might be where our models, our explanations of what's going on might be actually quite contradictory to what the cultural explanation might look like[...]*

Huaqin: *[...]Another example I thought of then is perhaps those having difficulties coping with grief. And I think that, in particular, is also quite hard to use any specific types of models. Especially if they might have a stronger belief in religions or (that) those who passed on (are) moving on to a better place with less pain[...]*

Felicia: *[...]But yeah, I think there's still quite a strong need to be sensitive to what the clients' values are[...]And that's quite difficult because in a CBT mode you – by right – you want to challenge some of these (religious) beliefs, or you wanna help them to show that some of these fears might be irrational. But that's quite insensitive of us also to do that right?[...]Even in the back of my mind, even if we know that, “oh this belief is actually reinforcing it”, but we need to be quite mindful on how we convey it or tell clients about it.*

Some participants also pointed out that cultural explanations of distress were also “very often[...]more about interpersonal conflicts, poor culture/generation fit, etc.” (Chende). Others added that “strong family bonds” (Guanjie) were an important value in our collectivistic society. In this respect, many felt that CBT was limited in its ability to address systemic issues like “relationship with[...]family” (Yibin) and “social roles” (Guanjie).

Finally, participants also spoke about how CBT, even though it “may work very well for very subclinical symptoms” (Ben) might be limited in its use (by itself) for more “complex cases” (Kristy).

3.3.3. CBT can be further adapted to fit Singapore

Participants discussed two approaches in managing CBT’s limitations. First, some participants felt that CBT could be further adapted for practice in Singapore:

I noticed this most when I do a lot of grief work with the clients – so it's really getting their understanding in what they believe culturally about grief and afterlife. And how can we address that. And even within the same culture there's also differences (in) how people view grief. So it's just really trying to get what the client's understanding is, what the family's understanding is surrounding grief and death, and bereavement. (Adeline)

Although Singaporeans’ expectations for goal-directed fixes might generally fit well with CBT, some participants shared additional ideas for adaptations in this area. Some suggested a more guided and active approach:

For example, the emphasis on collaboration might look very different in a western country and in our local context[...]For example, if you ask a question about what does this suggest,

or what does it mean to you, things like that. I think (it) might be quite challenging for our local population in general, unless they're really very psychologically-minded. So we might need maybe more close-ended question to guide them through, especially during formulation. Or even maybe coming up with ideas for BEs. So I think we generally have to be the one suggesting something before they start to chime in. (Huaqin)*

*Behaviour Experiments (BE)

At the same time, others also suggested establishing the collaborative nature of therapy early on. They suggested spending additional time with psychoeducation at the start of therapy, to *“address any questions or any misconceptions that they may have about therapy[...]so that they know it's both of us contribut(ing) together.”* (Megan)

Others suggested adaptations involving different ways of delivering CBT skills. For example, Huaqin shared that using *“a group format[...]might not be so confronting for parents”*, while Jiaqi shared that some CBT techniques do not work as well, and that *“there needs to be a lot more flexibility in Singapore cultural context in conducting thought challenging”*.

Perhaps in line with the fact that, for some participants, CBT tends to see culture as being separate from therapy (Section 3.3.1), some participants highlighted how therapists' own awareness of cultural issues also directly impacted our ability to “weave” it into our work:

[...]even with a CBT approach, I think if we're aware of some of the cultural aspects that might interfere with therapy then we can better weave it in to manage during therapy. Or find a more culturally relevant kind of explanation to some of the difficulties. (Guanjie)

3.3.4. CBT as the 'first line' intervention

As illustrated in the previous quote, participants recognized that sometimes adapting CBT was not enough to address its limitations, and other modalities were needed. When discussing how therapeutic models were chosen, many spoke about CBT as the "*foundation*" (Jiaqi) or "*first-line*" (Felicia) intervention. It seemed to be the 'go-to' therapy for many therapists, and a few reasons were cited for this. A common one was that CBT was the "*gold standard*" (Megan) therapy, *as it was the "most evidence-based, and tackles most things"* (Lexin).

Many participants also looked inward and shared that they started with CBT because they were most "*familiar and trained in that*" (Lexin), and that it's manualized approach felt "safer":

[...]when you're new to this right – I think depending on your personality also, if you're safer like me lah; I'm not so risk taking – so I preferred to really follow what has (been) manualized, preferably. But like you all said lah, it doesn't work out for everyone. I remember having one client, just one, (who) really liked CBT. (Diane)

Many participants described the process of bringing in other models as a 'trial-and-error' approach, with some also referencing the use of practice-based evidence in this process:

I think as a trainee myself, I must be able to try and then get the feedback personally[...]from my clients and placement supervisor. Then modifying it on my own (laughs) – not the best evidence-based (practice), but I think that helps lah. I think it's always a trial-and-error in this setting, because I think it's not wise to practice just purely with(in) that modality (CBT). So in my opinion it's more of being flexible to adjust on our own lor. (Jiaqi)

3.4. Modalities are tools in our toolbox

In discussing about their use of other models when CBT was seen as not sufficient, participants also shared about why they chose those particular models. In this theme, we look at those factors, how participants have sometimes introduced other models by incorporating them into a CBT framework, and which other models they found themselves using more.

3.4.1 Many factors affect which models we use

Many participants shared that many, if not all, of the statements from the PIA resonated with them and/or their clients. They felt that besides using CBT as a first-line therapy, many other factors (personal, client-related, organization-related, and training-related) affected which other models they brought in.

The least discussed factors were the personal ones. Some participants acknowledged that personal preferences (other than familiarity) and experiences also impacted their choice of models:

I think my personal experience of mindfulness-based things sit well with me[...]So just reflecting, I think that also one aspect (to deciding which models to bring in) is also, I think similar to (Lexin) and (Kristy), what resonates with my self. (Megan)

For client-related factors, participants spoke about modalities as “*tools in the toolbox*” (Huaqin), which allowed flexibility in meeting clients’ needs. Different needs were discussed, some of which included clients’ thinking styles, their preferences and goals, current situation and presenting concerns/diagnoses (along with the evidence base), and our formulations of their difficulties:

I think the diagnosis does play a role (in deciding which model to use). And rather than the diagnosis per se[...]what might be more helpful sometimes is what the presenting problems look like, and what modalities have been shown to be more effective in treating that presenting problem[...]You might also have clients[...]come up with their own interest also in terms of therapy – what they want to try[...]So I think largely – for me, at least, in my experience – the clients’ experiences, or what they expect in therapy can be quite helpful in deciding where I should go. (Guanjie)

Participants also noted some patterns in the models which work for some clients. For example, some participants noticed that some modalities tended to work better with certain religions and/or spiritual people:

Because I was at[...]a Buddhist-run organization – but I mean they provide secular services lah. But a lot of their people are trained in ACT. And I think even for many people who identify with Buddhism, mindfulness seems to be quite a big part. So I guess culturally, because we have a large percentage who are Buddhist right?[...]I think just culturally, that kind of stands out a bit. I think it's up and coming also, and seems to be quite relevant, I think, in our population. (Diane)

For organization-related factors, participants pointed out that their settings would affect the clients that they see. For example, Jiaqi noted that social services organizations served more families, and so systemic work would be more applicable there. Participants also discussed how the setting may also affect clients’ (and perhaps our own) expectations coming into therapy, which would in turn affect the models used:

Yibin: *For me right[...]spiritual or religious factors surprisingly doesn't really come up during my work with clients so far. And I don't know whether it's because of the setting that we're in – like (all my placements are hospitals or healthcare services)[...]I don't really hear people bringing up religion that much?[...]I guess let's say they're talking to a priest, or an imam, they might be more willing to talk about the spiritual dimension of mental health? But my hunch is that when they are in a so-called secular setting, it's just like not talked about.*

Jiaqi: *I also agree though, I don't think they openly talk about religion. When we talk about coping, for those that are more religious they say sometimes they will pray, and that's about it. Neither do I actually probe about the religion part. Because I think it can get tricky? I think lah. And I think most of them come in with the mindset of wanting to know something more objective and secular, and I don't think they actually expect us to go into religion[...]*

Participants also discussed how some organizations required their therapists to focus on certain models, often based on evidence base. This was especially common in specialized services, or organizations involved in research:

For my organization, from the get-go, they told us, "We're going to train you first in TF-CBT", because they found that that was the most evidence-based for our population, which is children and adolescents as well. So they had that for a few years, and only recently they have started to be more open to ACT and other types of modalities[...]Because in my organization we also have a research branch that is tracking all our data. So we talk a lot about fidelity and sticking to the evidence, (so) I've been sticking to the modality*

*sometimes[...]*And I think that's why they do – I'm not gonna say "harp on" sticking to the evidence-based technique, but I think they place a lot importance on it lah. (Kristy)

*Trauma-focused CBT (TF-CBT)

Finally, participants added that practical concerns like the lack of supervision opportunities in a model (especially if they were not confident in it) would also prevent them from practicing in that modality.

In terms of training-related factors, we have already discussed how participants' training in different models (and therefore their familiarity) influenced the models they chose to use. This included the learning done on both the academic course and placements, which participants highlighted as an important component of training. In this respect, participants found that their training was heavily focused on CBT, with more substantial exposure to other models only really happening on placements if they were lucky:

*From what I remember, we had two main modules, and then the first module was like heavily on CBT and then the second one was a mixture of ACT, Schema[...]*for our course I felt it was very touch and go. Maybe just one lecture they go through one modality –one or two lectures – and then if you want to find out more you read up and then you go and meet that lecturer to ask a bit more. Or if they happen to be your supervisor for placement or something, then you might have the opportunity to go deeper into applying that particular framework lah[...]*So I felt like it's a bit of chance also, who you get as your supervisor. Depends which model, which treatment modalities you get to kind of hone your skills in lah.*

(Diane)

One reason that came up often was the courses' focus on evidence-based practice, although there seemed to be a lack of discussion around the reason for the "obsession" (Lexin), both on the course and in workplaces:

Lexin: *I don't think we have ever discussed it. I think it's just a given that evidence base is important, but I think maybe it comes from a more medical kind of model? I think lah. Maybe because with medical stuff, all the clinical trials and all is actually important? I'm not sure whether that's where our obsession with (laughs) evidence base comes from?*

Megan: *I think similarly I haven't really discussed (it). The thought of discussing about it also hasn't really come across my mind[...]I think it's taken for granted that it has to be evidence based[...]In academics or in studies at that time, and then later on in work there isn't that discussion. People usually just say, "Oh, this is the most evidence-based", but we don't discuss about it.*

Some participants shared that they only started their own journey of questioning this due to their post-graduation experiences, which was what led them to start exploring other therapy models:

And I remember one thing my lecturer really emphasized was the idea of evidence: "There needs to be evidence"; "What kind of evidence that's involved?"; "Is there evidence?" Which I think now it still colours my lens. When I look at different modalities the first thing I think of is how much evidence is there, right? But then increasingly, I also doubt that as well? Because some modalities just tend to produce evidence (laughs). So then I start to question myself[...]I think it's perhaps more after training, because the kind of client population that I

was exposed to – a bit of context, outside of my main line of work I volunteer with stigmatized minorities, so LGBTQ+ queer folks, sexual health, substance abuse – and I found that the traditional CBT gold standard, go-for-it kind of thing, may not necessarily apply too well for that, and I start to wonder whether or not it's because these kinds of populations are not being captured within that kind of discourse in Singapore, right? (Ben)

Interestingly, some participants also wondered about how their training has shaped not just their *choice* of models, but their entire case conceptualization and the way in which they used other models:

I was thinking “hmm, is this where our training has been influencing us?” Because it's all about CBT, and then we also learn a bit of MI, we learn a bit (of) narrative, or, like (Diane) was saying, learn a bit of ACT, a bit of Schema. And then maybe that is also influencing (us to think), “Eh. Actually, CBT can work for everything. We just need to adjust and we just need to combine a bit with others.” I don't know. I'm just thinking how much is our experience or how much actually is the preconceived (ideas from) training that really influence us. (Chende)*

*Motivational Interviewing (MI)

3.4.2. Borrowing ideas but using CBT as a base

The previous quote ties into our next sub-theme, wherein participants shared more about how they frequently used other models by incorporating them into a CBT framework.

Participants spoke about how integrating different models together was possible because the models shared similar underlying philosophies and processes:

Amelia: I feel like we're distinguishing a lot between the different modalities right? But if you look at how in the recent edition of (inaudible). She's really saying that everything with a cognitive conceptualization is CBT. So, if we're talking about existential ideas, we're also working with thought. And that can also be perceived as CBT right? But I also wonder whether like this distinguishing between modalities is just like a(n) artificial construct that we're trying out lah. That actually, maybe it's really just doing the same thing from different angles.

Ella: Ya. I actually agree with that because I was thinking: if you look at a lot of these therapeutic models, they (are) also based off same philosophical ideas. Like Solipsism maps (on)to CBT and a lot of other things right? I think last time when I was struggling, it was with ACT and CBT – how do you accept but also change your thoughts? But I realized that it can still go together in some ways. They share a lot of very same basic foundations.

Many spoke about leveraging on the strengths of CBT by using it as a base. Other than the evidence base that supports CBT, participants spoke about it being “structured[...]and that also gives the flexibility to add on things (from other models) that you might find supplementary” (Kristy). Participants also felt CBT was easier for clients to understand:

I think if I had (used) Schema from the start it might not be as helpful, but I think the complement of CBT, then introducing Schema, it's a graded process for the client to understand her own difficulties lah. Because I think CBT is definitely easier to understand, the concepts and all, in my opinion lah. (Jiaqi)

Participants also spoke about using other models to supplement the gaps in CBT. In addition to limitations which have been discussed earlier (emotion-work, culture, and spirituality),

participants spoke about integrating mindfulness to help clients become more aware of their internal processes, and also narrative techniques to help clients externalize their difficulties.

However, participants also acknowledged some issues with this integrative approach, which included its lack of evidence base, and potential confusion on the therapist's end (even though clients gave positive feedback):

Huaqin: In terms of the overall experience (of the integrative approach), I find that sometimes it can be confusing though, realistically. So sometimes I'm not sure exactly which modality actually I'm following, but I think it's really going with what the client needs at that point in time[...]I think the confusion was more from my end[...]for (clients), so far when I check-in (with) them for the feedback, generally they respond quite well to it. Perhaps overall, just in terms of more process-related issues, and being present in the session, in general they tend to get a little more confused about what that is trying to bring about, or how to apply that in their future lah.

Felicia: I agree with (Huaqin) that there was also some elements of borrowing ideas, but using CBT is a base. I think the only advice our sup gave was to just make sure that it still links back lah, and it still makes sense to the client[...]

Guanjie: I agree also that sometimes (we) can get a little lost in applying a lot of these different ideas in therapy. But I think what helps for me is really still going back to the formulation and then explaining or understanding why I'm doing this.

Difficulties also arose when there was a misalignment between CBT and other approaches we (or our clients) are trying to introduce (particularly religious ones). Earlier we saw how clients might have expectations about keeping therapy separate from religious matters. Here, it seemed that these expectations might be mirrored in some of our models and in us as therapists as well, when we try to incorporate religion without “crossing the line”:

I don't think we're in a position to advise them on religious matters, I guess? But of course if it comes up, I will try to fit it into the framework that I have lah[...]Actually that reminded me of a client[...]several times we almost crossed the line in talking about religion[...]but I always try to remind myself to bring it back to the principles of CBT treatment and how whatever she says and shared can be incorporated into that framework instead of a religious one.

(Yibin)

3.4.3. Other models may be more aligned with our culture

Across the other themes and sub-themes, we have started to see a number of models being discussed, some more frequently than others. In this subtheme, we shift our focus away from CBT and consolidate the various models that participants raised as more culturally relevant alternatives. I have grouped the models into four groups: mindfulness-based approaches, emotion-focused approaches, systemic approaches, and other approaches.

Compared to CBT, many participants felt that mindfulness-based approaches aligned more closely with our cultural values, with some noting the Eastern roots of some of these models but expressing disappointment that it was still being seen through a Western lens:

I realized a lot of the things, like ACT and some of (the therapy models), that they said were derived from more Eastern philosophy – but it's just interesting that at the end of the day, it's

still a Western view on the Eastern philosophy that kind of made it big, in a way. That a lot of what we learn is still based on what the West first decided was OK before it gets to us and we learn it. (Ella)

In particular, ACT was felt to be culturally relevant because it fits with Buddhist practices (Section 3.4.1), and the values-work was thought to be helpful as Singaporeans *“rarely discussed values or[...]find it hard to be contented with life”* (Jiaqi). Both ACT and Compassion Focused Therapy (CFT) were thought to be useful for attending to emotions and because a lot of Singaporeans *“tend to be quite self-critical and harsh on themselves”* (Lexin). Here, CFT was useful in *“helping them see that actually they can be kind to themselves”* (Jiaqi). The dialectical approach to acceptance and change in Dialectical and Behavioural Therapy (DBT) was refreshing for clients, and DBT was felt to operate *“in a very safe manner through group skills teaching session(s)[...]which works quite well in our culture”* (Huaqin). Mindfulness-Based Cognitive Therapy (MBCT) was also mentioned because *“Singaporeans tend to be very cognitive, so[...]Mindfulness-based Cognitive Therapy[...]shifting that focus away from thoughts to other aspects like your own feelings, your own body, that would be something helpful.”* (Megan). These points, along with other discussion points about each of these models are shown in Table 7.

Table 7

Cultural Relevance of Mindfulness-Based Approaches

Therapy Model	
Acceptance and Commitment Therapy (ACT)	A large proportion of Singaporeans are Buddhists, and ACT fits well with Buddhist practices Singaporeans rarely discuss values and find it hard to be contented with life, so values-work resonates well with them – especially those who are seeking direction (e.g., younger Singaporeans, or people who feel hopeless and lost) Singaporeans tend to be quite self-critical, so ACT may be helpful ACT adopts a more nonjudgemental approach to difficulties ACT works well for things which we cannot change and require acceptance

	ACT metaphors help clients to externalize their difficulties and understand them better
Compassion Focused Therapy (CFT)	Singaporeans (especially students) tend to be very self-critical and harsh on themselves, so getting them to focus on positive aspects of themselves and learn to be kind to themselves was helpful
Dialectical Behavioural Therapy (DBT)	The group format of DBT may be experienced as safer for Singaporeans The dialectics of acceptance and change in DBT and the concept of walking the middle path can be helpful and refreshing, allowing helping clients get a new perspective of their difficulties DBT takes a more nonjudgemental approach towards difficult cases and provides a succinct guide on therapy-interfering behaviours DBT may be difficult to implement resource-wise: participants were not aware of any services which provided the full DBT setup The language needs to be adapted to more direct, and the assertiveness component may need to be adapted to avoid appearing rude to elders
Mindfulness-Based Cognitive Therapy (MBCT)	Singaporeans tend to be very cognitive, so shifting the focus from thoughts to their feelings and body was helpful

The importance of emotion-focused approaches in balancing Singaporeans' natural tendency to be more cognitive and less 'in tune' with their emotions was discussed in Section 3.3.2. Here, some participants mentioned Emotion-Focused Therapy (EFT) and psychodynamic therapy as useful alternatives to CBT. Schema Therapy, however, was discussed in more depth:

Jiaqi: *[...]But if I were to tap onto Schema Therapy, it's mainly about, like what Yibin said, helping the client see the different parts of the self – how they come up, and then the coping mechanisms[...]And then the emotion-focused parts.*

Yibin: *Ya. I really agree. The emotion-focus part is so... I guess neglected in CBT.*

Jiaqi: *Yes.*

Yibin: *But when we do imagery rescripting, chairwork, and, you know, it's just so... Sometimes it's just so powerful for the client.*

Jiaqi: *Very experiential.*

Systemic therapy has also already been mentioned as a model that was more sensitive to culture and better at addressing social and interpersonal difficulties. Some participants also felt that its approach fits better in a collectivistic culture like Singapore:

[...]these systemic therapists[...]talked about how systemic frameworks, and the whole relational frameworks, may actually have more value within our cultures, because they come from the idea that we are part of a system and we are relating to other people, as opposed to perhaps other frameworks that start with the individual – like your thoughts, your feelings, your behaviours. (Ben)

Its cultural relevance is also highlighted by participants' aforementioned observations that many Singaporeans, especially the older generations, viewed their difficulties through a social, religious, or cultural lens.

While many participants noted that Systemic Therapy was especially important when working with families, some shared that *"Even though the individual is our main client, but we also want to consider systemic therapy right? How do the different systems around the individual also come into play to affect the client's condition?"* (Felicia). However, some cautioned about difficulties in implementing Systemic Therapy. For example, some felt that it was sometimes more difficult for clients to understand, while others spoke about organizational structures which meant that clients with relationship difficulties were referred to other MHPs, and CPs were expected to practice with individual approaches.

Under this systemic umbrella, some participants mentioned Narrative Therapy (NT) as being culturally relevant. In particular, the externalizing component of NT was highlighted as helpful for clients who overidentified with their difficulties.

Finally, participants discussed two other models which did not fit neatly with the other categories – existential therapy and strengths-based approaches. Some participants felt that a strengths-based approach was also helpful to address the self-critical nature of many Singaporeans, while Existential Therapy was discussed as a more suitable alternative for marginalized populations, compared to CBT and other evidence-based therapies.

Given the number of models discussed, it is helpful to note that participants also highlighted that we do not have to do everything alone. They pointed out that while it might be useful for CPs in Singapore to know about more different models, there were also other professionals (e.g., mentors, MHPs, clergy) who might be equally or better able to work within some of these models:

Ideally, I would love to be good at all of this (therapy models; laughs), but there are some practical limitations[...]I guess the best-case scenario is that there is a good pool of people who are familiar with diverse, different modalities, so that clients have sufficient choice that is hopefully affordable, so that they can find something that fits their needs lah. (Lexin)

This should be held in mind as we continue to explore participants' thoughts about the cultural relevance of CP training in Singapore.

3.5. Improving cultural relevance of CP training

In this theme, participants shared their experiences of the training they received from the CP courses in Singapore. Participants had mixed views about the cultural relevance of the academic portion of their training, with many sharing about some changes they felt would make CP training

more culturally relevant. Some of these suggestions extended beyond the academic programme to structural issues as well.

3.5.1. Mixed views on the current level of training on culture

In the previous quote, Lexin spoke about there being “practical limitations”, and this was a view shared by many participants. These limitations were mainly around time, the diversity of culture in Singapore, and the practical nature of adaptations.

Because of these limitations, some participants felt that by helping them to become “*more mindful of culture, and to adapt (therapy) to the cultural contexts*” (Kristy), the academic teaching on their courses were “*sufficient in terms of knowledge*” (Huaqin).

When discussing time limitations, participants shared that there was already so much to learn within a two-year course, so cultural training needs to be balanced against other training needs:

[...]I'm just also thinking there's so many things to remember throughout the course of two years. If you give me another list, it'll probably just be filed somewhere – I wouldn't really read it, I guess. No time[...]So I think we also have to be realistic with our expectations of what we can learn within two years? So that's really like a launching pad for us to further build and develop our skills. (Amelia)

Related to this point, participants also spoke about the broad range of cultures in Singapore, and the impossible task of learning about every one. Instead, many participants agreed with their courses' approach, which was that a curious stance was more important in working with the diversity in Singapore:

Megan: *I'm also thinking about how could we ever be really sufficiently and totally prepared for all the cultural differences[...]Every person who comes to us is different, because they have their own family culture. Then there's different racial groups, different countries, different nationalities – they also have their own culture. So I feel like it's very hard to really have academic training really prepare for all the different kind of cultures[...]*

Kristy: *[...]Of course it would have been great to have a culture handbook, but I don't think that is possible with every client – it's so different, and within (the) same cultures you have a lot of differences. So they just taught us to individualize it for each client. I think that's what I would subscribe to as well[...]*

Additionally, they also described cultural competence as a “*work-in-progress*” (Huaqin), that learning should continue into our workplaces, and that “*experience, rather than a specific module which is just theoretical*” (Jiaqi) would be more important in developing this awareness.

Despite these limitations, some participants felt that more could still be done on the courses. Different reasons were discussed for the importance of better cultural training, including a reluctance to view clients as “*trial-and-error posters*” (Ella) before getting better at knowing what areas to be more curious about. Participants noted that they had little training on working with clients from other countries, who may not only use different languages, but also have different cultural values and beliefs. The lack of focus on cultural training also meant that trainees were implicitly expected to tap into their own knowledge of local culture. This in turn meant that international trainees found it difficult to navigate placements:

Even for us right, who are brought up here, we know that there's still so much nuances. But for someone who is coming in entirely from a new country here [...]there's so many different things (to learn). I honestly feel if I was an international trainee and I came here to study, I will struggle a lot during placements to navigate the diverse population group. But I'm not sure how the course will go about it because culture's such a big thing [...]but I do think it is important as well – for our learning lah. (Felicia)

Some participants also felt that their training was very westernized and individualistic, and wondered what training would look like from a different lens:

I don't know how much of what we start off learning really is from the lens of the individual. Whereas, perhaps, there could be value of starting from the "you" as a part of a network. And I wonder how that would be like lah. Imagine if your training started off from that perspective, how you would change your own thinking already? (Ben)

Like Felicia in the earlier quote, some participants felt cultural training on the courses was not enough but expressed uncertainty in thinking about how it could be improved, partly due to the breadth of cultures. Another common worry, which participants said their lecturers shared, was that focusing on the cultures of different groups would be "*slanting into discrimination*" (Chende). Regardless, participants were still able to offer some suggestions, which were split into two groups: improving training on cultural differences, and including more models.

In terms of training on cultural differences, participants pointed out that academic teaching about culture tended to be on a "*broad, abstract level*" (Lexin). They felt that cultural competency went beyond just curiosity, because "*you don't know what you don't know*" (Ella) and it can be helpful to be more aware of the biases we have that can make it hard to be curious. In this area,

they suggested that training can highlight some aspects of culture which we commonly encounter in therapy (e.g., religion), as well as common areas of culture to direct our curiosity towards. They also suggested for teaching to include more concrete examples of adaptations, more localized teaching resources, and more roleplays for cultural issues. Additionally, they suggested that having more spaces to reflect on culture together could help them to understand our culture and their personal biases better.

Many participants also felt that learning more models would allow them to be more flexible in meeting the needs of their clients, and expressed disappointment that they were *“hammered over the head with CBT, rather than given more exposure to the various different kinds of therapeutic techniques out there”* (Yibin). However, many pointed to the limited time on training again, with some noting that by focusing on just one model, the course was *“not just honing your skills, but honing the way you think about modalities[...]realis(ing) the rigour of focusing on one modality”* (Ben) which then allowed them to transfer this critical thinking to other modalities in the future. Regardless, most participants agreed that the main focus should remain on CBT, with some suggesting that one additional model might be a way forward.

Moving slightly away from academic teaching, an interesting suggestion was also made to use case studies as a way to develop trainees’ thinking about different models without spending too much time teaching it.

3.5.2. Non-academic components can also be more culturally relevant

In a similar vein, participants also discussed how non-academic components could be tweaked to facilitate the development of cultural competency without putting more burden on the academic teaching. One such suggestion was to leverage placements to: 1) include the use of (and supervision in) at least one other model besides CBT on placements, and 2) allocate placements to expose trainees to a range of diverse cultures (e.g., by ethnicity, religion) and/or therapeutic models (i.e., based on supervisor expertise).

Participants also spoke about having more diversity in the staff team. While there was a *“good mix of local and Western lecturers”* (Huaqin) at the moment, some hoped to see lecturers from other cultures as well (e.g., China, India, South America), or Asians trained in the West. Participants valued the ability of *“assimilated”* foreign professors to provide *“both a Western as well as local perspective”* (Yibin) and the expertise they might bring, but recognized that foreign lecturers who have been in Singapore for a shorter time or have stayed in academia might not be as able to integrate local culture into their teaching. In this respect, participants valued the presence of local lecturers to bring their local perspectives into the modules as well.

When the possibility of a longer training course was explored, many participants cited financial concerns (for some context, CP training in Singapore is self-funded, and trainees are not paid on their placements). A suggestion was made to have paid placements, which would make a longer courses more feasible.

Finally, some participants suggested the possibility of mandatory personal therapy for trainees to *“explore their inner world”* (Ben), in recognition of the fact that therapists are *“vessels[...]that bring these therapies to other people[...]and it filters through us, and our values, and whatever stations we are in life also”* (Diane).

3.6. Interview Activity Data

Given the somewhat mixed picture about the usefulness of flexibility and the benefits of focusing on one model (Section 3.5.1.), the descriptive data from the interview activity (Tables 8-10) could be helpful to provide a different perspective. Since this was an individual activity, participants were assigned numbers to add an additional layer of anonymization to the data.

Table 8

Participants' Experienced Course Allocation (Interview Activity Part 2)

Model	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	M_{eca}	n_{eca}
Acceptance and Commitment Therapy	5%	5%		20%	21%	-	5%	8%	5%	19%	15%	3%	5%	8.54%	11
Cognitive Behavioural Therapy	70%	70%	90%	40%	35%	90%	70%	50%	80%	58%	50%	75%	76%	65.69%	13
Compassion Focused Therapy	5%	5%	-	-	-	-	3%	-	5%	1%	-	3%	3%	1.92%	7
Dialectical Behavioural Therapy	5%	5%	-	20%	21%	-	5%	5%	3%	19%	15%	6%	-	8.00%	10
Indigenous Therapy / Traditional Healing	-	-	-	-	-	-	-	-	-	-	-	-	1%	0.08%	1
Mindfulness Based Cognitive Therapy	-	5%	-	-	-	-	3%	8%	1%	1%	-	8%	5%	2.38%	7
Narrative Therapy	10%	-	10%	20%	15%	5%	5%	4%	3%	1%	-	3%	10%	6.62%	11
Psychoanalytic Therapy	-	-	-	-	-	-	-	7%	-	-	-	-	-	0.54%	1
Psychodynamic Therapy	-	-	-	-	-	-	-	7%	-	-	-	-	-	0.54%	1
Schema Therapy	-	5%	-	-	5%	-	3%	7%	3%	1%	15%	-	-	3.00%	7
Systemic Therapy	5%	5%	-	-	3%	-	6%	4%	-	-	5%	2%	-	2.31%	7
Motivational Interviewing	-	-	-	-	-	5%	-	-	-	-	-	-	-	0.38%	1

M_{eca} = Mean of the experienced course allocation across participants

n_{eca} = Number of participants who indicated being taught the model

Table 9

Participants' Ideal Course Allocation (Interview Activity Part 2)

Model	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	M_{ica}	n_{ica}
Acceptance and Commitment Therapy	20%	10%	-	20%	10%	10%	10%	8%	15%	20%	10%	7%	10%	11.54%	12
Cognitive Behavioural Therapy	20%	55%	60%	40%	30%	60%	50%	45%	30%	25%	40%	30%	50%	41.15%	13
Compassion Focused Therapy	-	10%	-	-	10%	-	10%	-	5%	-	10%	7%	-	4.00%	6
Dialectical Behavioural Therapy	20%	5%	-	20%	10%	10%	10%	3%	15%	20%	10%	7%	-	10.00%	11
Indigenous Therapy / Traditional Healing	-	-	-	-	5%	-	5%	4%	-	-	-	7%	10%	2.38%	5
Mindfulness Based Cognitive Therapy	-	-	-	-	5%	10%	-	5%	5%	5%	-	7%	-	2.85%	6
Narrative Therapy	10%	-	-	-	5%	-	5%	5%	5%	5%	-	7%	10%	4.00%	8
Psychoanalytic Therapy	-	-	-	-	5%	-	-	5%	3%	-	-	7%	-	1.54%	4
Psychodynamic Therapy	-	-	40%	-	5%	-	-	5%	3%	-	10%	7%	5%	5.77%	7
Schema Therapy	20%	10%	-	-	5%	10%	5%	10%	15%	20%	10%	7%	5%	9.00%	11
Systemic Therapy	10%	10%	-	20%	10%	-	5%	10%	4%	5%	10%	7%	10%	7.77%	11
Motivational Interviewing	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0

M_{ica} = Mean of the ideal course allocation across participants

n_{ica} = Number of participants who endorsed the model as part of their ideal course

Table 10

Changes Between Participants' ICA and ECA (Interview Activity Part 2 - Interview Activity Part 1)

Model	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	n _{more}	n _{less}
Acceptance and Commitment Therapy	15%	5%	0%	0%	-11%	10%	5%	0%	10%	1%	-5%	4%	5%	8	2
Cognitive Behavioural Therapy	-50%	-15%	-30%	0%	-5%	-30%	-20%	-5%	-50%	-33%	-10%	-45%	-26%	0	12
Compassion Focused Therapy	-5%	5%	0%	0%	10%	0%	7%	0%	0%	-1%	10%	4%	-3%	5	3
Dialectical Behavioural Therapy	15%	0%	0%	0%	-11%	10%	5%	-2%	12%	1%	-5%	1%	0%	6	3
Indigenous Therapy / Traditional Healing	0%	0%	0%	0%	5%	0%	5%	4%	0%	0%	0%	7%	9%	5	0
Mindfulness Based Cognitive Therapy	0%	-5%	0%	0%	5%	10%	-3%	-3%	4%	4%	0%	-1%	-5%	4	5
Narrative Therapy	0%	0%	-10%	-20%	-10%	-5%	0%	1%	2%	4%	0%	4%	0%	4	4
Psychoanalytic Therapy	0%	0%	0%	0%	5%	0%	0%	-2%	3%	0%	0%	7%	0%	3	1
Psychodynamic Therapy	0%	0%	40%	0%	5%	0%	0%	-2%	3%	0%	10%	7%	5%	6	1
Schema Therapy	20%	5%	0%	0%	0%	10%	2%	3%	12%	19%	-5%	7%	5%	9	1
Systemic Therapy	5%	5%	0%	20%	7%	0%	-1%	6%	4%	5%	5%	5%	10%	10	1
Motivational Interviewing	0%	0%	0%	0%	0%	-5%	0%	0%	0%	0%	0%	0%	0%	0	1

n_{more} = number of participants who wanted courses to spend more time on the model

n_{less} = number of participants who wanted courses to spend less time of the model

Two data points are of particular interest for this study:

1. The mean of the ICA across participants (M_{ica}): This was taken as an indication of which models participants felt were important for a culturally relevant course.
2. The number of participants who indicated increased (n_{more}) or decreased (n_{less}) time allocation in a model in their ICA, when compared to their ECA: This was taken to indicate which models participants would recommend for courses to spend more or less time on. This data point was included as it was potentially more sensitive to individual differences in estimating the amount of time that was currently being spent on different models. The wide range of ECA estimates also reflects changes in the curriculum across cohorts, which participants also spoke about in the FGs.

As shown, the models which were more highly endorsed across participants were generally the same as those which participants discussed in more depth (Section 3.4.3). Namely, these were ACT, DBT, Schema Therapy, and Systemic Therapy. The mean of the ICA also reflected participants' commitment to having CBT remain the main focus. However, the large spread (with CBT averaging less than 50%) was somewhat surprising given some discussion around the benefits of focusing on just one model, but fit with discussions around the need for flexibility. This pattern was also supported when looking at the number of participants who wanted more (or less) time spent on each model – models which were discussed more had more participants wanting more allocated time, while almost all participants indicated a wish to spend less time on CBT.

Perhaps an unexpected difference can be seen in the endorsements for psychodynamic therapy in participants' ICA, both in terms of number of participants and time allocated. While the time allocated might be explained by P3's strong endorsement of the model, the number of participants who endorsed it is somewhat surprising given the relative lack of discussion around it during the FGs. For the same reason, another surprising data point is the sizable number of participants who indicated a wish to allocate more time to Indigenous Therapies/Traditional Healing,

with none wishing to allocate less time. However, looking at the corresponding data in Tables 8 and 9, this is easily explained by the almost complete lack of any representation of these models on current programmes. As such, any interest at all, however small, constituted an increase.

Chapter 4. Discussion

What can you do, then? Coloniality cannot be un-done, any more than you can un-read Chaucer or un-see Caravaggio, and it is undeniable that these things have broadened your mind. But the question is not how to retreat into some pristine, native state. In fact, it is the opposite: how to recognise the narrowness of this so-called broadened mind, to realise that Europe is not the universe.

– To my Eighteen-Year-Old Self, on your Departure for Cambridge

By Singaporean Michelle K. (2013, p.31)

4.1. Overview

In this chapter, I start by summarizing the results of the analysis. I then compare this study with previous literature to find areas of convergence and divergence. Potential implications are considered before its strengths and limitations are discussed. Recommendations are made for future research before I conclude with some personal reflections on this process.

4.2. Summary

This study sought to gather the views of Singaporean trainee and recently-graduated CPs on the cultural relevance of different therapeutic models, and how their course has prepared them to practice in a culturally relevant way in Singapore. The themes and subthemes described how although many CPs found it hard to identify what our culture was, there was general agreement that CBT was suitable for working within Singapore's culture because it fits with Singaporeans' more cognitive approach to mental health, and our expectations for concrete solutions.

However, they recognized some limitations. Compared to other models, CPs felt that CBT was less effective in addressing some aspects of our culture, including emotion-focused work (to balance our cognitive tendencies), systemic and relational issues, and cultural values and explanations of difficulties (especially spiritual ones). Regardless, CPs suggested that CBT could be

further adapted to fit Singapore better, and often used CBT as a first-line intervention until they decided other models were also needed. Among other models discussed, ACT, DBT, Schema Therapy, and Systemic Therapy stood out.

CPs shared that many factors guided their decisions about which models to use, including their training, which focused on CBT and an seemingly unquestioning acceptance of evidence base. Courses also advocated for a more curious stance towards culture rather than focusing on building content knowledge. There were mixed views about the sufficiency of such an approach, with CPs suggesting some changes to both the academic and non-academic components of training (see Section 4.5.2.).

4.3. The Study in Context

To make sense of my analysis, it might be helpful to look at it in the context of previous research. As with the interview activity, I merely seek to present different perspectives rather than to verify my results. I return to my research questions to structure a discussion.

4.3.1. Is the focus on CBT suitable for working within Singapore?

Despite CPs' lack of confidence in identifying local culture, many of the observations they made about Singaporeans – namely that Singaporeans are more cognitive and less in-tune with their emotions, expect more concrete solutions from therapy, and attribute more external (e.g., social and spiritual) origins to their distress – are consistent with literature on Singaporean and Chinese cultures (e.g., Davis et al., 2012; Geerlings et al., 2017; Loh et al., 2021; Ow, 1998; Shen et al., 2019; Sim, 2012). Generational differences in cultural values have also previously been noted (Foo et al., 2006; Thomas, 1990). This suggests that despite their hesitance, CPs had a fair grasp on the mainstream culture in Singapore.

As discussed in Chapter 1, previous studies have suggested that CBT can be effective (e.g., Drmic et al., 2017; Ooi et al., 2007) for Singaporeans. By examining the cultural fit of CBT, this study may also shed some light on its acceptability. In this regard, CPs in this study felt that CBT generally

fit with most of the above aspects of our culture, except for its limitations in fully accounting for cultural, social, and emotional issues. CPs' reflections that many clients held explanations of distress which differed from their models was consistent with B.O. Lee and Bishop's (2001) findings. Many points raised by CPs also appear in Chen and Davenport's (2005) exploration of the parallels and conflicts between CBT and Chinese culture. This somewhat ambivalent position is also reflected by the split in literature, with some studies supporting the relevance of CBT in Singapore (for a discussion see Foo et al., 2006), and others challenging it (e.g., Geerlings et al., 2017).

CPs felt that CBT could be adapted to be more culturally relevant. Similarly, despite highlighting more 'cautions' than parallels, Chen and Davenport (2005) concluded that CBT had a "high level of compatibility" with Chinese culture and would be viable with "a few modifications" (p.109). Participants' suggestions (providing more guidance, and adapting some skills to be more culturally sensitive) mirrored those in the literature (Jennings et al., 2008; Sim, 2012). Here, additional adaptations were proposed: spending more time psychoeducating clients on the collaborative nature of therapy, and using groups to deliver skills training.

4.3.2. What other models of therapy might be culturally relevant for Singapore?

CPs spoke about the need for flexibility and working with different explanatory models simultaneously, a theme which was also discussed in other studies (Geerlings et al., 2017; Jennings et al., 2008; B.O. Lee & Bishop, 2001; Yeo, 2002). In Section 1.6.5.6., we noted that extant literature on multicultural practice in Singapore was vague and often referred to the use of clinicians' 'intuition' and 'wisdom' (Sim, 2012). This study contributes to the literature by describing in greater detail one way in which CPs practiced flexibly and used different explanatory models simultaneously – by using CBT as a first-line intervention and subsequently integrating ideas from other models as needed – and the factors that guided their decisions.

One contribution of this study was to ask CPs directly which models they thought were culturally relevant. The analysis suggested four models which elicited more in-depth discussions: ACT,

DBT, Schema therapy, and Systemic therapy. The relevance of Systemic Therapy for Singapore has been discussed in literature (Jennings et al., 2008; Loh et al., 2021; Sim, 2012; Yeo, 2002). Meanwhile, literature from other countries have suggested the relevance of ACT (Hall et al., 2011; Llewelyn & Shimoyama, 2012) and DBT (Yang, et al., 2016) in East Asian and Confucian societies. Mao et al. (2022) found that while Schema Therapy was acceptable to clinicians in Singapore and Hong Kong, they faced a number of cultural challenges (e.g., reluctance to confront a parent figure during imagery rescripting due to the value of filial piety) which meant the model needed to be adapted. In this study, CPs felt that Schema Therapy was helpful in filling the emotion-work gap in CBT, but it is uncertain why CPs favoured this model over other emotion-focused approaches (e.g., EFT or CFT). It is therefore less clear if the discussion around Schema Therapy reflects CPs' acceptance of the model, their training exposure, or a cultural fit with clients.

In terms of IT/SH models, CPs agreed with MHPs in Foo and Merrick's (2004) study – while they respected clients' spiritual beliefs and may try to fit them within a Western psychological formulation, they seemed to expect religious and spiritual work to be conducted outside of the 'secular' therapy setting (and believed that clients did too). This lends some weight to our previous hypothesis that the views of MHPs in Parker et al.'s (1999) study did not fully reflect the views of the (current) wider profession in Singapore.

4.3.3. How prepared do Singaporean CPs feel for culturally relevant practice after training locally?

Almost all the CPs shared a sense of not being ready for culturally relevant practice after graduating. However, many acknowledged the limitations of a two-year course, with thoughts like *"Has our own academic training prepared us sufficiently for even the work (of a CP)?"* (Kristy) being shared. As such, some CPs felt that although they felt unprepared, what was being done on the courses was sufficient as a starting point to build on post-graduation.

Many CPs in this study felt that the cultural training they received was generic and wanted more teaching on the topic, a feeling echoed by those in Geerlings et al.'s (2017) study. Geerlings et

al. (2017) made some suggestions on how to improve cultural training, and most were voiced by CPs in my study (increased teaching on cultural content [also in B.O. Lee & Bishop, 2001], increased reflective spaces and cross-cultural interactions on the course and on placements, and the creation of local resources). CPs in this study also discussed how foreign professors who have been here for a shorter time did not integrate local culture into their lessons, which led Geerlings et al. (2017) to their final recommendation on supporting academics in developing cultural knowledge. CPs in my study provided additional suggestions for both academic and non-academic components of courses (see Section 4.5.2.), which also included this study's main focus: how culturally relevant courses should spread its focus across different models of therapy. Namely, most participants felt that courses should spend less time on CBT, spreading it instead across a range of other models.

Geerlings et al. (2017) reported that some CPs expressed a view that the support of an evidence base meant that a practice was universal, and this was also seen in this study. CPs spoke about how evidence base was often accepted uncritically on their courses, with some only starting to question it after they graduated. From a radical constructivist point of view, this was somewhat troubling to note (see Section 4.4.2.).

Given the consistent findings about the skills and training needed to make therapy more culturally relevant in Singapore, and that Geerlings et al., (2017) had noted that "some academics experienced that their curricula were insufficiently tailored to practice in Singapore, and felt that students were more interested to discuss local cases" (p.5), it is interesting to note that training courses do not seem to have responded to the recommendations made in these papers.

4.4. The Wider Context

In this section, I will expand the discussion to wider conversations around culture, training, and clinical psychology. Many of the things which participants spoke about go straight to the core of many debates in clinical psychology: what is culture and decolonisation; what is the value of evidence base; what are the processes of change in therapy; what is the purpose of training; what

are the goals of therapy. While it is beyond the scope of this paper to unpack all these wide-ranging questions, I will examine the first three within Singapore's context.

4.4.1. What is culture and decolonisation in therapy?

In Section 1.2.2, we highlighted the need to consider what 'decolonising' clinical psychology meant in Singapore's context. While many CPs in this study spoke about the importance of following (Western) evidence base, they were unable to articulate the reasons for its importance. Similarly, they seemed to implicitly recognize the importance of adapting these 'evidence-based practices' in their own practice (e.g., by incorporating other models), even if such adaptations were themselves not evidence-based. This harkens back to Bhabra et al.'s (2018) definition which highlighted the importance of questioning the privilege assigned to knowledge generated in the West as part of the process of decolonising education. I argue that this approach to decolonisation, which uses the broader definition of 'indigenous', makes sense for clinical psychology in Singapore, as a field which is meant to serve the needs of all clients as best as possible. However, this may not be the case for other fields of study in Singapore (e.g., history, anthropology, politics), or for clinical psychology in other countries.

Additionally, as noted in Section 1.2.4., there exists an ongoing debate between cultural competence and cultural humility (Greene-Moton & Minkler, 2019; Tervalon & Murray-García, 1998). CPs in this study seemed to straddle this divide, voicing familiar concerns about the unattainability of 'competence', the different layers of diversity (intersectionality), the perpetuation of cultural stereotypes, and the need to examine personal biases, while also recognizing the usefulness of enhancing our knowledge of different cultures. While CPs subscribed to a curious and non-expert stance towards diversity, they also spoke about how, given the broad scope of culture, having *some* understanding of the culture they were working with helps them to know where to direct their curiosity. As such, CPs in this study seemed to advocate a 'both/and' position similar to that of Greene-Moton and Minkler (2019), who argued that the concept of cultural competence is useful

not as something to be achieved, but as a reminder for us to strive to learn more. CPs here described it as cultural competence being a 'work-in-progress' which never ends.

This curious approach is especially important given the dynamic nature of culture noted by CPs. Younger generations of Singaporeans and those who are more well educated in English are becoming increasingly Westernized (Foo et al., 2006; B.O. Lee & Foo, 2019). CPs should not make assumptions about the cultural beliefs that Singaporeans hold, and should be able to work with those who hold 'traditional' as well as 'Westernized' beliefs. As an advocate for decolonisation seeing the footprints of a colonialised education system (Ngũgĩ, 1986) and a colonial mentality (an internalized perception of cultural inferiority to the West; David & Okazaki, 2010), one might be tempted to resist this in the therapy room – perhaps by looking to 'conscientize' the client (Freire, 1970). Such an approach is supported by findings from Torres (2010), who found that maintaining ties to one's culture of origin was negatively correlated with depression among Latino adults in America. If not implemented thoughtfully, however, we might become guilty of the precise thing we were fighting – imposing our own 'enlightened' views onto our clients. While White (1995) highlights that therapists cannot be 'truly' neutral, and attempts to do so tend to become pro-cultural, he also warns that all theories of health and normality have the potential to end up in the service of subjugation.

We should also be cautious of idealizing traditional beliefs (Akinyela, 2002). For example, Confucianism has been criticized as justifying social inequality (Nuyen, 2001), and the pressure to conform and sacrifice individual goals for the collective good can become a source of distress (Cao, 2020; Laungani, 2003). On another level, one might also argue that such resistance towards cultural change is, ironically, inconsistent with our cultural value of accepting change (Ma et al., 2019). Here, perhaps our other values of 'moderation' (Foo et al., 2006) or 'dialectical thinking' (Yang, et al., 2016) can help us to learn to compromise between and/or hold both positions of resisting Westernization and accepting of the inevitability of change. Perhaps what we should strive for then is a form of

'bicultural competence' (which has been linked to reduced depressive symptoms among minority college students in America [Wei et al., 2010]).

This study suggests that in a multicultural and increasingly Westernized country like Singapore, CPs may benefit from a both-and stand towards acquiring cultural knowledge and adopting a curious stance towards cultural diversity. CPs may want to exercise caution not to let personal views about Westernization (whether for or against) overshadow clients' own worldviews. Training courses should engage trainees in such debates to facilitate their awareness of personal positions.

4.4.2. What is the value of evidence base?

It can be argued that one way a colonialised education system imparts a colonial mentality is by adopting a position of 'culture blindness' via the uncritical (mis)use of evidence base. In this view, psychological theories developed through scientific methods are beyond reproach, because they "enter society as truths beyond tradition, beyond value, beyond question" (Gergen, 2009, p.21). However, Gergen (2001) warned that science only reflects local 'truths' about nature, and to presume them to be universal is arrogant and silencing. Often, it ends up privileging Western perspectives over non-Western ones (Geerlings et al., 2014). Lyddon (1995) wrote that cognitive therapy was particularly guilty of this conceptual complacency, such that disagreements in the field have largely kept to minor issues within the theory rather than challenging its basic assumptions. This seemed to be reflected in some CPs' views that "*everything with a cognitive conceptualization is CBT*" (Amelia).

CPs shared that they were not given many opportunities to unpack the meaning and value of evidence base on their courses, although some found themselves doing so independently post-graduation. Others wanted to learn more about therapies from cultures which "*haven't been super affected by the Western society*" (Ella). This aspect of the courses seems to fit what Freire (1970) described as a 'banking concept of education', where "knowledge is a gift bestowed by those who

consider themselves knowledgeable upon those whom they consider to know nothing” (p.72), and can be seen as a tool of oppression – in this case, of ongoing colonialism. For example, an uncritical acceptance of CBT does not consider the fact that traditionally, Chinese did not differentiate between cognitive and affective states, believing both to come from the heart, or 心 (xīn; translated as ‘heart-mind’ in philosophy; Rošker, 2021), or that ancient Indian philosophies do not see the self as separate from its social, physical, natural, and supernatural surroundings (B.O. Lee & Foo, 2019). CPs’ lack of interest in IT/SH models may reflect how science often positions itself against such ‘folk thought’, believing it has nothing to learn from them (Harding, 2004).

The British Psychological Society (BPS; 2011) acknowledges the importance of reflective practice in formulation, noting that our profession is “not best served by the narrow ‘technical-rational’ application of research to practice. Rather, it requires a kind of artistry that also involves intuition, flexibility and critical evaluation of one’s experience” (p.7). Such guidelines would support Singapore CPs’ flexible use of assimilative integration (Zarbo et al., 2016), in which they incorporated techniques (but not necessarily theories) from other models into a ‘base’ therapeutic framework. However, while integrative approaches are gaining acceptance, their ‘evidence base’ remains small (Norcross, 2001), at least in part because they do not fit well into the kind of ‘gold standard’ research methods that define the evidence for other models like CBT (i.e., randomized controlled trials [RCTs]; Wachtel, 2018). Given the seemingly uncritical approach towards ‘evidence base’ adopted by CPs and their courses, however, I was curious how they made sense of this deviation from an evidence-based model (CBT) to adopt an integrative approach that has little evidence.

4.4.3. What are the processes of change in therapy

Another question that the use of integrative practices raised is about the processes of change in therapy. Some CPs felt that many of the models share similar philosophical foundations and are “quite similar in what they’re trying to say” (Felicia). This belief, however, might be a contentious statement. For example, CBT traditionally follows a realist, empiricist framework

(Lyddon, 1995), while other models such as narrative therapy are based on postmodern and social constructionist epistemologies (Chenail et al., 2020). Norcross (2001) noted that the difficulty of theoretical integration was the possibility of “smushing theories fraught with epistemological incompatibilities” (p.12492), but that an integration at the level of change processes avoided this trap. As such, while CP’s use of assimilative integration does not face epistemological inconsistencies, their chosen base therapy would still guide their epistemology and formulation about the case. As such, a legitimate question remains about the potential impact of CPs using a different base model which might be more culturally relevant. However, perhaps because CPs have not had the chance to unpack the meaning of evidence base, or discuss about the epistemological underpinnings of various models, they tended to cite more practical reasons (e.g., familiarity with the model, CBT having a useful structure) for their choice.

Another interesting area of discussion revolved around ‘balancing’ and ‘matching’ clients’ tendencies. For example, when discussing the cognitive thinking styles of Singaporeans, CPs spoke about how it was sometimes useful to use a CBT model which fits with that nature, while at other times it was more helpful to use emotion-focused work to balance it out. Much of the focus in literature in cultural adaptations involve ‘compatibility’ and ‘alignment’ (Alfonso & Botbol, 2021), but here CPs suggest that ‘balancing’ can be a part of cultural relevance too. On a meta level, the concept of balance itself is a Chinese value (Shen et al., 2019), and TCM continues to understand ‘diseases’ as the result of an imbalance of *yin* and *yang*, and of both internal and external factors (Ng, 1998; Shen et al., 2019). Perhaps this value might also underpin CPs’ clinical decisions in balancing clients’ tendencies.

In considering when ‘matching’ or ‘balancing’ might be more helpful, I considered Frank’s (1982) concept of therapeutic ‘myths’ and ‘rituals’. Frank (1982) discussed the placebo effect in relation to the effectiveness of therapies, and suggested some common factors which contribute to positive outcomes, including a shared confidence in the effectiveness of the therapy. Arguably,

'matching' our models to clients' pre-existing beliefs could instil more confidence and acceptance, resulting in improved outcomes (Chowdhary et al., 2014). This suggestion is supported by Benish et al.'s (2011) meta-analysis, which found that cultural adaptations of the 'illness myth' was the sole moderator for improved treatment outcomes in culturally adapted therapy. However, in our culture, clients may also be convinced of the effectiveness of rituals which 'balanced' out their current situation (perhaps especially those who felt 'stuck'). Perhaps 'matching' might be more useful at the level of 'myths' (or explanatory models), while 'balancing' could (sometimes) be applied at the level of 'rituals' (or techniques). However, it is beyond the scope of this study to fully address this hypothesis, and more research would be required to reach a conclusion.

The debate between 'model specific' and 'common factors' as most important in facilitating change in therapy is longstanding (e.g., Strauss et al., 2018; Wampold, 2015). If the position is adopted that the modality per se is less important than creating therapeutic myths and rituals that clients can have faith in, then arguments can be made for using models which are less grounded in Western values and beliefs; it can be argued that by 'psychoeducating'/'socializing' our clients to Western models, we risk imposing Western norms on locals who have different views (Geerlings et al., 2014), thereby becoming (unwitting) instruments of colonisation. This is especially true in Singapore, where clients may show more deference due to a greater respect for authority (Foo et al., 2006) and educational achievements (Han, 2014), both of which may be perceived qualities of a CP. However, the practical temptation is strong, because scientific evidence has as much power over our clients as it does us, and it can be a very useful (but sometimes colonial) tool to build confidence in interventions.

Given the breadth and complexity of these fundamental debates, this discussion was not intended to provide answers, but to consider examine them through the lens of this study. Singapore CPs may benefit from reflecting on these important issues and develop an awareness of their personal positions (see Section 4.5.1.).

4.6. Strengths and Limitations

The present study adds to extant literature in many ways, and represents an expansion on the work of Geerlings et al. (2017) by exploring the models that local CPs used and the decision-making process underpinning it. Culturally relevant therapeutic models were suggested along with some ideas of how to divide their focus across different models. The study's main strengths were in giving voice to trainees, the use of FGs which allowed the co-creation of new knowledge during the interviews, and my 'space between' position which I believe allowed CPs to share more openly with me. It is possible that the models identified as culturally relevant here may apply to other Confucian societies, and/or that this flexible integrative approach might be used by CPs in other multicultural societies. Readers should judge the similarity of their contexts and determine the transferability (Lincoln & Guba, 1985) of the results and clinical implications outlined below.

However, this study had some limitations as well. From a different angle, one might argue that my familiarity with the participants, or alternatively my distance from them as a UK trainee, might have skewed their responses (see Section 2.6.4. for a discussion). A limitation that I did not anticipate, however, was the impact of my project title, which one participant referred to during the FG. Pairing this with a snowball sampling recruitment strategy might have resulted in a selection bias, attracting mostly people who were interested in the decolonial agenda.

I also noted an unequal representation of JCU and NUS students, which might be problematic as these courses could be quite different (although a comparison between the courses was not the main intention of the study). However, the FGs did not suggest any big differences besides a greater spread of models which was taught in JCU. More strikingly, the lack of representation from other ethnicities was a major limitation, as what Chinese trainees consider to be culturally relevant may be different to what Malay or Indian trainees think. However, given the potential pool of participants, this was somewhat inevitable.

The final limitation discussed here is about how I had not reached a point of data saturation in this study. It is possible therefore that more similar or different themes might have been identified if more FGs were conducted. While part of the reason is due to difficulties in recruiting from a small pool, it has also been argued that the concept of saturation is inconsistent with theoretical positions who do not presume to be able to arrive at a complete and accurate account of their topic (Braun & Clarke, 2012).

4.5. Clinical implications

Based on all these discussions, I suggest implications for clinical practice at the level of the individual, training courses, and the professional bodies.

4.5.1. Implications for Individual Therapists

CPs in this study discussed some practical adaptations for more culturally relevant clinical practice, which included being more directive, spending more time with psychoeducation, using skills training groups, and attending to cultural values in teaching skills.

The discussions around the need for flexible use of multiple modalities suggests that CPs in Singapore might benefit from being versed in a few different modalities, and it may be insufficient for them to be 'experts' in just one (or maybe even two) models. CPs might wish to familiarize themselves with the models participants in this study suggest as potentially culturally relevant (ACT, DBT, Schema Therapy, and Systemic Therapy).

Braun and Clarke (2012) suggested that FGs can be particularly useful for research with some social change agenda, as it can have a 'consciousness-raising' effect on its' members. As I had hoped, some participants provided feedback that they valued the chance to reflect on these issues together with other local CPs. This suggests potential value in additional reflective spaces for CPs to explore these topics (e.g., the clinical value of evidence base, the values and epistemologies of different models, ongoing coloniality, integrative practice) both on training courses and in their

workplaces. Other studies have also supported the usefulness of reflective spaces in developing cultural competence (Geerlings et al., 2017; Sim, 2012).

Regardless of model, CPs could usefully explore the cultural beliefs of clients and their families, perhaps paying closer attention to intergenerational differences. To do so effectively, individual therapists could pursue cultural knowledge and reflect on their own biases, instead of only relying on their own experiences and/or the training they had received. Even so, CPs need to also maintain their curiosity about different (and similar) cultures, and remember that cultural competence is a continuous work-in-progress.

4.5.2. Implications for Training Courses

This also points towards a duty that training courses have to prepare CPs for culturally relevant practice in Singapore. To this end, CPs gave some suggestions for the courses: 1) More concrete teaching on things to be curious about within culture, reflective groups about culture, and roleplays on how to incorporate it; 2) Using localized training resources (e.g., videos) in teaching; 3) Exposure to more (culturally relevant) therapy models in academic lessons; 4) Using case studies to explore different formulations and expand trainees' thinking about different models; 5) Allocating placements based on the diversity of the clients seen and/or the models of therapy used; 6) More diversity in teaching staff (not just from Western countries) to provide alternative perspectives; 7) Providing paid internships so that courses can be longer; 8) Making personal therapy mandatory so that trainees can reflect on personal beliefs and biases.

In teaching about different models of therapy, an understanding of the Western roots of these models could be important. This could help us to learn how to adapt them to our culture (Akinyela, 2002). One way to teach about different models of therapy in a culturally sensitive way could be to use the decolonisation tool shared by Burgess et al. (2021), which encourages looking at models' roots, development, and present applications in a critical and self-reflexive way. While trainees requested for quite a wide spread of different models, it is perhaps useful to spend more

time on one or two postmodern therapies as well, so trainees can also explore alternative epistemologies to aid in their reflections on evidence base.

This study highlighted that courses should not assume that local trainees are adept at addressing local cultural issues. Additionally, CPs also needed to work with clients from other countries too. Courses could consider how to equip CPs with more concrete skills on *how* to be curious about culture. CPs discussed how it was difficult for them, but even harder for the international trainees. Courses have a responsibility to prepare their international trainees for their placements, and for practicing in Singapore. Not doing so could impact on the mental health of their trainees (Teo & Yong, 2020). In their survey of international trainees in the UK, Teo & Yong (2020) reported that trainees requested to be linked up with international trainees from previous years for support, while also having a local buddy with whom they can speak about local culture. They also wanted more information about local healthcare systems and processes to help with their placements. Perhaps these measures could, to some extent, be helpful for new foreign lecturers too.

All the participants in the study were Chinese, and trainees told me that this was generally reflective of the overwhelming majority-Chinese make-up of courses in Singapore. This meant that trainees had less chances for cross-cultural interactions on the course, which Geerlings et al. (2017) identified as an important part of building cultural competence. Courses could invest more effort into recruiting from other ethnicities, since this is likely to benefit not only trainees, but clients from those ethnicities (Field & Caetano, 2009; Hussain et al., 2020).

Courses could also consider providing more reflective spaces to explore culture and evidence base. To avoid perpetuating the 'banking' model of education, Freire (1970) states that education must impart critical thinking, and recognize that both students and teachers are simultaneously teachers and students. The latter might be especially useful for foreign lecturers who are in the early stages of understanding local culture. Such an approach should value the knowledge and experience of the students, and involve their reflective participation (Freire, 1970). Given the

common use of integrative practice, and the relatively smaller evidence base around it, this might be another area where shared learning and reflection might be helpful. Courses could also consider encouraging and supporting local research into the effectiveness and acceptability of this integrative practice.

4.5.3. Implications for Professional Bodies

While there are no accreditations presently for training courses in Singapore (Department of Psychology, n.d.), professional bodies like the Singapore Psychological Society (SPS) guide the profession at a national level. Therefore, it would be useful if SPS engaged with some of the matters raised in this study. This could include creating guidelines for training programmes which include an emphasis on cultural training, and/or raising awareness of the cultural relevance of different psychotherapy models so that organizations may consider allowing their CPs to practice using other models instead of solely relying on 'evidence base'.

However, any efforts at accrediting courses should be done thoughtfully, as Geerlings et al. (2014) suggested that such standardization might result in less local cultural translations of psychology. Similarly, as SPS works towards regulating the title of CP (Singapore Psychological Society, n.d.), it might be useful to consider the impact of uncritically accepting foreign accreditation without registration or vetting, as this might send an implicit message that clinical psychology training is universally applicable across cultures.

Finally, professional bodies could consider lobbying for increased funding and subsidies for courses and/or paid internships which would make it financially more feasible for longer courses, giving trainees more time to engage in discussions around evidence base, culture, and adapting Western psychology for local practice. More importantly, this could help to make the course more accessible to a more diverse group of aspiring clinical psychologists as well.

4.7. Recommendation for Future Research

Given the discussion about ‘balancing’ and ‘matching’ in Section 4.6.3., more research might be helpful to tease apart the levels (i.e., explanatory model or technique) at which CPs choose to ‘match’ or ‘balance’, and when and why they decide to use different strategies. It would also be interesting to see if CPs in cultures with less emphasis on ‘balance’ also go through similar decision-making processes.

The present study also suggests that further research may be needed to determine what a ‘decolonial’ and/or Singaporean clinical psychology might look like for in our local context. Despite expressing some concerns, CPs in our study still favoured the use of ‘evidence-based’ interventions and expressed a much greater interest in Western practices than indigenous ones. It is possible that a ‘decolonial’ Singaporean clinical psychology does not eschew Western practices but rather adapts them and blends them with indigenous knowledge and beliefs. Future studies may want to place more emphasis on the question of ‘decolonising’, and perhaps compare that with other countries.

It might also be enlightening to repeat this research with more experienced CPs in Singapore, to find out their thoughts about culture in clinical psychology and what models they felt were culturally relevant. This study specifically chose recently-qualified and current trainees to give a more recent account of training programmes, but future research can explore whether increased experience would change CPs’ thinking about these questions.

A final suggestion would be for this research to be repeated either after courses have started encouraging more discussions about evidence base, or perhaps a future study could use a PIA focused on deconstructing evidence base (rather than one exploring different models, as was done in this study). Since many participants seem to fall back on ‘evidence base’ without having had much opportunity to unpack that belief, it would be interesting to find out if their responses might be different otherwise.

4.8. Conclusion

This study has surprised me in many ways, and I have learned much from this process and from my participants.

My own training journey brought me to the UK and back to Singapore, and many things were gained and lost along the way. While adjusting to UK culture was not easy at the best of times, being a fish out of water allowed me to see my own culture with a fresh set of eyes – after all, it is hard to see the water when you are the fish. Much of what was shared by participants was reflected in my own thoughts and experiences coming back to Singapore, while others have influenced the way I understand my clients.

I have gained new perspectives; I now find myself more aligned with a decolonial agenda and holding some postmodern beliefs – these were things I picked up in the UK (even if some seeds had already been there). But in return, I have been forced to ask myself if I would, ironically, become a proxy for continued Westernization if I brought some of these discourses back to Singapore. This was an important consideration for this study, and continues to be something that I reflect on regularly. Because of my own experiences with a colonial mentality, I have sometimes been quite keen to challenge it in different areas. This paper has made me think more deeply about the changing nature of culture, and how to balance or hold a dialectical position of staying rooted to my culture, while also accepting change and not being afraid to learn from the West. To me, this is a position which holds greater hope for the future, compared to the impossible task of fully stopping modernization/Westernization.

References

- Akinyela, M. (2002). De-colonizing our lives: Divining a post-colonial therapy. *The International Journal of Narrative Therapy and Community Work*, 2, 32-43.
- Alfonso, C. A., & Botbol, M. (2021). Editorial: Transcultural aspects and cultural adaptations of psychotherapeutic treatments in the Asia Pacific-Rim Region. *Asia-Pacific psychiatry*, 13(1), e12429. doi:10.1111/appy.12429
- Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using Zoom Videoconferencing for Qualitative Data Collection: Perceptions and Experiences of Researchers and Participants. *International Journal of Qualitative Methods*, 18, 1-8. doi:10.1177/1609406919874596
- Arnold, W., & Cartwright, H. A. (Eds.). (1908). *Twentieth century impressions of British Malaya: its history, people, commerce, industries, and resources*. London: Lloyd's Greater Britain Publishing Company. Retrieved from <http://reader.library.cornell.edu/docviewer/digital?id=sea:233#page/43/mode/1up>
- BBC News. (1998, February 12). Indonesia: Why ethnic Chinese are afraid. *BBC News*. Retrieved May 5, 2022, from <http://news.bbc.co.uk/1/hi/world/analysis/51981.stm>
- Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: a direct-comparison meta-analysis. *Journal of Counseling Psychology*, 58(3), 279-289. doi:10.1037/a0023626
- Bernal, G., & Sáez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology*, 34(2), 121-132. doi:10.1002/jcop.20096
- Bhambra, G. K., Nişancioğlu, K., & Gebrial, D. (Eds.). (2018). *Decolonising the University*. Pluto Press.

- Biedermann, N. (2018). The use of Facebook for virtual asynchronous focus groups in qualitative research. *Social Media, Technology and Communication*, 54(1), 26-34.
doi:10.1080/10376178.2017.1386072
- Blackmore, J. (2010). 'The Other Within': race/gender disruptions to the professional learning of white educational leaders. *Theory and Practice*, 13(1), 45-61.
doi:10.1080/13603120903242931
- Bloch, S., Sharpe, M., & Allman, P. (1991). Systemic Family Therapy in Adult Psychiatry a Review of 50 Families. *British Journal of Psychiatry*, 159(3), 357-364. doi:10.1192/bjp.159.3.357
- Booth, A. (2004). Formulating answering questions. In A. Booth, & A. Brice (Eds.), *Evidence Based Practice for Information Professionals: A handbook* (pp. 61-70). London: Facet Publishing.
- Booth, A. (2006). Clear and present questions: formulating questions for evidence based practice. *Library Hi Tech*, 24(3), 355-368. doi:10.1108/07378830610692127
- Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology. Vol. 2, Research designs: Quantitative, qualitative, neuropsychological, and biological*. (pp. 57-71). American Psychological Association. doi:10.1037/13620-004
- Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*. London: Sage.
- Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 11(4), 589-597. doi:10.1080/2159676X.2019.1628806
- Braun, V., Clarke, V., & Weate, P. (2016). Using thematic analysis in sport and exercise research. In B. Smith, & A. C. Sparkes (Eds.), *Routledge handbook of qualitative research in* (pp. 191-205). London: Routledge.

- Breen, L. (2007). The researcher 'in the middle'?: Negotiating the insider/outsider dichotomy. *The Australian Community Psychologist*, 19(1), 163-174.
- Breen, R. L. (2006). A Practical Guide to Focus-Group Research. *Journal of Geography in Higher Education*, 30(3), 463-475. doi:10.1080/03098260600927575
- British Psychological Society. (2011, December). *Good Practice Guidelines on the use of psychological formulation*. Leicester: the British Psychological Society.
- Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design* (Vol. 34). Cambridge, Massachusetts: Harvard University Press. doi:10.1037/0003-066X.34.10.844
- Burgess, A., Butler, H., Havlin, H., Holding, S., Milroy, C., Trainee Clinical Psychologists, & Dixon, C. (2021, February 9). 'Decolonising the Curriculum: Promoting Cultural Humility': a trainee-developed tool. Retrieved from Lancaster University Web site:
<https://www.lancaster.ac.uk/health-and-medicine/dhr/dclinpsy/news/decolonising-the-curriculum-promoting-cultural-humility-a-trainee-developed-tool>
- Butler, E. A., Lee, T. L., & Gross, J. J. (2007). Emotion Regulation and Culture: Are the Social Consequences of Emotion Suppression Culture-Specific? *Emotion*, 7(1), 30-48.
doi:10.1037/1528-3542.7.1.30
- Cambridge University Press. (n.d.-a). Culture. In *Cambridge Online Dictionary*. Retrieved May 3, 2022, from <https://dictionary.cambridge.org/dictionary/english/culture>
- Cambridge University Press. (n.d.-b). *Indigenous*. Retrieved October 13, 2022, from Cambridge Online Dictionary: <https://dictionary.cambridge.org/dictionary/english/indigenous>
- Campbell, D., Coldicott, T., & Kinsella, K. (1994). *Systemic Work with Organizations : A New Model for Managers and Change Agents*. London: Karnac Books.

- Cao, S. S. (2020). Story variations: Resisting the cultural gaze. *The International Journal of Narrative Therapy and Community Work*, 46(1), 46-60.
- Carr, A., & McNulty, M. (Eds.). (2006). *The Handbook of Adult Clinical Psychology*. New York: Routledge.
- Caty. (2015, September 7). *On my therapist*. Retrieved May 21, 2022, from Everyday Victim Blaming: <http://everydayvictimblaming.com/personal-experiences/on-my-therapist/>
- Chen, S. W.-H., & Davenport, D. S. (2005). Cognitive-Behavioral Therapy With Chinese American Clients: Cautions and Modifications. *Psychotherapy: Theory, Research, Practice, Training*, 42(1), 101–110. doi:10.1037/0033-3204.42.1.101
- Chenail, R. J., Reiter, M. D., Torres-Gregory, M., & Ilic, D. (2020). Postmodern Family Therapy. In K. Wampler, R. Miller, & R. Seedall (Eds.), *The Handbook of Systemic Family Therapy* (pp. 417-442). John Wiley & Sons Ltd. doi:10.1002/9781119438519.ch18
- Chong, S. A., Abin, E., Vaingankar, J. A., Kwok, K. W., & Subramaniam, M. (2012). Where do people with mental disorders in Singapore go to for help? *Annals of the Academy of Medicine, Singapore*, 41(4), 154-160.
- Chowdhary, N., Jotheeswaran, A. T., Nadkarni, A., Hollon, S. D., King, M., Jordans, M. J., . . . Patel, V. (2014). The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: a systematic review. *Psychological Medicine*, 44(6), 1131-1146. doi:10.1017/S0033291713001785
- Clammer, J. (1981). Malay Society in Singapore: A Preliminary Analysis. *Southeast Asian Journal of Social Science*, 9(1/2), 19-32. Retrieved from <https://www.jstor.org/stable/24490837>
- Clarke, V., & Braun, V. (2016). Thematic analysis. *The Journal of Positive Psychology*, 12(3), 1-2. doi:10.1080/17439760.2016.1262613

- Collins, P. H. (1990). Toward an Afrocentric Feminist Epistemology. In *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. London: Routledge.
- Colucci, E. (2008). "Focus Groups Can Be Fun": The Use of Activity-Oriented Questions in Focus Group Discussions. *Qualitative Health Research*, 17(10), 1422-33.
doi:10.1177/1049732307308129
- Constantine, M. G., & Sue, D. W. (2006). Factors Contributing to Optimal Human Functioning in People of Color in the United States. *The Counseling Psychologist*, 34(2), 228-244.
doi:10.1177/0011000005281318
- Cummings, J. R., Case, B. G., Ji, X., Chae, D. H., & Druss, B. G. (2014). Racial/Ethnic Differences in Perceived Reasons for Mental Health Treatment in US Adolescents With Major Depression. *Journal of the American Academy of Child & Adolescent Psychiatry*, 53(9), 980-990.
doi:10.1016/j.jaac.2014.05.016
- Danso, R. (2018). Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts. *Journal of Social Work*, 18(4), 410-430. doi:10.1177/1468017316654341
- Dattilio, F. M., & Nichols, M. P. (2011). Reuniting Estranged Family Members: A Cognitive-Behavioural-Systemic Perspective. *The American Journal of Family Therapy*, 39(2), 88-99.
doi:10.1080/01926187.2010.530169
- David, D., Cristea, I. A., & Hofmann, S. G. (2018). Why Cognitive Behavioral Therapy Is the Current Gold Standard of Psychotherapy. *Frontiers in Psychiatry*, 9(4). doi:10.3389/fpsy.2018.00004
- David, E., & Okazaki, S. (2010). Activation and Automaticity of Colonial Mentality. *Journal of Applied Social Psychology*, 40(4), 850-887. doi:10.1111/j.1559-1816.2010.00601.x
- Davis, E., Greenberger, E., Charles, S., Chen, C., Zhao, L., & Dong, Q. (2012). Emotion experience and regulation in China and the United States: How do culture and gender shape emotion

responding? *International Journal of Psychology*, 47(3), 230-239.

doi:10.1080/00207594.2011.626043

Davis, V. (2017). My Meeting Place: Rearing ourselves with cultural knowledge, spirituality, and community connectedness. *The international journal of narrative therapy and community work*, 3, 5-16.

Dawson, D. L., & Moghaddam, N. G. (2015). *Formulation In Action: Applying Psychological Theory to Clinical Practice*. Warsaw/Berlin: De Gruyter Open Ltd.

Department of Psychology. (n.d.). *Master of Psychology (Clinical): FAQs*. Retrieved August 10, 2022, from National University of Singapore Web site: <https://fass.nus.edu.sg/psy/master-of-psychology-clinical/>

Drmic, I. E., Aljunied, M., & Reavan, J. (2017). Feasibility, Acceptability and Preliminary Treatment Outcomes in a School-Based CBT Intervention Program for Adolescents with ASD and Anxiety in Singapore. *Journal of Autism and Developmental Disorders*, 47, 3909–3929.
doi:10.1007/s10803-016-3007-y

Dwyer, S. C., & Buckle, J. L. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods*, 8(1), 54-63.
doi:10.1177/160940690900800105

eChineseLearning. (2015, August 12). *Kong Rong Gave Away Bigger Pears*. Retrieved May 6, 2022, from eChineseLearning: <https://www.echineselearning.com/blog/kong-rong-rang-li-kong-rong-gave-away-bigger-pears-2>

Epstein, N., & Baucom, D. H. (1989). Cognitive-Behavioral Marital Therapy. In A. Freeman, K. M. Simon, L. E. Beutler, & H. Arkowitz (Eds.), *Comprehensive Handbook of Cognitive Therapy* (pp. 491-513). New York: Springer. doi:10.1007/978-1-4757-9779-4_25

- Eyal, J. (2015, March 27). Remembering Lee Kuan Yew: Mr Lee Kuan Yew had close ties with Britain, but was never a 'colonial nostalgic'. *The Straits Times*. Retrieved from <https://www.straitstimes.com/singapore/mr-lee-kuan-yew-had-close-ties-with-britain-but-was-never-a-colonial-nostalgic>
- Falter, M. M., Arenas, A. A., Maples, G. W., Smith, C. T., Lamb, L. J., Anderson, M. G., . . . Wafa, N. Z. (2022). Making Room for Zoom in Focus Group Methods: Opportunities and Challenges for Novice Researchers (During and Beyond COVID-19). *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 23(1). doi:doi.org/10.17169/fqs-23.1.3768
- Field, C., & Caetano, R. (2010). The role of ethnic matching between patient and provider on the effectiveness of brief alcohol interventions with Hispanics. *Alcoholism, clinical and experimental research*, 34(2), 262–271. doi:10.1111/j.1530-0277.2009.01089.x
- Foo, K. H., & Merrick, P. L. (2004). Practitioner Characteristics with comparisons of counselling and psychotherapy practices between New Zealand and Singapore Mental Health Practitioners. In S. Tse, A. Thapliyal, S. Garg, G. Lim, & M. Chatterji (Ed.), *Proceedings of the Inaugural International Asian Health Conference* (pp. 223-239). New Zealand: The University of Auckland, School of Population Health.
- Foo, K. H., Merrick, P. L., & Kazantzis, N. (2006). Counseling/Psychotherapy with Chinese Singaporean clients. *Asian Journal of Counselling*, 13(2), 271-293.
- Frank, J. D. (1982). Therapeutic components shared by all psychotherapies. In J. H. Harvey, & M. M. Parks (Eds.), *Psychotherapy research and behavior change* (pp. 9-37). American Psychological Association. doi:10.1037/10083-001
- Freire, P. (1970). *Pedagogy of the Oppressed*. New York: Herder & Herder.
- Fricker, M. (2007). *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford: Oxford University Press.

Gao, Z., & Wang, B. (2014). Chinese Psychology. In *Encyclopedia of Critical Psychology* (pp. 221-227).

New York, New York: Springer. doi:10.1007/978-1-4614-5583-7_40

Garneau, A. B., & Pepin, J. (2015). Cultural Competence: A Constructivist Definition. *Journal of*

Transcultural Nursing, 26(1), 9-15. doi:10.1177/1043659614541294

Geerlings, L. R., 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. doi:10.1017/jtp.2014.4

Geerlings, L. R., Thompson, C. L., & Tan, G. (2017). Culturally Competent Practice: Experiences of

Students, Academics, and Alumni of Clinical Psychology Degrees in Singapore. *Journal of*

Tropical Psychology, 7(e3), 1-10. doi:10.1017/jtp.2017.3

Gergen, K. (2009). *Relational being: Beyond self and community*. New York, NY: Oxford University

Press.

Gergen, K. J. (1985). The Social Constructionist Movement in Modern Psychology. *American*

Psychologist, 40(3), 266-275. doi:10.1037/0003-066X.40.3.266

Gergen, K. J. (2001). Psychological science in a postmodern context. *American Psychologist*, 56(10),

803-813. doi:10.1037/0003-066X.56.10.803

Gergen, K. J. (2009). *Relational being: Beyond self and community*. New York, NY: Oxford University

Press.

Greene-Moton, E., & Minkler, M. (2019). Cultural Competence or Cultural Humility? Moving Beyond

the Debate. *Health Promotion Practice*, 21(1), 142-145. doi:10.1177/1524839919884912

Guest, G., Namey, E., & McKenna, K. (2016). How Many Focus Groups Are Enough? Building an

Evidence Base for Nonprobability Sample Sizes. *Field Methods*, 29(1), 1-20.

doi:10.1177/1525822X16639015

- Hall, G. C., Hong, J. J., Zane, N. W., & Oanh, M. L. (2011). Culturally Competent Treatments for Asian Americans: The Relevance of Mindfulness and Acceptance-Based Psychotherapies. *Clinical Psychology: Science and Practice*, 18(3), 215-231. doi:10.1111/j.1468-2850.2011.01253.x
- Han, C. (2014). The 'Myth' of Singaporeanness: Values and Identity in Citizenship Education. In K. S. Loh, P. T. Thum, & J. M.-T. Chia (Eds.), *Living with Myths in Singapore* (pp. 41-51). Singapore: Ethos books.
- Harding, S. (2004). Introduction: Standpoint Theory as a Site of Political, Philosophic, and Scientific Debate. In *The Feminist Standpoint Theory Reader: Intellectual & Political Controversies* (pp. 1-15). New York: Routledge.
- Harding, S. G. (1994). Is Science Multicultural?: Challenges, Resources, Opportunities, Uncertainties. *Configurations*, 2(2), 301-330. doi:10.1353/con.1994.0019
- Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and Brain Sciences*, 33(2-3), 61-83. doi:10.1017/S0140525X0999152X
- Henwood, K. L., & Pidgeon, N. F. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology*, 83(1), 97-111. doi:10.1111/j.2044-8295.1992.tb02426.x
- Hirschman, C. (1987). The Meaning and Measurement of Ethnicity in Malaysia: An Analysis of Census Classifications. *The Journal of Asian Studies*, 46(3), 555-582. doi:10.2307/2056899
- HistorySG. (2014a). *Shared Values are Adopted*. Retrieved May 06, 2022, from HistorySG: <https://eresources.nlb.gov.sg/history/events/62f98f76-d54d-415d-93a1-4561c776ab97>
- HistorySG. (2014b). *Singapore separates from Malaysia and becomes independent*. Retrieved May 05, 2020, from HistorySG: <https://eresources.nlb.gov.sg/history/events/dc1efe7a-8159-40b2-9244-cdb078755013>

- Hong, Q. N., Pluye, P., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., . . . Vedel, I. (2018). Mixed Methods Appraisal Tool (MMAT), version 2018. Registration of Copyright (#1148552), Canadian Intellectual Property Office, Industry Canada. Retrieved May 14, 2022, from http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/attach/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf
- Huang, C. Y., & Zane, N. (2016). Cultural influences in mental health treatment. *Current Opinion in Psychology, 8*, 131-136. doi:10.1016/j.copsyc.2015.10.009
- Hussain, B., Sheikh, A., Timmons, S., Stickley, T., & Repper, J. (2020). Workforce diversity, diversity training and ethnic minorities: The case of the UK National Health Service. *International Journal of Cross Cultural Management, 20*(2), 201–221. doi:10.1177/1470595820938412
- Jagers, R. J., & Mock, L. O. (1995). The Communalism Scale and Collectivistic-Individualistic Tendencies: Some Preliminary Findings. *Journal of Black Psychology, 21*(2), 153-167. doi:10.1177/00957984950212004
- Jennings, L., D'Rozario, V., Goh, M., Sovereign, A., Brogger, M., & Skovholt, T. (2008). Psychotherapy expertise in Singapore: A qualitative investigation. *Psychotherapy Research, 18*(5), 508-522. doi:10.1080/10503300802189782
- Johnstone, L., & Dallos, R. (Eds.). (2014). *Formulation in Psychology and Psychotherapy* (2nd ed.). New York: Routledge.
- Kathiravelu, L. (2017). Rethinking Race: Beyond the CMIO Categorisations. In K. Loh, P. Thum, & J. M.-T. Chia (Eds.), *Living with Myths in Singapore* (pp. 159-168). Singapore: Ethos Books.
- Kitzinger, J. (1994). The methodology of Focus Groups: the importance of interaction between research participants. *Sociology of Health & Illness, 16*(1), 103-121. doi:10.1111/1467-9566.ep11347023

- Koh, Y. L. (2017, August 08). Singaporean dishes are a melting pot of influences. *Today Online*. Retrieved May 05, 2022, from <https://www.todayonline.com/lifestyle/food/singaporean-dishes-are-melting-pot-influences>
- Krueger, R. A. (2002, October). *Designing and Conducting Focus Group Interviews*. Retrieved February 15, 2021, from <https://www.eiu.edu/ihec/Krueger-FocusGroupInterviews.pdf>
- Kua, E. H., Chew, P. H., & Ko, S. M. (1993). Spirit possession and healing among Chinese psychiatric patients. *Acta Psychiatrica Scandinavica*, 88(6), 447-450. doi:10.1111/j.1600-0447.1993.tb03489.x
- La Roche, M. J., Fuentes, M. A., & Hinton, D. (2015). A Cultural Examination of the DSM-5: Research and Clinical Implications for Cultural Minorities. *Professional Psychology: Research and Practice*, 46(3), 183-189. doi:10.1037/a0039278
- Lai, A. E. (2017). Maze and Minefield: Reflections on Multiculturalism in Singapore. In K. S. Loh, P. T. Thum, & J. M.-T. Chia (Eds.), *Living with Myths in Singapore* (pp. 169-179). Singapore: Ethos Books.
- Lambert, M. J., & Barley, D. E. (2001). Research Summary of the Therapeutic Relationship and Psychotherapy Outcome. *Psychotherapy Theory Research & Practice*, 38(4), 357-361. doi:10.1037/0033-3204.38.4.357
- Lange, G., Davison, J., & Goh, D. A. (2015). Introduction: Clinical Psychology in Singapore. In G. Lange, & J. Davison (Eds.), *Clinical Psychology in Singapore: An Asian Casebook* (pp. xiii-xxiv). Singapore: NUS Press.
- Laungani, P. (2004). Counselling and therapy in a multi-cultural setting. *Counselling Psychology Quarterly*, 17(2), 195-207. doi:10.1080/09515070410001728262
- Lee, B. O. (2002a). Chinese indigenous psychotherapies in Singapore. *Counselling and Psychotherapy Research*, 2(1), 2-10. doi:10.1080/14733140212331384938

- Lee, B. O. (2002b). Psychotherapy in Chinese Medicine: A theoretical review. In A.-G. Tan, & M. Goh (Eds.), *Psychology in Singapore: Issues of an emerging discipline* (pp. 124-146). Singapore: McGraw-Hill.
- Lee, B. O. (2002b). Psychotherapy in Chinese Medicine: A theoretical review. In A.-G. Tan, & M. Goh (Eds.), *Psychology in Singapore: Issues of an emerging discipline* (pp. 124-146). Singapore: McGraw-Hill.
- Lee, B. O. (2018). Indigenous psychologies and approaches to wellbeing in East Asia. In S. Fernando, & R. Moodley (Eds.), *Global Psychologies* (pp. 263-277). London: Palgrave Macmillan.
doi:10.1057/978-1-349-95816-0_16
- Lee, B. O., & Bishop, G. D. (2001). Chinese clients' belief systems about psychological problems in Singapore. *Counselling Psychology Quarterly*, 14(3), 219-240.
doi:10.1080/09515070110088834
- Lee, B. O., & Foo, K. H. (2019). Psychology of culture: The case of Singapore. In W. W. Li, D. Hodgetts, & K. H. Foo (Eds.), *Asia-Pacific Perspectives on Intercultural Psychology* (pp. 75-98). New York: Routledge.
- Lee, B. O., & Foo, K. H. (2019). Psychology of culture: The case of Singapore. In W. Li, D. Hodgetts, & K. H. Foo, *Asia-Pacific Perspectives on Intercultural Psychology* (pp. 75-98). New York: Routledge.
- Lee, B. O., & Kirmayer, L. J. (2020). Dang-Ki healing: An embodied relational healing practice in Singapore. *Transcultural Psychiatry*, 57(6), 786-800. doi:10.1177/1363461519858448
- Lee, J. J., & Lee, K. P. (2009). Facilitating Dynamics of Focus Group Interviews in East Asia: Evidence and Tools by Cross-Cultural Study. *International Journal of Design*, 3(1), 17-28.
- Lee, J. W., Jones, P. S., Mineyama, Y., & Zhang, X. E. (2002). Cultural differences in responses to a Likert scale. *Research in nursing & health*, 25(4), 295-306. doi:10.1002/nur.10041

Lee, K. Y. (1979, March 10). *Prime Minister Lee Kuan Yew's Reply to the Report of Education Study*

Team. Retrieved May 06, 2022, from National Archives of Singapore:

<https://www.nas.gov.sg/archivesonline/data/pdfdoc/lky19790310b.pdf>

Lekas, H.-M., Pahl, K., & Lewis, C. F. (2020). Rethinking Cultural Competence: Shifting to Cultural

Humility. *Health Services Insights*, 13, 1-4. doi:10.1177/1178632920970580

Lepoer, B. L. (Ed.). (1989). *Singapore: A Country Study*. Washington: GPO for the Library of Congress.

Retrieved from <http://countrystudies.us/singapore/>

Lincoln, Y. S. (2010). "What a Long, Strange Trip It's Been...": Twenty-Five Years of Qualitative and

New Paradigm Research. *Qualitative Inquiry*, 16(1), 3-9. doi:10.1177/1077800409349754

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.

Llewelyn, S., & Shimoyama, H. (2012). Working with CBT across Cultures in Clinical Psychology with

Particular Reference to Japanese Clinical Psychology, Part Three - Adapting CBT for Japanese Culture. *Japanese Journal of Clinical Psychology*, 12(4), 580-589.

Loh, C., Liang, W., Lee, H., & Koh, A. (2021). Development of Multi-Family Therapy for First Episode

Psychosis in Singapore. *Frontiers in Psychiatry*, 12. doi:10.3389/fpsyt.2021.788827

Lu, S. H., Assudani, H. A., Kwek, T. R., Ng, S. W., Teoh, T. E., & Tan, G. C. (2021). A Randomised

Controlled Trial of Clinician-Guided Internet-Based Cognitive Behavioural Therapy for Depressed Patients in Singapore. *Frontiers in Psychology*, 12.

doi:10.3389/fpsyg.2021.668384

Lyddon, W. J. (1995). Cognitive Therapy and Theories of Knowing: A Social Constructionist View.

Journal of Counseling & Development, 73(6), 579-585. doi:10.1002/j.1556-

6676.1995.tb01799.x

- Ma, G., Wang, M., & Wang, W. (2019). Societal Culture from Late Imperial to Contemporary China: As Indirectly Reflected in A Dream of Red Mansions. In W. Wang (Ed.), *Chinese Perspectives on Cultural Psychiatry* (pp. 21-39). Springer.
- Mathews, M. (2007). An Investigation of Singaporean Clergy Treatment Models for Mental Problems. *Journal of Religion and Health, 46*, 558-570. doi:10.1007/s10943-007-9113-6
- Michelle K. (2013). To my Eighteen-Year-Old Self, on your Departure for Cambridge. In A. Lockward, & W. Mignolo (Eds.), *BE.BOP 2013: Decolonizing the 'Cold' War* (pp. 24-32). Retrieved May 19, 2022, from <https://decolonizingthecoldwar.files.wordpress.com/2013/03/bebop-2013-catalogue-online.pdf>
- Minuchin, P. (1985). Families and Individual Development: Provocations from the Field of Family Therapy. *Child Development, 56*(2), 289-302. doi:10.2307/1129720
- Moon, K., & Blackman, D. (2014). A Guide to Understanding Social Science Research for Natural Scientists. *Conservation Biology, 28*(5), 1167-77. doi:10.1111/cobi.12326
- Naeem, F., Gobbi, M., Ayub, M., & Kingdon, D. (2009). University students' views about compatibility of cognitive behaviour therapy (CBT) with their personal, social and religious values (a study from Pakistan). *Mental Health, Religion & Culture, 12*(8), 847-855. doi:10.1080/13674670903115226
- Naeem, F., Gobbi, M., Ayub, M., & Kingdon, D. (2010). Psychologists experience of cognitive behaviour therapy in a developing country: a qualitative study from Pakistan. *International Journal of Mental Health Systems, 4*(2). doi:10.1186/1752-4458-4-2
- Naeem, F., Latif, M., Mukhtar, F., Kim, Y.-R., Li, W., Butt, M. G., . . . Ng, R. (2021). Transcultural adaptation of cognitive behavioral therapy (CBT) in Asia. *Asia-Pacific Psychiatry, 13*(1). doi:10.1111/appy.12442

National Archives Singapore. (2018, February 28). *Blast From the Past*. Retrieved May 21, 2022, from

National Archives Singapore:

<https://www.nas.gov.sg/archivesonline/blastfromthepast/kampungspirit>

Neuberg, S. L., & Schaller, M. (2015). Evolutionary Social Cognition. In M. Mikulincer, & P. R. Shaver

(Eds.), *APA Handbook of Personality and Social Psychology* (Vol. 1. Attitudes and Social

Cognition, pp. 3-45). American Psychological Association. doi:10.1037/14341.001

New World Encyclopedia contributors. (2019, January 08). *Overseas Chinese*. Retrieved May 05,

2022, from New World Encyclopedia:

https://www.newworldencyclopedia.org/p/index.php?title=Overseas_Chinese&oldid=10170

23

Ng, B. Y. (1998). Wei han zheng (frigophobia): a culture-related psychiatric syndrome. *The Australian*

& New Zealand Journal of Psychiatry, 32(4), 582-585. doi:10.3109/00048679809068335

Ngũgĩ, w. T. (1986). *Decolonizing the Mind: The Politics of Language in African Literature*. Heinemann

Educational Books.

Norcross, J. C. (2001). Psychotherapy Integration. *International Encyclopedia of the Social &*

Behavioral Sciences, 12491-12494. doi:10.1016/B0-08-043076-7/01322-X.

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions

and clinical practices. *Psychotherapy*, 48(1), 98-102. doi:10.1037/a0022161

Nuyen, A. T. (2001). Confucianism and the Idea of Equality. *Asian Philosophy*, 11(2), 61-71.

doi:10.1080/09552360120087840

Ooi, Y. P., Ang, R., Fung, D., Wong, G., & Cai, Y. (2007). Effects of CBT on children with disruptive

behaviour disorders: findings from a Singapore study. *ASEAN Journal of Psychiatry*, 8(2), 71-

81.

- Ow, R. (1998). Mental Health Care: The Singapore Context. *Asia Pacific Journal of Social Work and Development, 8*(1), 120-130. doi:10.1080/21650993.1998.9755783
- Padesky, C. A., & Mooney, K. A. (2012). Strengths-Based Cognitive-Behavioural Therapy: A Four-Step Model to Build Resilience. *Clinical Psychology and Psychotherapy, 19*(4), 283-290. doi:10.1002/cpp.179
- Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., . . . Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *Systematic Reviews, 10*(89). doi:10.1186/s13643-021-01626-4
- Parker, G., Chen, H., Kua, J. H., Loh, J., & Jorm, A. F. (2000). A Comparative Mental Health Literacy Survey of Psychiatrists and Other Mental Health Professionals in Singapore. *Australian and New Zealand Journal of Psychiatry, 34*(4), 627-636. doi:10.1080/j.1440-1614.2000.00739.x
- Parker, G., Mahendran, R., Yeo, S. G., Loh, M. I., & Jorm, A. F. (1999). Diagnosis and treatment of mental disorders: a survey of Singapore mental health professionals. *Social Psychiatry and Psychiatric Epidemiology, 34*(10), 555-563. doi:10.1007/s001270050175
- Picco, L., Subramaniam, M., Abdin, E., Vaingankar, J. A., Zhang, Y., & Chong, S. A. (2013). Roles of Religious and Spiritual Advisors Among Adults in Singapore With Mental Illnesses. *Psychiatric Services, 64*(11), 1150-1156. doi:10.1176/appi.ps.201200533
- Poston, D. L., & Yu, M.-Y. (1990). The Distribution of the Overseas Chinese in the Contemporary World. *The International Migration Review, 24*(3), 480-508. doi:10.2307/2546370
- Rahman, N. A. (2014, January 01). *Kampung Living: A-Z*. Retrieved June 02, 2022, from biblioasia: National Library, Singapore: <https://biblioasia.nlb.gov.sg/vol-9/issue-4/jan-march-2014/kampung-living-singapore>

- Raskin, J. D. (2002). Constructivism in Psychology: Personal Construct Psychology, Radical Constructivism, and Social Constructionism. *American Communication Journal*, 5(3), 1-26. doi:10.1080/10720537.2014.850367
- Remember Singapore. (2012, April 4). *From Villages to Flats (Part 1) – The Kampong Days*. Retrieved June 2, 2022, from Remember Singapore: <https://remembersingapore.org/2012/04/04/from-villages-to-flats-part-1/>
- Rošker, J. (2021). Epistemology in Chinese Philosophy. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Spring 2021 Edition ed.). Metaphysics Research Lab, Stanford University. Retrieved May 05, 2022, from <https://plato.stanford.edu/archives/spr2021/entries/chinese-epistemology/>
- Russell, G. (2020). Reflecting on a Way of Being: Anchor Principles of Cultural Competence. In J. Frawley, G. Russell, & J. Sherwood (Eds.), *Cultural Competence and the Higher Education Sector* (pp. 31-42). Singapore: Springer. doi:10.1007/978-981-15-5362-2_3
- Sa'at, A., Joraimi, F., & Sai, S. M. (Eds.). (2021). *Raffles Renounced: Towards a Merdeka History*. Singapore: Ethos Books.
- Saltz, A. (2021, November 11). *How CBT Harmed Me: The Interview That the New York Times Erased*. Retrieved May 21, 2022, from Disability Visibility Project: <https://disabilityvisibilityproject.com/2021/11/11/how-cbt-harmed-me-the-interview-that-the-new-york-times-erased/>
- Scheurich, J. J., & Young, M. D. (1997). Coloring Epistemologies: Are Our Research Epistemologies Racially Biased? *Educational Researcher*, 26(4), 4-16. doi:10.3102/0013189X026004004
- Scorzelli, J. F., & Reinke-Scorzelli, M. (1994). Cultural Sensitivity and Cognitive Therapy in India. *The Counseling Psychologist*, 22(4), 603-610. doi:10.1177/0011000094224006

- Segal, Z. V., Williams, J., & Teasdale, J. D. (2013). *Mindfulness-Based Cognitive Therapy for Depression* (2nd ed.). New York: The Guilford Press.
- Seligman, M. E., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *The American psychologist*, 61(8), 774-788. doi:10.1037/0003-066X.61.8.774
- Shah, R. (2012, March 08). *Nothing about us without us*. Retrieved July 19, 2022, from USAID Blog: <https://blog.usaid.gov/2012/03/nothing-about-us-without-us/>
- Shen, C., Jia, Y., & Wang, W. (2019). Bipolar Disorders in Chinese Culture: From a Perspective of Harmony. In W. Wang (Ed.), *Chinese Perspectives on Cultural Psychiatry* (pp. 145-165). Springer.
- Sim, T. (2010). The growing pains of family therapy in Singapore. *Journal of Family Therapy*, 34(2), 204-224. doi:10.1111/j.1467-6427.2010.00519.x
- Singapore Department of Statistics. (2021a, June 16). *Singapore Census of Population 2020, Statistical Release 1: Demographic Characteristics, Education, Language and Religion*. Retrieved May 06, 2022, from Singapore Department of Statistics: https://www.singstat.gov.sg/publications/reference/cop2020/cop2020-sr1/census20_stat_release1
- Singapore Department of Statistics. (2021b, November 19). *Singapore Residents By Age Group, Ethnic Group And Sex, End June*. Retrieved May 05, 2022, from Singapore Department of Statistics: <https://tablebuilder.singstat.gov.sg/table/TS/M810011>
- Singapore Land Authority. (2021, June 23). *Total Land Area of Singapore*. Retrieved May 03, 2022, from data.gov.sg: https://data.gov.sg/dataset/total-land-area-of-singapore?view_id=e6e37f25-01ef-4c23-a7cb-5682ab5edb75&resource_id=f4bbfac9-c3ed-4f71-9b9a-238517b214ef

Singapore Psychological Society. (n.d.). *SRP FAQs*. Retrieved August 10, 2022, from Singapore

Psychological Society Web site: <https://singaporepsychologicalsociety.org/srp-faqs/>

Smith, B. (2018, April 17). Indonesians Hate the Chinese, Because They Are Jewish. *Tablet*. Retrieved

from <https://www.tabletmag.com/sections/arts-letters/articles/indonesians-hate-the-chinese-because-they-are-jewish>

Smith, L. T. (1999). *Decolonizing Methodologies: Research and Indigenous Peoples*. London: Zed Books.

Stanton, M., & Welsh, R. (2012). Systemic Thinking in Couple and Family Psychology Research and Practice. *Couple and Family Psychology: Research and Practice, 1*(1), 14-30.

doi:10.1037/a0027461

Sternberg, R. J. (2002). Preface. In A.-G. Tan, & M. Goh (Eds.), *Psychology in Singapore: Issues of an Emerging Discipline* (pp. xi-xiii). Singapore: McGraw-Hill.

Strauss, A. Y., Huppert, J. D., Simpson, H. B., & Foa, E. B. (2018). What Matters More? Common or Specific Factors in Cognitive Behavioral Therapy for OCD: Therapeutic Alliance and Expectations as Predictors of Treatment Outcome. *Behaviour research and therapy, 105*(1), 43-51. doi:10.1016/j.brat.2018.03.007

Sulmasy, D. P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life.

The Gerontologist, 42(Special No 3), 24-33. doi:10.1093/geront/42.suppl_3.24

Teo, C., & Yong, S. (2020, August 7). *DClinPsy International Trainee Survey*. Retrieved August 7, 2022, from Facebook:

<https://www.facebook.com/groups/intdclintrainees/permalink/353253412335389>

Tervalon, M., & Murray-García, J. (1998). Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117-125. doi:10.1353/hpu.2010.0233

- Tham, S. C. (1993). *Defining "Malay"*. Singapore: Dept. of Malay Studies, National University of Singapore.
- The Economist. (2005, August 25). Failing to spread the wealth. *The Economist*. Retrieved May 5, 2022, from <https://www.economist.com/asia/2005/08/25/failing-to-spread-the-wealth>
- Thomas, E. (1990). Filial Piety, Social Change and Singapore Youth. *Journal of Moral Education*, 19(3), 192-205. doi:10.1080/0305724900190305
- Tomkins, L., & Eatough, V. (2010). Reflecting on the Use of IPA with Focus Groups: Pitfalls and Potentials. *Qualitative Research in Psychology*, 7(3), 244-262.
doi:10.1080/14780880903121491
- Tonsing, K. N. (2018). A review of mental health literacy in Singapore. *Social Work in Health Care*, 57(1), 27-47. doi:10.1080/00981389.2017.1383335
- Torres, L. (2010). Predicting levels of Latino depression: acculturation, acculturative stress, and coping. *Cultural diversity & ethnic minority psychology*, 16(2), 256-263.
doi:10.1037/a0017357
- Tracy, S. J. (2010). Qualitative Quality: Eight "Big-Tent" Criteria for Excellent Qualitative Research. *Qualitative Inquiry*, 16(10), 837-851. doi:10.1177/1077800410383121
- Turnbull, C. M. (2009). *A History of Modern Singapore, 1819-2005*. Singapore: NUS Press.
- von Glasersfeld, E. (1984). An introduction to radical constructivism. In *The invented reality* (pp. 17-40). New York: Norton.
- Wachtel, P. L. (2018). Pathways to Progress for Integrative Psychotherapy: Perspectives on Practice and Research. *Journal of Psychotherapy Integration*, 28(2), 202-212. doi:10.1037/int0000089
- Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, 14(3), 270-277. doi:10.1002/wps.20238

- Weaver, A. J. (1995). Has there been a failure to prepare and support parish-based clergy in their role as frontline community mental health workers: a review. *Journal of pastoral care, 49*(2), 129-147. doi:10.1177/002234099504900203
- Wei, M., Liao, K. Y.-H., Chao, R. C.-L., Mallinckrodt, B., Tsai, P.-C., & Botello-Zamarron, R. (2010). Minority stress, perceived bicultural competence, and depressive symptoms among ethnic minority college students. *Journal of Counseling Psychology, 57*(4), 411-422. doi:10.1037/a0020790
- Wellings, K., Branigan, P., & Mitchell, K. (2000). Discomfort, discord and discontinuity as data: Using focus groups to research sensitive topics. *Culture, Health & Sexuality, 2*(3), 255-267. doi:10.1080/136910500422241
- White, M. (1995). *Re-authoring lives: Interviews and essays*. Adelaide: Dulwich Centre Publications.
- Wilkinson, S. (1998). Focus group methodology: a review. *Journal of Social Research Methodology, 1*(3), 181-203. doi:10.1080/13645579.1998.10846874
- Wongsurawat, W. (2016). Beyond Jews of the Orient: A New Interpretation of the Problematic Relationship between the Thai State and Its Ethnic Chinese Community. *Positions, 24*(2), 555-582. doi:10.1215/10679847-3458721
- Yang, X., Zhang, P., Zhao, J., Zhao, J., Wang, J., Chen, Y., . . . Zhang, X. (2016). Confucian Culture Still Matters: The Benefits of Zhongyong Thinking (Doctrine of the Mean) for Mental Health. *Journal of Cross-Cultural Psychology, 47*(8), 1097-1113. doi:10.1177/0022022116658260
- Yeo, A. (1993). *Counselling: A Problem-solving Approach*. Singapore: Armour Publishing.
- Yeo, A. (2002). Pastoral Care and Counselling: An Asian Perspective. *American Journal of Pastoral Counseling, 5*(3-4), 175-189. doi:10.1300/J062v05n03_01

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford Press.

Zarbo, C., Tasca, G. A., Cattafi, F., & Compare, A. (2016). Integrative Psychotherapy Works. *Frontiers in Psychology*, 6, 1-3. doi:10.3389/fpsyg.2015.02021

Appendix A

Search Strings Used for the Systematic Literature Review

Database	Search String
Medline	TI ((Singapore*) AND (decolon* OR local* OR indigen* OR cultur* OR adapt* OR race* OR racial* OR ethn* OR minori* OR religio* OR spirit*) AND (psycholog* OR "mental health" OR psychotherap* OR counsel* OR well?being OR psychiatr* OR therap*) AND (profession* OR worker* OR nurse* OR therapist* OR psychotherapist* OR psychiatrist* OR psychologist* OR practitioner* OR counselor* OR psychoanal*) AND (experience* OR view* OR belief* or philosophy or opinion*)) OR AB ((Singapore*) AND (decolon* OR local* OR indigen* OR cultur* OR adapt* OR race* OR racial* OR ethn* OR minori* OR religio* OR spirit*) AND (psycholog* OR "mental health" OR psychotherap* OR counsel* OR well?being OR psychiatr* OR therap*) AND (profession* OR worker* OR nurse* OR therapist* OR psychotherapist* OR psychiatrist* OR psychologist* OR practitioner* OR counselor* OR psychoanal*) AND (experience* OR view* OR belief* or philosophy or opinion*))
PsycArticles	(Title: Singapore*) AND (Title: decolon* OR Title: local* OR Title: indigen* OR Title: cultur* OR Title: adapt* OR Title: race* OR Title: racial* OR Title: ethn* OR Title: minori* OR Title: religio* OR Title: spirit*) AND (Title: psycholog* OR Title: "mental health" OR Title: psychotherap* OR Title: counsel* OR Title: well?being OR Title: psychiatr* OR Title: therap*) AND (Title: profession* OR Title: worker* OR Title: nurse* OR Title: therapist* OR Title: psychotherapist* OR Title: psychiatrist* OR Title: psychologist* OR Title: practitioner* OR Title: counselor* OR Title: psychoanal*) AND (Title: experience* OR Title: view* OR Title: belief* OR Title: philosophy OR Title: opinion*) OR (Abstract: Singapore*) AND (Abstract: decolon* OR Abstract: local* OR Abstract: indigen* OR Abstract: cultur* OR Abstract: adapt* OR Abstract: race* OR Abstract: racial* OR Abstract: ethn* OR Abstract: minori* OR Abstract: religio* OR Abstract: spirit*) AND (Abstract: psycholog* OR Abstract: "mental health" OR Abstract: psychotherap* OR Abstract: counsel* OR Abstract: well?being OR Abstract: psychiatr* OR Abstract: therap*) AND (Abstract: profession* OR Abstract: worker* OR Abstract: nurse* OR Abstract: therapist* OR Abstract: psychotherapist* OR Abstract: psychiatrist* OR Abstract: psychologist* OR Abstract: practitioner* OR Abstract: counselor* OR Abstract: psychoanal*) AND (Abstract: experience* OR Abstract: view* OR Abstract: belief* OR Abstract: philosophy OR Abstract: opinion*)
PubMed	(Singapore*[Title/Abstract]) AND (decolon*[Title/Abstract] OR local*[Title/Abstract] OR indigen*[Title/Abstract] OR cultur*[Title/Abstract] OR adapt*[Title/Abstract] OR race*[Title/Abstract] OR racial*[Title/Abstract] OR ethn*[Title/Abstract] OR minori*[Title/Abstract] OR religio*[Title/Abstract] OR spirit*[Title/Abstract]) AND (psycholog*[Title/Abstract] OR "mental health"[Title/Abstract] OR psychotherap*[Title/Abstract] OR counsel*[Title/Abstract] OR well?being[Title/Abstract] OR psychiatr*[Title/Abstract] OR therap*[Title/Abstract]) AND (profession*[Title/Abstract] OR worker*[Title/Abstract] OR nurse*[Title/Abstract] OR therapist*[Title/Abstract] OR

Scopus

psychotherapist*[Title/Abstract] OR psychiatrist*[Title/Abstract] OR
 psychologist*[Title/Abstract] OR practitioner*[Title/Abstract] OR
 counselor*[Title/Abstract] OR psychoanal*[Title/Abstract]) AND
 (experience*[Title/Abstract] OR view*[Title/Abstract] OR
 belief*[Title/Abstract] OR philosophy[Title/Abstract] OR
 opinion*[Title/Abstract])
 (TITLE ((singapore*) AND (decolon* OR local* OR indigen* OR
 cultur* OR adapt* OR race* OR racial* OR ethn* OR minori* OR
 religio* OR spirit*) AND (psycholog* OR "mental health" OR
 psychotherap* OR counsel* OR well?being OR psychiatr* OR
 therap*) AND (profession* OR worker* OR nurse* OR therapist* OR
 psychotherapist* OR psychiatrist* OR psychologist* OR practitioner*
 OR counselor* OR psychoanal*) AND (experience* OR view* OR
 belief* OR philosophy OR opinion*)) OR ABS ((singapore*) AND
 (decolon* OR local* OR indigen* OR cultur* OR adapt* OR race*
 OR racial* OR ethn* OR minori* OR religio* OR spirit*) AND
 (psycholog* OR "mental health" OR psychotherap* OR counsel* OR
 well?being OR psychiatr* OR therap*) AND (profession* OR worker*
 OR nurse* OR therapist* OR psychotherapist* OR psychiatrist* OR
 psychologist* OR practitioner* OR counselor* OR psychoanal*) AND
 (experience* OR view* OR belief* OR philosophy OR opinion*)))

Appendix B

Summary of Research in the Systematic Literature Review

	Authors	Study Design	Participants / Professionals	Therapeutic Model	Cultural challenges, adaptations, and key findings	Strengths and Weaknesses
1	Foo & Merrick, 2004	Surveys and interviews were conducted among Singapore and New Zealand mental health professionals, examining their background, training, and practice; Results were compared between countries	<p>MHPs (counsellors, psychiatrists, psychologists, psychotherapists, and social workers) from Singapore and New Zealand</p> <ul style="list-style-type: none"> • 61 Singapore MHPs surveyed • 41 New Zealand MHPs surveyed • 12 MHPs from each country interviewed <p>Participants drawn from National registries and online directories</p>	<p>Western counselling and psychotherapy models, including:</p> <ul style="list-style-type: none"> • Behavioural management • Cognitive therapy • Cognitive-behavioural therapy • Marital therapy <p>And other practices:</p> <ul style="list-style-type: none"> • Discussions of religious issues • Acceptance of traditional healers 	<ul style="list-style-type: none"> • Western models of counselling and psychotherapy, with modifications for non-Caucasian clients, were deemed to be ≥ 50% relevant to their clientele by 67.1% of Singapore MHPs (compared to 69.8% in New Zealand) • Singapore MHPs found that counselling and psychotherapy practices were more acceptable with English-educated clients; Similarly New Zealand MHPs found that in Asians, their degree of acculturation of to mainstream New Zealand culture might affect their acceptance of therapy • 67.1% of Singapore MHPs (compared to 81.1% in New Zealand) consented to discuss religious issues “and then refer on” • The use of traditional healers was accepted by 65.8% of Singapore MHPs (compared to 66% in New Zealand); Singapore MHPs preferred traditional healing to be conducted outside, although Muslim practitioners frequently prayed with their clients in sessions; New Zealand MHPs sometimes allowed traditional healers 	<p>+ The research methodology allowed for a cross-cultural comparison of two multi-cultural countries</p> <p>+ A number of demographics were provided which allows readers to determine if sufficient diversity was included in the study</p> <p>± While there was some diversity in their participants, it was noted that Singapore participants were mostly Chinese, Christian, female, below 40 years old, and with less than 10 years of experience</p> <p>- There was no description of statistical analyses, and not all data was provided (e.g., no Likert scale data was presented)</p>

					<p>in the session for certain cultural groups</p> <ul style="list-style-type: none"> • Singapore MHPs usually offered less sessions than New Zealand MHPs (only 9.6% of Singapore MHPs reported an average of more than 11 sessions, compared to 34% in New Zealand) • Only Singapore practitioners reported seeing clients with financial problems (5.5%) and parenting issues (6.8%) • Chinese clients from both countries were noted for a culture-specific preference in therapy: fewer (6 or less), solution-focused, concrete, and structured sessions, with some talking little in sessions and disliking therapists delving into their background history • Interviews also revealed that indigenous models of therapy were available but were not fully developed: PADI (Yeo, 1993) for Singapore, and Just Therapy (Waldegrave et al., 2003) for New Zealand • 35.6% of Singapore MHPs were trained locally (compared to 58.5% in New Zealand); All were trained in Western models • 20.5% of Singapore MHPs (compared to 50.9% in New Zealand) based their therapy preference on empirical evidence and training; Others based their preference of personal preference (15.1%), Clients' preferences (19.2%), and a combination of all three (20.5%) 	
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					<p>Adaptations</p> <ul style="list-style-type: none"> • Using different languages in session • Applying cultural metaphors • Using more rapport-building sessions before therapy • Reframing concepts to fit client's cultural values and beliefs • Allowing traditional and alternative therapies to complement sessions • Working alongside traditional healers, • Discussing religious issues in therapy • Using appropriate self-disclosure to build rapport • Including client's family in session • (In New Zealand) Including interpreters and using cultural support groups and ethnic mental health services 	
2	Geerlings et al., 2017	Students, alumni, and academics from Clinical Psychology courses in Singapore were interviewed about their experiences about preparation for culturally competent practice in	5 students, 5 alumni, and 5 academics Students had at least 1 academic semester of graduate training and placement experience, while alumni and academics both had at least a few years of experience in practice within	No model specified, but Cognitive Behavioural Therapy (CBT) was a frequent example of a 'western' psychotherapy given by participants	<ul style="list-style-type: none"> • Clinical psychology was experienced as partly universal and partly western • Some aspects of clinical psychology were seen as culturally 'western' and less appropriate for local clients (theories, tools, therapeutic approaches, and psychotherapies) • Clinical psychologists often described cultural differences in an eastern-western and collectivist-individualist dichotomy • Participants felt that CBT was more suitable for western cultures than for Singapore, and did not meet 	<p>+ Inclusion of MHPs at various stages training and experience (academics, alumni, and students), as well as members of different ethnicities allowed a broader view of training from different perspectives</p> <p>- The views of different groups were not compared even though a table showed that there</p>

		Singapore	and outside of Singapore		<p>Singaporeans' expectations</p> <ul style="list-style-type: none"> • Clinical psychologists based their strategies mainly on professional and personal experiences instead of on their training experience • Both practitioner-client and trainee-academic/supervisor relationships were experienced as more hierarchical <p>Adaptations</p> <ul style="list-style-type: none"> • Using and creating more translated resources (e.g., test kits, psychoeducational materials) • An openness to diversity and adopting a cultural relativist stance which recognizes that the solutions provided by Western psychology may not always be the best • Developing an awareness of the clients', clinical psychology's, and one's own culture • Being able to hold and work with different explanatory models simultaneously, as clinical psychology models may sometimes be incompatible with clients' beliefs • Adjusting therapeutic approach, repackaging advice, altering standardized procedures for assessment and therapy, using Singlish (colloquial Singaporean English) – although these adaptations mostly depended on therapists' understanding 	<p>were differences</p> <ul style="list-style-type: none"> - Some demographics (e.g., the experience of participants, which courses participants were from) were not specified, which may impact the interpretation of their data - The inclusion of trainees who only had 1 academic semester worth of training may result in skewed/uninformed opinions about training
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					<p>of their clients' cultural needs</p> <ul style="list-style-type: none"> • Accepting greater power differences as a cultural norm or putting more effort into establishing more egalitarian relationships 	
3	Jennings, et al., 2008	<p>Master therapists were interviewed about their personal characteristics and therapy practices; Results were compared with a similar study done in America</p>	<p>9 master therapists were nominated by a group of 45 peers (including members from Singapore Counselling Association, Singapore Psychological Society, and field supervisors) – out of 127 nominations, only 9 had 3 or more votes</p> <ul style="list-style-type: none"> • 2 clinical psychologists • 1 counselling psychologist • 1 social worker <p>5 therapists with various levels of qualification</p>	<p>Therapists identified with a variety of theoretical orientations:</p> <ul style="list-style-type: none"> • 5 family systems therapists • 2 psychodynamic therapists • 2 existential-humanistic therapists <p>Several also incorporated other approaches like CBT, solution-focused, and Jungian</p>	<ul style="list-style-type: none"> • Expert therapists in Singapore were 'psychotherapy innovators' who integrated Eastern and Western philosophies in helping and healing • There was a high degree of correspondence in the themes generated by Singaporeans and Americans • 4 out of 16 themes identified by Singaporeans were unique (challenges to professional development, embraces working within a multicultural context, comfortable addressing spirituality, and self-doubt) • Greater attention should be paid to basic counselling skills (e.g., gentleness and tact, which might come more naturally to Western trainers) versus more specialized technical training • Western therapies were described as individualistic and based on western values (e.g., autonomy, assertiveness) and family structures • There was strong agreement regarding the need for more emphasis on clinical supervision, self-care and burnout prevention, the need for psychotherapy opportunities for therapists, and 	<p>+ Questions are included in Appendix and based on a previous study by Jennings and Skovholt (1999) in the US, allowing for cross-cultural comparisons and replication</p> <p>+ Representation from different therapeutic modalities could lead to more diverse views</p> <p>- 'Master' therapists were determined using only one criterion (nominated by peers), and so may suffer from biases inherent within the profession</p> <p>- 2 of the researchers were involved in the American research, which might influence their interpretation of results</p> <p>- The interview protocol followed the original American study, and thus</p>

					<p>continuing education in Singapore</p> <p>Adaptations</p> <ul style="list-style-type: none"> • Balancing between support and challenge • Adopting a flexible therapeutic stance, • Using empowerment/strength-based approaches • Understanding the primacy of the therapeutic alliance • Being comfortable with addressing spirituality, • Embracing working within a multicultural context • Understanding how religious beliefs shape clients' views and problems, as well as how they can be resources <p>Tapping into their own spirituality in their work (e.g., privately praying for clients)</p>	<p>did not allow from greater exploration of avenues like cultural differences</p> <ul style="list-style-type: none"> - Lack of diversity in some participant demographics (e.g., ethnicity, western education) might lead to biases in views - Criteria for excluding preliminary themes might have meant that some themes which were not picked up by the majority were not highlighted
4	B.O. Lee & Bishop, 2001	Therapists, clients, and non-clients were surveyed about the degree to which they agreed with various aetiology and treatment beliefs	56 therapists (social workers, counsellors, psychologists, and psychiatrists) and 149 clients from 21 organizations across various mental health settings; 136 non-clients from 6 community centres	<p>Three groups of models were examined:</p> <ul style="list-style-type: none"> • Indigenous (Chinese medicine, dang-ki, feng-shui) • Psychological (psychodynamic, behavioural, humanistic, and cognitive therapies) • Other (organic, 	<ul style="list-style-type: none"> • All groups had higher endorsement of psychological and other models than of indigenous models, for both aetiology and treatment beliefs • Compared to therapists, clients and non-clients had higher endorsement of indigenous models and other models for both indigenous aetiology and treatment beliefs • On average all groups endorsed Chinese medicine but disagreed with dang-ki and feng-shui aetiology and treatment beliefs, with therapists showing the strongest disagreement across sub- 	<p>+ Several potential confounding variables (e.g., age, gender, religion) were controlled for, allowing for more robust conclusions to be made</p> <p>+ Survey was translated to Chinese to include Chinese-speaking populations</p> <ul style="list-style-type: none"> - Lower educated or illiterate people from

				<p>socioeconomic, and naïve beliefs)</p>	<p>models</p> <ul style="list-style-type: none"> • Aetiology and treatment beliefs were correlated across all models, which was strongest in the indigenous models <p>Adaptations</p> <ul style="list-style-type: none"> • Clients’ beliefs about mental health should be considered in treatment, which should integrate both indigenous and Western approaches to make it more culturally appropriate • Treatment should incorporate an ecological approach alongside biological and psychological approaches to account for clients’ and non-clients’ endorsement or socioeconomic models in addition to organic and psychological models • Therapists (who were mostly Christian) should be aware that Buddhists and Taoists had higher endorsements of indigenous therapies (especially Chinese medicine) • Authors suggest teaching about mainstream religions such as Buddhism, Taoism, Hinduism, Christianity, and Islam as part of counselling training programmes in Singapore 	<p>lower socio-economic classes were under-represented in the study</p>
5	Loh et al., 2021	Clients and their families, as well as members of their MDTs who had participated	<p>17 clients and 25 MDT professionals</p> <p>MDT professions:</p> <ul style="list-style-type: none"> • 3 psychiatrists 	Multi-Family Therapy (MFT)	<ul style="list-style-type: none"> • MDT members suggested ways to help other MDT members understand more about MFT • MDT members shared that they had experienced difficulties recruiting for 	+ A description of the various activities and adaptations allows for the possibility of replicating similar groups in other

		<p>in the intervention, were surveyed about their experiences</p>	<ul style="list-style-type: none"> • 19 case managers • 2 occupational therapists • 1 psychologist 		<p>the MFT: (i) families' difficulties committing to all four sessions, (ii) families' discomfort with speaking in group settings, (iii) families perceiving client as the 'problem', (iv) difficulties explaining the benefits of MFT to families, (v) some team members not involved in recruitment due to lower contact with family and clients, and (vi) families declining due to language issues (less proficient in English)</p> <ul style="list-style-type: none"> • Asian families are more likely to expect professionals to take an active and expert role • No families in Singapore are the same given the cultural diversity of the city state <p>Adaptations</p> <ul style="list-style-type: none"> • Refining the structure and content of programmes • Attending to engagement and developing therapeutic relationships • Beginning sessions by focusing on more practical concerns and acknowledging the vulnerability that families might feel • Providing expert input and asked facilitating questions throughout, although using more questions to invite discussion in later sessions • Providing practical advice and avoid being too reflective and insight-oriented • Sharing positive feedback from families 	<p>services</p> <p>+ Feedback was also sought from participants of the intervention, allowing for a different perspective on further adaptations</p> <p>+ Feedback was sought from MDT colleagues who referred clients, enabling some insight into clients who turned down the groups as well</p> <p>- No control groups were used, so the effectiveness of the intervention could not be compared to other conditions</p> <p>- Study did not evaluate differences between client, carer, and sibling groups, which might have important implications</p>
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					<p>in previous groups</p> <ul style="list-style-type: none"> • Staying curious about every family's unique cultural background and checking their understanding with the families • Providing more psychoeducation to families about the relational impact of mental health issues • Delivering the MFT in other commonly spoken languages in Singapore 	
6	Ng, 1998	Case study of 45-year-old female suffering from a culture-related syndrome (Frigophobia – fear of cold temperature, the wind, and food of a cold/ <i>yin</i> nature)	Author is a male psychiatrist who was a senior registrar; Experience not stated	<p>Course of treatment included:</p> <ul style="list-style-type: none"> • Western medication • Cognitive and Behavioural strategies • Marital therapy <p>Outside of clinic: Traditional Chinese Medicine</p>	<ul style="list-style-type: none"> • Cultural and traditional view of health impacted on the patient's presentation • Traditional healers, as well as patient's friends, continued to suggest avoidance which reinforced the problem <p>Adaptations</p> <ul style="list-style-type: none"> • Some suggestions were made by the author: (i) Therapists need to understand cultural expressions and classifications of distress, as opposed to diagnostic criteria from other cultures; (ii) Therapists should be respectful of patients' beliefs and not be antagonistic; (iii) Therapists and patients should collaborate to arrive at a shared explanation of symptoms which includes links with psychosocial stressors • Helping with control of symptoms early helped to make the patient more amenable to psychological interventions 	<p>+ Clear example of how cultural beliefs directly impacted on the presentation of distress in the patient</p> <p>+ Significant contribution to the literature on a presentation which has little existing literature</p> <p>- Limited inferences can be made about the relative effectiveness of treatments and adaptations as this was a single case study with little literature to compare against</p> <p>- Little discussion around the impact of traditional healers on the psychiatrist's work, or his views on it</p>

7	Parker et al., 1999	Members of various mental health professions were surveyed; They were asked to rate the helpfulness of various professions and interventions, along with the predicted prognosis for three mental health conditions (major depression, schizophrenia, and mania)	403 staff from the principal psychiatric hospital in Singapore <ul style="list-style-type: none"> • 69 psychiatrists • 128 psychiatric nurses • 102 general nurses • 104 allied health staff (including occupational therapists, psychologists, and social workers) 	Various resources, medication, activities, and therapies, including: <ul style="list-style-type: none"> • Western doctors and medicine • Allied health • Traditional healers and interventions • Religious leaders • Family and social support • Lifestyle changes 	<ul style="list-style-type: none"> • Psychiatrists were consistently rated as the most helpful across conditions; In depression and mania, it was followed by the individual recognizing that they have a problem, and in depression, it was also followed by talking with friends and family • Psychiatrists were less keen on counsellors and lifestyle interventions than other professions • Across conditions, all professions agreed that most (if not all) traditional treatments would not be helpful • Most professions also did not think that religious leaders would be helpful for mania and schizophrenia, except for 29% of general nurses who felt that they might be helpful for schizophrenia • There were considerable similarities between the current Singapore study and the original Australian study in terms of the treatments which were endorsed, and a rejection of indigenous healing interventions 	<p>+ Survey is based on an Australian study, which allowed for cross-cultural comparisons</p> <p>+ Options specific to Singapore's context were added to the original Australian survey</p> <p>+ The use of quotation marks when discussing the 'correct' identification of diagnoses in the vignettes reflects a consistency in recognizing cultural influences of interpreting mental health difficulties and interventions</p> <p>- Although the survey was conducted in the biggest psychiatric hospital in Singapore, sampling from only one hospital may represent the culture of one service rather than the country</p> <p>- The study does not consider or report the rates at which other options (e.g. 'harmful', 'depends') were selected for each treatment, which</p>
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						might provide richer information about professionals' views of treatments (i.e., not being 'helpful' is different than being 'harmful')
8	Sim, 2012	Experienced family therapists and trainers were interviewed about the challenges of developing and practicing family therapy in Singapore	7 experienced family therapists (each with more than 30 years of experience) who had contributed significantly to the field of family therapy in Singapore were invited	Family therapy	<ul style="list-style-type: none"> • Many professionals pursued family therapy training due to a sense of inadequacy in working with patients and their family • Discussions under "Cultural challenges of family therapy in Singapore" included: (i) dealing with overt expression of emotions, (ii) observing hierarchy in social intercourse and family relationships, (iii) expectation that therapist should be an expert who is certain, directive and efficient, and (iv) ability to note the idiosyncratic differences which may seem similar • Engaging family members can also be difficult due to various reasons (e.g., stigma, family members feeling blamed, therapists' discomfort, family members' work pressures) <p>Adaptations</p> <ul style="list-style-type: none"> • Getting couples to talk to each other through therapist before slowly doing so directly • Teaming up with psychiatrists and using their status to facilitate engagement of father 	<p>+ Participants were very experienced, and many held leadership positions which might give them a broader view of the field</p> <p>± Researcher was personally familiar with all the participants, which may influence analysis</p> <p>- Possible sampling bias: Participants were selected by researcher based on their perceived contributions to the field</p>

					<ul style="list-style-type: none"> • Respecting that families do not normally talk openly, and children might get into trouble for speaking up in front of others and embarrassing their parents • Strategic therapy can be appealing to Asian families because they are problem-focused, directive, active, and concrete • Noting the idiosyncratic differences which may seem similar – be curious and respectful instead of assuming similarities in culture 	
9	Yeo, 2002	Opinion article about the current state of counselling and pastoral care in Asia, with a specific focus on Singapore	Author is a pioneer in counselling in Singapore, who was involved in Christian and secular counselling and training in Singapore and Asia	Counselling and Pastoral Care	<ul style="list-style-type: none"> • Counselling and pastoral care in Singapore has Western roots; While it continues to follow developments in the West, Western models need to be modified for Singapore • Because Asians have a communal orientation to relationships and prefer casual relationships, a clinical approach might be considered offensive in pastoral care • Asians may have less boundaries and expect access to pastoral personnel whenever the need arises, which might be due to a 'village mind-set' where elders would inquire into the welfare of members of the community and were readily accessible whenever needed <p>Adaptations</p> <ul style="list-style-type: none"> • Counselling in this context should be 	<p>+ A history of counselling and pastoral care in Singapore is discussed, along with other cultural observations</p> <p>- The article refers to both pastoral care and counselling skills, and it is not entirely clear if some of these cultural adaptations are recommended solely for pastoral care or also for the wider field of counselling and mental health professions</p> <p>- Observations about culture are not backed up by data or anecdotes</p>

					<p>done informally and through relationships and conversations rather than through formalized structures and techniques</p> <ul style="list-style-type: none"> • Therapeutic conversations should follow these ideas: i) adopting an exploratory approach, ii) keeping an open mind, adopting a not-knowing position, iii) being respectful, iv) being health-oriented and strength-based rather than deficit-based, and v) adopting a systemic and multi-perspectival orientation • Family roles and hierarchy should be respected – younger members should not be asked to express (negative) feelings and opinions of their parents or elders • Some people may choose not to speak about personal issues, and this needs to be respected and they should not be coerced into speaking about them 	
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Appendix C

Quality Appraisal for Papers in the Systematic Literature Review (using MMAT, version 2018; Hong, et al., 2018)

Foo & Merrick (2004)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	✓			+ To compare characteristics of New Zealand and Singapore mental health practitioners and their counselling and psychotherapy practices
	S2. Do the collected data allow to address the research questions?	✓			+ The data collected was appropriate to answer the research question
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	✓			+ A qualitative approach would enable an in-depth exploration of cultural issues
	1.2. Are the qualitative data collection methods adequate to address the research question?	✓			+ Individual interviews were appropriate to gather in-depth information about a relatively new topic + Participants came from a variety of different demographic groups, which could provide a wider range of views
	1.3. Are the findings adequately derived from the data?			✓	- Data analyses method not specified
	1.4. Is the interpretation of results sufficiently substantiated by data?		✓		- Qualitative data was not discussed separately and instead combined with the analyses of quantitative data, so it is impossible to know how the qualitative data was interpreted - No quotes were given to substantiate the interpretation of qualitative data
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?			✓	+ Qualitative data was analysed with reference to quantitative data, existing literature, and cultural context of participants

					- Without knowing how the data was analysed, it is impossible to comment on how it was interpreted
2. Quantitative randomized control trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	✓			+ Mail questionnaires were sent to MHPs on National registries and directories in New Zealand and Singapore; structured interview participants were called or emailed + The sampling strategy was adequate in attempting to recruit a large participant pool (n=604) across both countries
	4.2. Is the sample representative of the target population?			✓	- Based on the demographics of respondents, it is probable that the sample was not representative of the population in either country, however this was not discussed
	4.3. Are the measurements appropriate?	✓			+ A mail questionnaire was suitable to gather responses from a larger number of participants, although it sacrifices some depth
	4.4. Is the risk of nonresponse bias low?			✓	+ Although Section E (on self-disclosure, religious issues,

					and traditional healers) was optional, reported data indicates that all participants responded, reducing the possibility of self-selection bias - Response rates were very low in both countries, and might have contributed to the differences in sample demographics (e.g., age, experience, profession) - The differences in sample demographics might affect the responses and skew the results if they are not representative samples of their countries
	4.5. Is the statistical analysis appropriate to answer the research question?			✓	- It is unclear what statistical analyses were used (although it was specified that SPSS was used), so it was unclear what guided authors to decide when statistics were 'similar' or 'different'
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	✓			+ The aim of the structured interviews was to provide validation for the findings from the mail questionnaire and an in-depth examination of the topics
	5.2. Are the different components of the study effectively integrated to answer the research question?			✓	+ While analysis methods were not stated, it is stated that findings from the mail questionnaires supported or augmented the findings from the structure interviews, so it may be assumed that they were analysed separately before being combined - Because qualitative and quantitative data was combined, it is unclear which data came from the mail questionnaire and which from the interviews
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	✓			+ The interpretation of both quantitative and qualitative data added to each other and are discussed together to form a coherent picture
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	✓			+ No inconsistencies were reported
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				✓

Geerlings et al. (2017)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	✓			+ How do students, academics, and alumni of clinical psychology programmes in Singapore experience preparation for culturally competent clinical psychology practice in Singapore? + According to students, academics, and alumni, how well is clinical psychology training meeting the needs for cultural competency?
	S2. Do the collected data allow to address the research questions?	✓			+ Data collection method (interview) was appropriate for the research question
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	✓			+ A qualitative approach allows for an in-depth exploration of a new topic
	1.2. Are the qualitative data collection methods adequate to address the research question?	✓			+ Individual interviews were appropriate to allow participants to share opinions openly, especially since students and academics were both involved + Inclusion of academics along with students and alumni, as well as members of different ethnicities allowed a broader view of training from different perspectives - Some important demographic information is not available (e.g., which programmes the participants are from, specifics about their professional experience in Singapore or familiarity with the culture) - Including students who have a minimum of 1 academic semester of training might mean students are not in the best position to comment on their training in its entirety
	1.3. Are the findings adequately derived from the data?	✓			+ Participants were invited to check the accuracy of their own transcripts

					+ Data was analysed using Interpretative Phenomenological Analysis (IPA), process described in paper + Audits of two analyses was done to control for biases (1 by participant, and 1 by experienced IPA researcher)
	1.4. Is the interpretation of results sufficiently substantiated by data?	✓			+ Themes were adequately substantiated by participant quotes
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	✓			+ Findings were discussed in relation to existing research and formed a cohesive argument
2. Quantitative randomized control trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer				

	the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Jennings et al. (2008)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	✓			+ Research aims to explore the personal characteristics and therapy practices of Singaporean master therapists
	S2. Do the collected data allow to address the research questions?	✓			+ Data collection method and participant selection was appropriate to address the research question
<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>					
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	✓			+ A qualitative approach is suitable for an in-depth exploration of the question, and follows a previous study in America
	1.2. Are the qualitative data collection methods adequate to address the research question?	✓			+ Individual interviews were appropriate to allow participants to share in-depth opinions about a complex topic openly, especially given their hesitation to be identified as experts + Interview questions are available in appendix, which allows for transparency and replication + Participant size adequate to balance breadth of views and depth of exploration + Inclusion of different professions from various therapeutic orientations increased breadth of views + Selection of 'master therapists' through peer-nomination is theoretically sound and follows the process used by a previous study; however, it may lead to some bias as the only method of determining expertise - Lack of diversity in some participant demographics (e.g., ethnicity, westernized education) might lead to biases in views
	1.3. Are the findings adequately derived from the data?	✓			+ Grounded theory was used and transcripts were analysed line by line through open coding

					+ Personal biases and consideration of researcher impact were adequately discussed and monitored + Used a Singaporean auditor who was experienced in qualitative research and had practiced in Singapore + Cross-cultural comparisons were possible due to similarity of methodology to previous study in America - Criteria for excluding preliminary themes might have meant that some themes which were not picked up by the majority were not highlighted
	1.4. Is the interpretation of results sufficiently substantiated by data?	✓			+ Quotes provided to substantiate the themes were adequate
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	✓			+ Themes were discussed in the context of Singapore and previous literature, and differences with the previous study in America were also discussed adequately
2. Quantitative randomized control trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative	4.1. Is the sampling strategy relevant to address the				

descriptive	research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

B.O. Lee & Bishop (2001)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	✓			+ To explore Singaporean Chinese clients' beliefs about the aetiology and treatment of psychological problems, compared to the beliefs of non-clients and professional therapists trained in western models
	S2. Do the collected data allow to address the research questions?	✓			+ Data collected was sufficient to address the research question + Questionnaire was modified from a previous study
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized control trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-	3.1. Are the participants representative of the target population?				

randomized	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	✓			+ 21 organizations across different settings were drawn from lists and six community centres selected at random; This allowed recruitment of participants from a range of settings and professions - Clients and therapists were recruited through letters to organizations requesting for Chinese participants, and non-clients were recruited and submitted their responses in-person; Efforts to maintain anonymity were not described, so there is a possibility of a greater risk of bias due to social desirability (especially for non-clients)
	4.2. Is the sample representative of the target population?			✓	+ Measures were translated to Chinese to include Chinese-speaking populations - As reported by the authors, lower educated or illiterate people from lower socio-economic classes were probably under-represented in the study
	4.3. Are the measurements appropriate?	✓			+ A 6-point Likert scale was used which had did not provide a 'neutral' option - this is appropriate for Asian settings as a study has found that Asians tend to select midpoints more frequently (J.W. Lee et al., 2002) + The original Opinions and Psychological Problems questionnaire had good content validity and high internal consistency (as reported by authors) + Additional items were described in the paper which allows for transparency and replication, and designed based on a literature review and a field study with IT/SH

					<p>practitioners in Singapore</p> <ul style="list-style-type: none"> + A pilot study was conducted to assess the test-retest reliability of the modified questionnaire + Translations to Chinese were also checked for accuracy using two professional translators for back translations
	4.4. Is the risk of nonresponse bias low?		✓		<ul style="list-style-type: none"> + Despite varying response rates, sample sizes were fairly large (56 therapists, 159 clients, and 146 non-clients), reducing risk of nonresponse bias - The response rate for clients (49%) was lower than those of non-clients (76%) and therapists (67%) and might reflect some reluctance to share their views given that they were still receiving help from the services they were recruited from
	4.5. Is the statistical analysis appropriate to answer the research question?		✓		<ul style="list-style-type: none"> + Several potential confounding variables (e.g., age, gender, religion) were controlled for + A more conservative significance level (<0.01) was used to control for the large number of statistical tests - Likert scale item scores were analysed as continuous variables at times, which is associated with some limitations - Full statistics of responses in each category (i.e., 'disagree strongly' to 'agree strongly') not presented
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				

	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				
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Loh et al. (2021)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	✓			+ To describe the newly developed multi-family therapy intervention and observations of families' responses + To present findings on the feedback from clients, families, and multi-disciplinary team about the content, structure, and effects of the intervention
	S2. Do the collected data allow to address the research questions?	✓			+ Data collected and participant selection is appropriate to address research questions - A control condition could have been helpful to allow for a comparison of the efficacy of the intervention - Without follow-up data, maintenance of positive changes could not be examined
<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>					
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	✓			+ A qualitative method was appropriate for exploring an areas with limited existing research
	1.2. Are the qualitative data collection methods adequate to address the research question?	✓			+ Open-ended questions available in paper and appendix + Use of questionnaires to gather qualitative data facilitates gathering data from more participants - Use of questionnaires may also result in less in-depth qualitative data without less elaboration
	1.3. Are the findings adequately derived from the data?	✓			+ Data analysis method (thematic analysis) was described in detail + A second researcher helped to review data coding and discuss discrepancies
	1.4. Is the interpretation of results sufficiently substantiated by data?	✓			+ Qualitative themes adequately supported by quotes - Participants not given individual anonymized identities in quotes, so it could not be ascertained whether quotes came from a range of different participants
	1.5. Is there coherence between qualitative data	✓			+ Themes from qualitative study were in relation to

	sources, collection, analysis and interpretation?				existing literature + Adaptations to therapy were described with reference to literature on cultural differences
2. Quantitative randomized control trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	✓			+ All participants in the MFT were invited to the study
	4.2. Is the sample representative of the target population?	✓			+ Almost all participants responded to the questionnaire (94.55%)
	4.3. Are the measurements appropriate?	✓			+ Feedback forms available in appendix + A 4-point Likert scale was used which did not provide a 'neutral' option - this is appropriate for Asian settings as a study has found that Asians tend to select midpoints more frequently (J.W. Lee et al., 2002) - Outcome measures could have provided additional information about any improvements after therapy
	4.4. Is the risk of nonresponse bias low?	✓			+ The risk of bias seems low given high response rates
	4.5. Is the statistical analysis appropriate to answer			✓	- Likert scale item scores were analysed as continuous

	the research question?				variables at times, which is associated with some limitations - Full statistics of responses in each category (i.e., 'strongly disagree' to 'strongly agree') not presented - A comparison between feedback from clients, carers, and siblings was not conducted, which might yield important differences
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	✓			+ The open-ended questions were designed for more in-depth exploration into other areas to supplement the quantitative data
	5.2. Are the different components of the study effectively integrated to answer the research question?	✓			+ The components integrated well to describe how the current intervention was received, and to suggest improvements and future plans based on feedback
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	✓			+ During the discussion, links were made between quantitative and qualitative components where appropriate, including with the therapists' own observations
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	✓			+ A divergence was pointed out and discussed in terms of culture (between therapists' observations of participants' reservedness and their self-report of feeling able to and benefiting from group sharing)
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	✓			+ There were no significant threats to the quality of each of the qualitative and quantitative components of the study

Ng (1998)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	✓			+ To describe more about the course of frigophobia
	S2. Do the collected data allow to address the research questions?	✓			+ Addresses aetiology of the condition, a general pattern in relapse, and some treatments attempted - Unable to satisfactorily address the chronology and efficacy of treatments as patient is still under treatment
<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>					
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	✓			+ Since frigophobia is a rare condition with little written about it, a qualitative single case study is appropriate for an in-depth exploration
	1.2. Are the qualitative data collection methods adequate to address the research question?		✓		- While observations of the case are described, it is unclear how these observations were tracked over 8 years - The use of outcome measures or feedback from the client could have bolstered claims about the effectiveness of various interventions
	1.3. Are the findings adequately derived from the data?			✓	- Data analysis method not specified
	1.4. Is the interpretation of results sufficiently substantiated by data?	✓			+ Discussion points substantiated by observations of the client's behaviours - Observations not substantiated by quotes from patient feedback or case notes
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	✓			+ Discussion points were substantiated by reference to concepts in Chinese medicine and cultural expressions - Some incoherence (not discussed) between recognizing the importance of understanding indigenous classifications of distress and employing western personality tools (Eysenck Personality Questionnaire) to diagnose a neurotic disorder

2. Quantitative randomized control trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				

	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Parker et al. (1999)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	✓			+ To assess differences in beliefs about interventions among Singapore professional groups working in mental health, and to compare beliefs about interventions with the earlier Australian survey
	S2. Do the collected data allow to address the research questions?	✓			+ Using a questionnaire adapted from Australian study allowed comparisons with Australian psychiatrists + Culturally specific adaptations were made to options presented for diagnosis, as well as options for resources and interventions
<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>					
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized control trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative	3.1. Are the participants representative of the target				

non-randomized	population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	✓			+ Different professional groups are represented in the sample (psychiatrists, psychiatric nurses, general nurses, and a range of allied health staff) + A large number of questionnaires were distributed resulting in a large participant pool (n=386) + Anonymous submissions through 'postal boxes' reduced the risk of possible social desirability and other biases - Psychiatrists and allied health staff responded to all 3 vignettes as compared to nursing staff who only responded to one, risking respondent fatigue and biases
	4.2. Is the sample representative of the target population?			✓	- Although the survey was conducted in the biggest psychiatric hospital in Singapore, sampling from only one hospital may represent the views of one service rather than the country - A breakdown of the number of returned surveys for different professions was given, but not for the final number of complete data sets (n=386), which was noted to be different from the total number of returned surveys (n=403)
	4.3. Are the measurements appropriate?	✓			+ The inclusion of culturally relevant options (instead of using the same options from the original Australian study) was appropriate + Vignettes and treatment options are provided in the report, allowing for transparency and replication

					+ The inclusion of 'depends' and 'don't know' options allowed for more nuanced responses; however, these were not analysed or discussed other than as a limitation
	4.4. Is the risk of nonresponse bias low?	✓			+ Response rates were fairly high across groups (70% - 92%) and there were large pools of participants in each group (69 - 128) which reduces the risk of nonresponse bias - In the allied health group, rates of response differed across profession (51% - 86%) which might have skewed the representation within that group
	4.5. Is the statistical analysis appropriate to answer the research question?	✓			+ An explanation for the use of the extension of Fischer's exact test instead of a chi-square test was given (i.e., due to low frequencies in some cells) + A more conservative significance level (<0.01) was used to control for the large number of statistical tests - Full statistics of responses in each category (i.e., rates of 'neither', 'unhelpful', 'depends' and 'don't know') were not presented or examined - Statistical analyses were not conducted to compare the results with the Australian study
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere				

	to the quality criteria of each tradition of the methods involved?				
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Sim (2012)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	✓			+ To explore the challenges of developing family therapy in Singapore, and how these can contribute to the global understanding of cultural issues in therapy
	S2. Do the collected data allow to address the research questions?	✓			+ Data collection method (interview) and participant selection were appropriate for the research question
<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>					
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	✓			+ A qualitative approach allows for an in-depth exploration of a new topic + Method adapted from a previous survey in America
	1.2. Are the qualitative data collection methods adequate to address the research question?	✓			+ Individual interviews were appropriate to allow participants to share in-depth opinions openly + Participants were selected by researcher based on their perceived contributions to the field; this may result in a sampling bias, but also in more expert views (some achievements are listed) - Researcher was personally familiar with all the participants, which allowed ease of interviewing but may also influence data collection and analysis, which was not addressed
	1.3. Are the findings adequately derived from the data?	✓			+ Transcripts were sent to individual participants to check for accuracy + Content analysis was conducted with NVivo to identify themes + Analysis was then reviewed and verified by participants again
	1.4. Is the interpretation of results sufficiently substantiated by data?	✓			+ Quotes given were adequate to substantiate key points + Background information about Singapore's context

					provided where appropriate
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	✓			+ Discussion of results was done with reference to previous literature and the wider socio-political contexts of Singapore, and formed a cohesive argument
2. Quantitative randomized control trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research				

	question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Yeo (2002)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	✓			+ To discuss current issues in Pastoral Care and Counselling in Asia, and particularly Singapore
	S2. Do the collected data allow to address the research questions?		✓		- No data was collected, and instead observations are drawn from the author's own rich experience
<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>					
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	✓			+ A reflective opinion article from a pioneer in pastoral care and counselling in Singapore was appropriate to for an in-depth exploration into the impact of culture on the development of the field in Singapore over the years
	1.2. Are the qualitative data collection methods adequate to address the research question?			✓	- Observations are drawn directly from the author's own experience; no mention was made of any records of experiences, which might result in biases related to memory
	1.3. Are the findings adequately derived from the data?		✓		- Data analyses methods were not specified, and it is unlikely that any were used
	1.4. Is the interpretation of results sufficiently substantiated by data?			✓	- Observations are not substantiated with anecdotes; however, suggestions are sometimes supported by Bible verses, which might count as valid references according to other epistemologies
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	✓			+ The development of pastoral care and counselling in Singapore was discussed in relation to the wider socio-political context and the recommendations provided were consistent with the author's observations
2. Quantitative randomized control trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				

	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods				

	involved?				
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Appendix D

Excerpts from Reflexive Research Journal

Preparing for MRP Presentation (23/10/20)

Exploring Decolonization for Clinical Psychology in Singapore: Narrowing down to therapies.

- Personal interest in different philosophies of psychological therapies and how some third-wave therapies seem to draw from eastern influences. Found myself resonating with some ideas when I was learning these models.
- Looking at training courses as the gatekeepers of the profession – what they teach will then be what Clinical Psychology looks like in Singapore.
- Curious about the influence of my own training and the shift in my opinions about CBT and other models of therapy, while also recognizing that I had always felt that more could be done with systems
- Wanting to explore to also provide an alternative to what a decolonized curriculum would look like; influenced by the earlier readings in PALS where I felt that many postmodern papers critiqued modernist perspectives but provided no alternatives
- Reflections after readings from Lee Boon Ooi: “True” decolonization should also probably include local knowledge (e.g., indigenous therapies)

Target population: Trainees vs client population

- Trainees as the service-users of education systems, but the benefit should be geared towards clients’ needs
 - o Need to consider that trainee population is low – unlikely to recruit many from JCU given busy-ness and research culture
 - o If including people I know, need to think about impact on study:
 - Will they try to give socially ‘desirable’ answers if they know my personal interests? Most will not know my interests though
 - When I’ve discussed these topics with some of them, we have had friendly arguments acknowledging different views, so I don’t think they will try to give different answers – and if they do, I will probably be able to spot it
 - As reflected with Pieter, excluding people I’ve discussed concepts of decolonization with implies an assumption that these conversations don’t happen in my absence, which is unlikely – My friends were aware of some of the literature beforehand
 - It also stems from a belief and hope that the researcher can and should be neutral and has limited impact on the study
- Clients may not be able to comment about what other therapies could be useful
- Clients may not have needed to reflect much about their cultural identity in the past, identities may be more fluid?
- Including both voices
 - o Clients to find out how well CBT fits their own views of mental health
 - o Trainees to find out what their own views of mental health are
 - o Trainees to find out what views they feel clients hold
 - o Trainees to find out what other models have been helpful

Position: Singaporean studying in a UK course

- “Foreigner”: Agent for a western agenda to change local courses could itself be an instance of coloniality
 - o Need to ask their opinion about whether decolonization needs to happen

- Being open to accept “no” for an answer
- Power: DClinPsy vs Masters – is there a power imbalance? Will participants defer or will they resist?
 - Being open and naming position (Singaporean who trained in the UK, most of my clinical experience has been with White clients) and positioning participants as experts

Potential complications:

- Singapore’s relationship with coloniality/westernization may be mixed
 - Narratives about “owing” some success to coloniality vs being “abandoned” in WWII
 - Western culture may have some unifying/neutral value for a multicultural population
 - Some idealization of westernization in the past, and still in some circles; different Singaporeans may have different relationships with westernization
 - Hypothesis: Singaporeans who identify with more western values are less likely to feel the need for decolonization
 - Get participants to reflect on their cultural values (e.g., collectivistic/individualistic; cultural identity questionnaires) & compare their views of CBT (i.e., endorsement of statements underpinning CBT)
- Changes should benefit not just the “majority” of Singaporeans at the risk of ignoring minority groups
 - Cannot just look at Chinese philosophies & indigenous therapies
 - Consider “common ground” vs “pluralistic” approach

Interviews must be given context:

- Participants will be unable to comment on therapies they have no knowledge of
- Interviews will need to include some introduction to different models of therapy which are thought to be useful
- “Decolonization” may need to be defined and operationalized within the conversations (e.g., therapy models vs evidence base, epistemology, diversity in lecturers/lesson materials/trainees)

19/02/22 (personal reflections about participant recruitment)

Recruitment from NUS quite quick – hopeful that these conversations are interesting to people. Having difficulties recruiting from JCU – wondering if JCU students less interested in these conversations? Perhaps about research style (i.e. qualitative)

- Had to request help from JCU course team to disseminate due to lack of other avenues (e.g., SPS website charges fees to advertise studies, no Facebook group that I’m aware of)
 - Even though might highlight “outsider” dynamic as compared to snowball sampling, which seems to have worked well within NUS circles
- Found myself also curious that even in workplaces there doesn’t seem to be as many connections between NUS graduates and JCU graduates as I’d hoped?
- Might need to extend cut-off for recent graduates to 5 years after all, to leverage on personal connections and snowball sampling (since recruiting through course didn’t work)

01/04/22 (Supervisory Meeting)

Over the past few days, I reflected more about what I could have done differently about the group:

- It felt like the size of the group might have been too big, especially given that it was online. At that size, participants tended to naturally do more “turn-taking” than might otherwise be the case in-person, leading to less spontaneous discussion. I discussed this with another trainee who did a focus group online, who also agreed that smaller groups might be more suitable for online groups.
 - In the supervisory meeting, we agreed that a group size of 2 or 3 should be fine, although 3 might be ideal to prevent it from turning into a two-way interview (rather than a discussion)
- Lack of depth for CBT adaptations – this can be expanded upon in following interviews, but needs to be balanced against wider goals about thinking of other models to introduce
 - Discussed the use of member-checking in supervision as a way to gain more depth from individual interviews; Do all groups and come up with preliminary themes first
 - We discussed the tension between a group and individual format, recognizing that Singaporean culture might not fit as well with a group format because of hesitance to disagree; However, going back to benefits of groups – perhaps spending a bit more time to warm context, less formal
 - Some discussion that the dichotomy between group and individual study methods might be a western approach that might not fit Singaporean culture
- I recognized a tension between not wanting to “lead” the participants and the discussion too much – for example when a participant mentioned about collectivism, I hoped conversation would carry on around it, but it moved on, and I did not want to probe. However, I would have been less hesitant to probe about CBT and ACT, and I reflected that in recognizing my own potential biases, I was perhaps leaning too far to become “avoidant” of probing about systemic ideas. I also recognized that this tension was partly due to an awareness of what I represented as a western-trained trainee.

Appendix E

Recruitment Poster

Decolonizing Clinical Psychology
Training in Singapore



PARTICIPANTS WANTED!



We would like to hear about **Singaporeans'** experiences of Clinical Psychology courses, with a focus on the **models of therapy being taught** and their **cultural relevance** to working in Singapore. The findings may help to gain a better understanding of how to **make training courses more culturally relevant**.

WHAT IS INVOLVED



The study will involve 2 main parts:

1. A pre-interview 5-minute **reflective checklist** about different views of mental health
2. A 90 to 120 minute **focus group** on Zoom or MS Teams with 3 to 6 participants

Trainees and graduates will be placed in separate groups. Interviews will be in **March or April**, and will be recorded for transcription.



Participation is voluntary, and all data will be anonymized. You may decide to withdraw at any time until the end of interviews.

All participants will be reimbursed for their time with a **\$20 eVoucher** of your choice from Grab, Capitaland, or Amazon SG.

WHO CAN TAKE PART



We would love to hear from you if you are:

1. A **Singaporean**
2. A **2nd year trainee or recent graduate** (within 3 years) from a Clinical Psychology course in Singapore, and
3. Have **at least 1 year of experience** working therapeutically with clients in Singapore (including placement experience)

Approved by UH Health, Science, Engineering & Technology ECDA (Protocol number: LMS/PGT/UH/04737).

CONTACT US

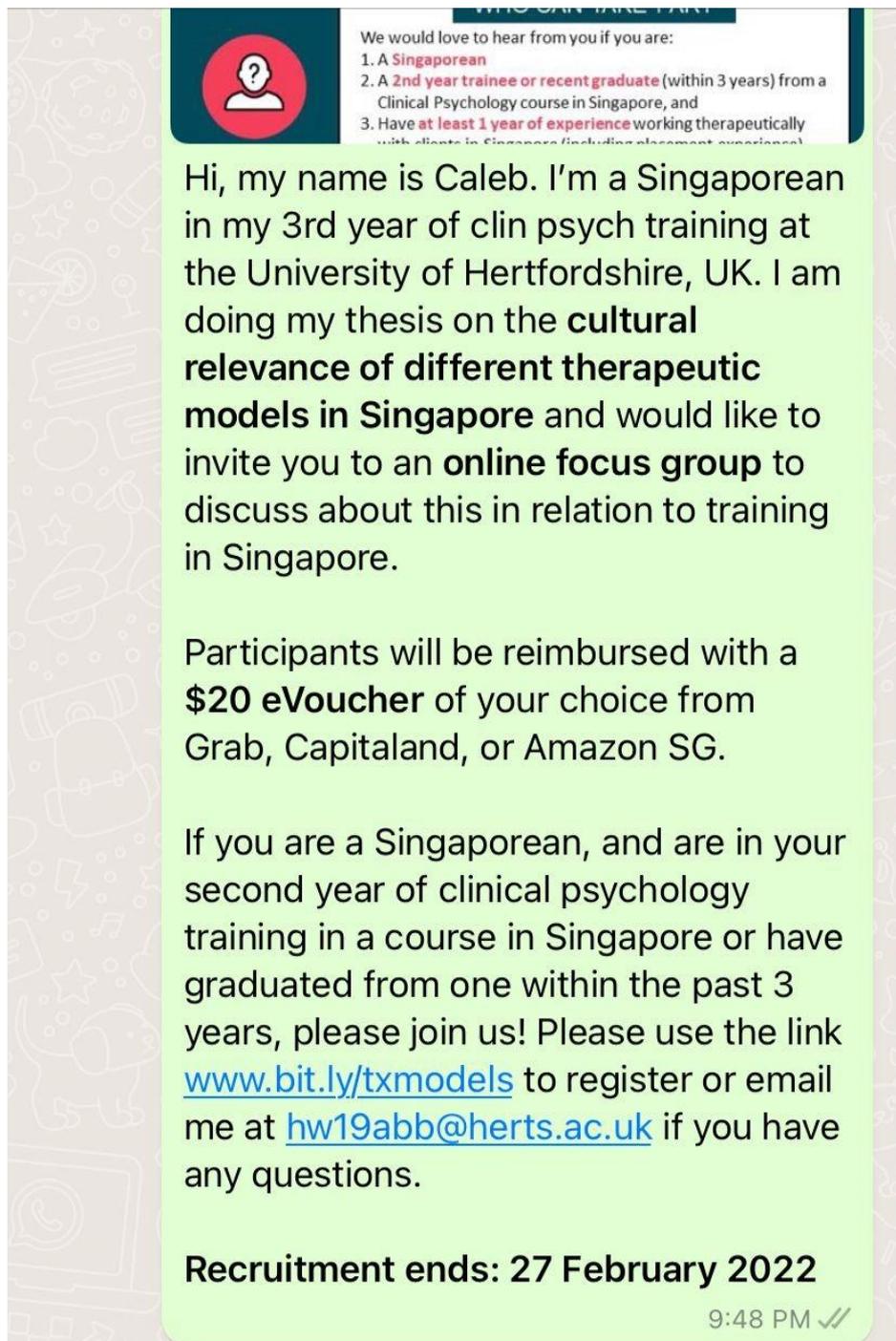
If you would like to join us, please use the link below or drop me an email if you have any questions

Caleb Wong (Trainee Clinical Psychologist)

www.bit.ly/txmodels |
 hw19abb@herts.ac.uk

Appendix F

Recruitment Blurb



WHO CAN TAKE PART

We would love to hear from you if you are:

1. A **Singaporean**
2. A **2nd year trainee or recent graduate** (within 3 years) from a Clinical Psychology course in Singapore, and
3. Have **at least 1 year of experience** working therapeutically with clients in Singapore (including placement experience)

Hi, my name is Caleb. I'm a Singaporean in my 3rd year of clin psych training at the University of Hertfordshire, UK. I am doing my thesis on the **cultural relevance of different therapeutic models in Singapore** and would like to invite you to an **online focus group** to discuss about this in relation to training in Singapore.

Participants will be reimbursed with a **\$20 eVoucher** of your choice from Grab, Capitaland, or Amazon SG.

If you are a Singaporean, and are in your second year of clinical psychology training in a course in Singapore or have graduated from one within the past 3 years, please join us! Please use the link www.bit.ly/txmodels to register or email me at hw19abb@herts.ac.uk if you have any questions.

Recruitment ends: 27 February 2022

9:48 PM ✓✓

Appendix G

Interview Schedule

Interview schedule (adapted from Krueger, 2002; Breen, 2006; J.J. Lee & K.P. Lee, 2009)

Welcome & Self-introduction

Hi everyone. Good (morning/afternoon/evening) and welcome. Thanks for taking the time to join us in discussing about clinical psychology training in Singapore. My name is Caleb Wong, and I'm currently a trainee in the Doctorate of Clinical Psychology programme in the University of Hertfordshire in the UK. I am conducting these focus groups for my thesis project, and I am interviewing different groups of trainees and recently qualified clinical psychologists from both NUS and JCU courses for my research. Today's group is made up of (second-year trainees from [JCU/NUS] / practicing clinical psychologists who have recently graduated from either JCU or NUS).

I did my undergraduate psychology course in NUS and worked for a while in different psychology-related jobs before going to the UK. Since beginning my training in the UK I have been reflecting a lot about cultural differences and the cultural relevance of various psychological therapies in Singapore's context. So while I have some ideas about the general psychology curriculum in Singapore, I'm also aware that my own opinions would have been swayed by my own training and experiences in a western programme, and that my experience of practicing clinical psychology in Singapore is limited. So I think it's really important to hear from people who actually have more experience in this area and know more than I do about this.

After the discussion, I will be staying behind for a while to answer any questions people might have about myself, my research, or my position in relation to the topic.

Overview of the topic

The aim of my research is really to find out more about the experiences of teaching on the programmes in Singapore, with a focus on different models of therapy and how well that prepares trainees for practice in Singapore. For example, CBT would be a model of therapy, and so would Acceptance and Commitment Therapy, Dialectical Behaviour Therapy, Psychodynamic therapy, Systemic therapy, Indigenous Therapies, and so on.

The interviews will be analysed using thematic analysis and I will be doing a write-up based on my findings for my thesis. I'm also hoping to disseminate my findings by publishing them in a peer-reviewed journal, sharing with local course teams, and perhaps presenting at relevant local conferences.

Ground rules & Confidentiality

Before beginning, I would like to go through some guidelines for the discussion today. I'm recording our discussion because I don't want to miss anything, and I can't type as fast as people talk. Please also turn off any handphones and pagers or switch them to silent mode to avoid any disruptions.

I hope that everyone is OK with addressing each other on a first name basis for our discussion, but I will not be using any actual names in any of my reports, and all data will be stored securely and

anonymously where possible. I would also like to remind everyone that you've all agreed to maintain the confidentiality of other group members' identities in your consent forms, so everyone can be assured of full confidentiality. Due to the use of online platforms, I need to also inform you that there is a potential risk of zoom-bombing, but I would also like to assure you that I have taken the precaution of setting passwords and enabling the waiting room to avoid Zoom-bombers. Can I also just check whether everyone is joining us from a private space, or if not, that you're using earphones? If you need some time to move or get your earphones, please just let me know now.

Please leave your video cameras on as experience from hours of online lectures and seminars tells me that this usually increases engagement and discussion.

There are no right or wrong opinions, and I'm really interested to hear all points of view. Differing views can often make for more engaging discussions so please feel free to share them if you have any. Because I am recording the discussion, it would be helpful if everyone can remember to speak only one at a time. We don't have to all agree with each other, but please listen respectfully to differing opinions without interrupting before sharing your own thoughts. Also, because the recording will not be able to pick up on non-verbal cues and actions, please speak clearly and try to voice everything without interrupting the speaker.

As the facilitator, I hope to stimulate discussions, but will not be contributing directly to them. I will be keeping track of time and guiding the discussion to make sure that all of the issues I am interested are discussed.

You may also choose to withdraw from the study at any time. It would be helpful if you could let me know if you do decide to leave, so that I'm not just wondering if you'd just (decided to go to the toilet / disconnected).

Now that I'm done with the guidelines, let's begin with some introductions going around from my (left/right). Please tell us your name and (your current placement/what your training journey has been like).

Questions

- (Ice-breaker) Before coming here today, you would all have completed a checklist exercise with several statements about different views on mental wellbeing. The exercise was meant to help us to start reflecting about the topic today, and I will be asking some questions based on that exercise later on. But I thought a good place to start the discussion would be to share about how much time you spent on it and how easy or difficult it was?
 - Thanks for sharing your experiences everyone. That was really interesting. We'll put a pin in that and come back to this exercise again later.
- 1. What has your experience been like with using different therapeutic models in your clinical practice?
 - What impact did this have on your clients?
 - How often do you use CBT in your practice?
- 2. For the next questions, please think back only to the academic teaching that was done during your training rather than the learning that happened during placements. I will be asking everyone to complete an individual activity to estimate the amount of focus your training placed on different models of therapy.

3. Continue to think back only on the academic teaching during your training. Bearing in mind Singapore's diversity (for example in age, culture, ethnicity, religion, socioeconomic background), do you think your academic lessons on these models prepared you for practicing in a culturally relevant way in Singapore?
 - Why or why not?
 - What impact did this have on your clients?
4. Now thinking back to the statements in the pre-interview exercise, how well do you feel the views you and your clients hold fit with a CBT approach?
5. (After introducing therapeutic models which statements were taken from) Looking at these models and any others you may be familiar with, what therapeutic models do you feel are culturally relevant for Singapore? These could be models we've already discussed about or not.
 - Why would these models be relevant?
 - What impact would using these models have on your clients?
6. Thinking about your own training, how could teaching about therapeutic models be done differently to make it more culturally relevant?
 - Would it include different models?
 - Would it place more focus on making adaptations to CBT?
 - What impact would it have on your clients?
7. (After summarizing key points in relation to the key research questions) Based on that summary, is there anything that I might have missed or that we have not discussed about?

Post-interview task and consent for contact

Thank you for the very engaging discussion and for sharing your thoughts with the group today. Earlier on, I asked everyone to estimate the focus their training placed on different therapeutic approaches. I will now be asking everyone to complete a similar activity to share what they feel would be an ideal distribution of focus for training in Singapore to be culturally relevant. This might look the same as your original estimate, or it might look different.

I will also be asking everyone to indicate whether they wish to be contacted again after the interview for any of the following purposes: 1) a post-analysis summary of my findings, 2) updates about the research progress (e.g., publication), and 3) member-checking to confirm that themes identified through the thematic analysis accurately reflected our discussions.

Post-interview Debrief & Q&A

Thank you all once again for your participation today. After analysing the data from all of the focus groups, I hope to do our discussions justice by reporting and disseminating my findings in a useful way. Just to share a little bit more about how this study came about, it was based on research suggesting that western psychology and models might not be as culturally appropriate for practice in other cultures (e.g. Henrich, Heine, and Norenzayan, 2010; Llewelyn and Shimoyama, 2012). A previous study in 2017 conducted in NUS & JCU also suggested that changes should be made to their curricula, which included the inclusion of other explanatory models (e.g., cultural or spiritual models; Geerlings, Thompson, and Tan, 2017). I wanted to get an updated picture of training five years on, and to expand on their research by taking a closer look at which models might be more useful to

include. I will also be sending around a debrief sheet with this information with a few relevant references for further reading if you are interested.

We have now come to the end of our focus group. I will also be staying behind for a while if anyone wishes to ask me any questions about myself, my research, or my position in relation to this topic.

References

- Breen, R. L. (2006). A Practical Guide to Focus-Group Research. *Journal of Geography in Higher Education*, 30(3), 463-475. doi:10.1080/03098260600927575
- Geerlings, L. R., Thompson, C. L., & Tan, G. (2017). Culturally Competent Practice: Experiences of Students, Academics, and Alumni of Clinical Psychology Degrees in Singapore. *Journal of Tropical Psychology*, 7(e3), 1-10. doi:10.1017/jtp.2017.3
- Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and Brain Sciences*, 33(2-3), 61-83. doi:10.1017/S0140525X0999152X
- Krueger, R. A. (2002, October). *Designing and Conducting Focus Group Interviews*. Retrieved February 15, 2021, from <https://www.eiu.edu/ihec/Krueger-FocusGroupInterviews.pdf>
- Lee, J. J., & Lee, K. P. (2009). Facilitating Dynamics of Focus Group Interviews in East Asia: Evidence and Tools by Cross-Cultural Study. *International Journal of Design*, 3(1), 17-28.
- Llewelyn, S., & Shimoyama, H. (2012). Working with CBT across Cultures in Clinical Psychology with Particular Reference to Japanese Clinical Psychology, Part Three - Adapting CBT for Japanese Culture. *Japanese Journal of Clinical Psychology*, 12(4), 580-589.

Appendix H

Pre-interview Activity

Pre-Interview Activity

Thank you for agreeing to participate in my study by joining the focus groups. I would like to invite you to complete this pre-interview activity before joining your group interview. Hopefully, this will help us to start reflecting about the topic and facilitate a smoother discussion during the focus group.

Everyone experiences psychological distress at different points in their life. Below are some statements about psychological distress and mental wellbeing in general.

Think about your work with clients both past and present. Try to hold in mind clients from different backgrounds (e.g., age, culture, ethnicity, religion, socioeconomic background).

Please indicate (with a ✓) which ones you feel some of your clients would have endorsed about their own mental health. Next, do the same for the statements which resonate with you personally and/or professionally.

Statements	Resonates with my clients	Resonates with me
Mental health difficulties may be maintained by the reactivation of habitual patterns of negative thinking during periods of low mood, leading to a downward spiral. Psychological distress may be alleviated by recognizing and stepping out of automatic patterns of mind and body. (Segal, Williams, & Teasdale, 2013)	<input type="checkbox"/>	<input type="checkbox"/>
Mental health difficulties occur when people are locked into unhelpful patterns of interpretation and behaviours based on enduring beliefs about ourselves, other people, and the world around us. Psychological distress may be alleviated by evaluating and modifying unrealistic or unhelpful thinking. (Johnstone & Dallos, 2014)	<input type="checkbox"/>	<input type="checkbox"/>
Mental health has a spiritual dimension, and spiritual or religious factors (e.g., karma; fate; sin) may contribute to mental health difficulties. Psychological distress may be alleviated by attending to these spiritual needs. (Sulmasy, 2002)	<input type="checkbox"/>	<input type="checkbox"/>

<p>Mental health difficulties are the product of cycles of interactions and communication in the family and wider systems which maintain the problem. Problems are not intrapersonal, but parts of larger processes involving many other people, behaviours, and meanings.</p> <p>Psychological distress may be alleviated by addressing these patterns and cycles of communication.</p> <p>(Campbell, Coldicott, & Kinsella, 1994; Dawson & Moghaddam, 2015; Johnstone & Dallos, 2014)</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Mental health difficulties may result from the psychological suffering caused by attempting to avoid psychological pain.</p> <p>Psychological distress may be alleviated by reducing experiential avoidance and focusing on connecting with the present moment, and living a life that we value.</p> <p>(Dawson & Moghaddam, 2015)</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Mental health difficulties may result from our emotion systems being out of balance. Particularly, people need and respond to care and affectionate relationships.</p> <p>Psychological distress may be alleviated by learning to be non-judgemental and more compassionate with ourselves.</p> <p>(Dawson & Moghaddam, 2015)</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Mental health difficulties may result from pervasive dysfunctions of the emotional regulation system, caused jointly by biological vulnerability to high emotionality and an invalidating environment.</p> <p>Psychological distress can be alleviated by recognizing the contradictory positions between acceptance and change, and balancing them using various strategies.</p> <p>(Carr & McNulty, 2006)</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Mental health difficulties may be due to maladaptive organizing principles about life which were developed earlier in life and continued to be applied in later life. This results in maladaptive coping behaviours which in turn reinforce these principles for understanding life.</p> <p>Psychological distress can be alleviated by challenging and modifying these principles.</p> <p>(Young, Klosko, & Weishaar, 2003)</p>	<input type="checkbox"/>	<input type="checkbox"/>

<p>Mental health difficulties are maintained when people only have one story being told about their lives and it becomes limiting, limited, superficial, and problem-saturated.</p> <p>Psychological distress can be alleviated by strengthening alternate narratives which enrich our lives.</p> <p>(Johnstone & Dallos, 2014)</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Mental health difficulties are the result of failed unconscious attempts to avoid pain (through ways of seeing, thinking, feeling, and behaving), which are repeated again and again due to our limited awareness of these processes.</p> <p>Psychological distress can be alleviated by getting in touch with thoughts and feelings which we previously shut off and learning to tolerate the distress caused by this.</p> <p>(Johnstone & Dallos, 2014)</p>	<input type="checkbox"/>	<input type="checkbox"/>

References

Campbell, D., Coldicott, T., & Kinsella, K. (1994). *Systemic Work with Organizations : A New Model for Managers and Change Agents*. London: Karnac Books.

Carr, A., & McNulty, M. (Eds.). (2006). *The Handbook of Adult Clinical Psychology*. New York: Routledge.

Dawson, D. L., & Moghaddam, N. G. (2015). *Formulation In Action: Applying Psychological Theory to Clinical Practice*. Warsaw/Berlin: De Gruyter Open Ltd.

Johnstone, L., & Dallos, R. (Eds.). (2014). *Formulation in Psychology and Psychotherapy (2nd ed.)*. New York: Routledge.

Segal, Z. V., Williams, J., & Teasdale, J. D. (2013). *Mindfulness-Based Cognitive Therapy for Depression (2nd ed.)*. New York: The Guilford Press.

Sulmasy, D. P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist*, 42(Special No 3), 24-33. doi:10.1093/geront/42.suppl_3.24

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford Press.

Appendix K

Participant Debrief Sheet

PARTICIPANT DEBRIEF SHEET

Thank you once again for taking the time to take part in my study.

Title of study

Decolonizing Clinical Psychology Training in Singapore: Trainee and Recently Qualified Psychologist views about diversifying therapeutic models

Aim

Research suggests that western psychology and models might not be as culturally appropriate for practice in other cultures (e.g. Henrich, Heine, and Norenzayan, 2010; Llewelyn and Shimoyama, 2012).

In their paper, Geerlings, Thompson, and Lundberg (2014) examined the history of clinical psychology in Singapore and the psychology education programmes there, concluding that western models remained dominant and cultural adjustments existed only to a “small extent”. In 2017, Geerlings, Thompson, and Tan interviewed students, faculty, and alumni from both universities which offer clinical psychology programmes in Singapore. They suggested that changes needed to be made to the curricula to develop academics’ and students’ cultural competency, which included the inclusion of other explanatory models (e.g., cultural or spiritual models). I wanted to get an updated picture of training five years on, and to expand on it by taking a closer look at which models might be more useful inclusions.

It is hoped that this study will contribute to conversations and interest around cultural competency (or cultural humility; Burgess et al., 2021), and the decolonization of clinical psychology and clinical psychology training programmes in Singapore.

Questions or Concerns

If you have any questions or concerns about the research, please contact Caleb at hw19abb@herts.ac.uk.

Alternatively, you can contact the project supervisor, Dr Pieter Nel, at p.w.nel@herts.ac.uk.

Further Reading

Burgess, A., Butler, H., Havlin, H., Holding, S., Milroy, C., Trainee Clinical Psychologists, & Dixon, C. (2021, February 9). ‘Decolonising the Curriculum: Promoting Cultural Humility’: a trainee-developed tool. Retrieved from Lancaster University Web site:
<https://www.lancaster.ac.uk/health-and-medicine/dhr/dclinpsy/news/decolonising-the-curriculum-promoting-cultural-humility-a-trainee-developed-tool>

- Geerlings, L. R., 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. doi:10.1017/jtp.2014.4
- Geerlings, L. R., Thompson, C. L., & Tan, G. (2017). Culturally Competent Practice: Experiences of Students, Academics, and Alumni of Clinical Psychology Degrees in Singapore. *Journal of Tropical Psychology*, 7(e3), 1-10. doi:10.1017/jtp.2017.3
- Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and Brain Sciences*, 33(2-3), 61-83. doi:10.1017/S0140525X0999152X
- Lee, B. O. (2018). Indigenous psychologies and approaches to wellbeing in East Asia. In S. Fernando, & R. Moodley (Eds.), *Global Psychologies* (pp. 263-277). London: Palgrave Macmillan. doi:10.1057/978-1-349-95816-0_16
- Lee, B. O., & Foo, K. H. (2019). Psychology of culture: The case of Singapore. In W. W. Li, D. Hodgetts, & K. H. Foo (Eds.), *Asia-Pacific Perspectives on Intercultural Psychology* (pp. 75-98). New York: Routledge.
- Llewelyn, S., & Shimoyama, H. (2012). Working with CBT across Cultures in Clinical Psychology with Particular Reference to Japanese Clinical Psychology, Part Three - Adapting CBT for Japanese Culture. *Japanese Journal of Clinical Psychology*, 12(4), 580-589.

Appendix L

Ethics Approval



HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Wong Hong Qiang, Caleb
CC Dr Pieter W Nel
FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair
DATE 06/12/2021

Protocol number: **LMS/PGT/UH/04737**

Title of study: Decolonizing Clinical Psychology Training in Singapore: Trainee and Recently Qualified Psychologist views about diversifying therapeutic models.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

no additional workers named

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 06/12/2021

To: 30/09/2022

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.

Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

Appendix M

Participant Information Sheet



PARTICIPANT INFORMATION SHEET

1 Title of study

Decolonizing Clinical Psychology Training in Singapore: Trainee and Recently Qualified Psychologist views about diversifying therapeutic models

2 Introduction

My name is Caleb, and I would like to invite you to take part in a study which I am undertaking as part of my Doctorate in Clinical Psychology at the University of Hertfordshire. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask me anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link:

<https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs>
(after accessing this website, scroll down to Letter S where you will find the regulation)

Thank you for reading this.

3 What is the purpose of this study?

Literature suggests that western psychology and models might not be as culturally appropriate for practice in other cultures (e.g. Henrich, Heine, and Norenzayan, 2010; Llewelyn and Shimoyama, 2012). As a student in the United Kingdom, I have been reflecting a lot on cultural differences and the cultural relevance of various therapies in working with Singaporeans. While I did my undergraduate degree in Singapore and worked in various psychology-related positions before beginning my clinical training, I am aware that I have limited experience working clinically with Singaporeans and my own training and experiences may have swayed my opinions on this.

I became curious about other Singaporeans' views about the cultural relevance of different therapeutic approaches, and how (or if) training on Clinical Psychology programmes in Singapore have tried to adapt their teaching to the local context. As such, I hope to find out more about the experiences of local trainees and recent graduates in using different therapies with Singaporean clients, and how well training on the courses might have prepared them for working with Singaporean clients.

4 Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not affect you in any way.

5 Are there any age or other restrictions that may prevent me from participating?

I am inviting **Singaporean** participants who are currently in their **final year of training or recently qualified practicing Clinical Psychologists (within the past 5 years) from local Clinical Psychology programmes** (both the National University of Singapore and James Cook University programmes). Participants should have completed their **full training in Singapore** (i.e., without any overseas components), and have **practiced Clinical Psychology with Singaporean clients for at least 1 year** (this includes placements). Participants should also be **aged 18 years old or above**.

6 How long will my part in the study take?

If you decide to take part in this study, you will be involved in it for a focus group involving a semi-structured interview and short activities, which may take place online. The focus group will last for approximately 90 minutes. There will also be short pre-interview activity for you to complete before the focus group.

7 What will happen to me if I take part?

Firstly, you will be asked to fill in some demographic questions such as your age, gender, ethnicity, training course, and current occupation. A pre-interview activity will also be given to you with a list of statements, and you will be asked to indicate which ones you related to and which ones you think your Singaporean clients relate to.

You will then be asked to join a focus group with a semi-structured interview. Participants will be split with trainees from the different courses in separate groups, which will also be separate from recently qualified Clinical Psychologists as well. You will be invited to discuss with peers about your experiences using different therapeutic models and about how well training in different therapies on your course might have prepared you for culturally-relevant practice in Singapore. Details of the focus group will be relayed to you via the contact you provide in the consent form.

8 What are the possible disadvantages, risks or side effects of taking part?

There are no known possible disadvantages, risks or side effects if you were to partake in this study.

9 What are the possible benefits of taking part?

There will be no direct benefit to you in taking part in the study. However, the discussions may be enriching as members reflect together. You may be able to see different perspectives, and these reflections may inform your learning and practice going forward, resulting in indirect benefit to you and/or your clients.

10 How will my taking part in this study be kept confidential?

Your identity will be kept anonymous and pseudonyms will be used in reports. All data will be password-protected and stored in encrypted mass storage devices. Transcripts and activity sheets will also be de-identified for storage. More details can be found in Section 12 "What will happen to the data collected within this study".

Taking part in a focus group may also mean that you may meet familiar people in the group. All participants will be asked to maintain the confidentiality of other members in the group, and will sign a consent form agreeing to do so.

11 Audio-visual material

Focus group interviews will be audio and/or video recorded. All recordings will be password-protected and stored securely on password-protected encrypted storage devices, with anonymized filenames. Only the research team will have access to all data. If transcription services are used, they will have clear General Data Protection Regulation (GDPR) policies, and will be asked to sign a confidentiality agreement. More details can be found in Section 12 "What will happen to the data collected within this study".

12 What will happen to the data collected within this study?

- The data collected within this study will be used for my thesis. All data will be reported anonymously.
- The data collected will be stored electronically on the University of Hertfordshire's One Drive. Filenames will be anonymized and files will be password-protected. Only the research team will have access to the passwords.
- The recordings will also be stored separately from data which contained personal information (e.g., consent forms).
- Consent forms, demographic data, and audio recordings will be destroyed securely upon completion of the study.
- Password protected and de-identified transcripts and activity sheets (with names removed) will continue to be stored securely on an encrypted mass storage device for 5 years to allow for potential secondary analysis. Following this period they will also be destroyed securely.
- If a transcription service is used for recordings, they will be sent with a different password. Passwords will be sent to the service in a separate email from the data files. The service will have clear General Data Protection Regulation (GDPR) policies, and will be asked to sign a confidentiality agreement.

13 Will the data be required for use in further studies?

- The data collected may be re-used or subjected to further analysis as part of a future ethically-approved study.
- Password protected and de-identified transcripts and activity sheets (with names removed) will continue to be stored securely on an encrypted mass storage device for 5 years to allow for this. Following this period they will also be destroyed securely.

14 Who has reviewed this study?

This study has been reviewed by the University of Hertfordshire Health, Science, Engineering & Technology Ethics Committee with Delegated Authority.

The UH protocol number is LMS/PGT/UH/04737.

15 Factors that might put others at risk



Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

16 Who can I contact if I have any questions?

If you would like further information about the study or would like to discuss any details personally, please get in touch with me via email at hw19abb@herts.ac.uk.

Alternatively, you can contact the project supervisor, Dr Pieter Nel, via email at p.w.nel@herts.ac.uk.

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix N

Participant Consent Form



CONSENT FORM

Please read the Information Sheet before completing this Consent Form. If you have any questions, please feel free to contact the Principal Researcher.

Title of Study: Decolonizing Clinical Psychology Training in Singapore: Trainee and Recently Qualified Psychologist views about diversifying therapeutic models

The study has been approved by the University of Hertfordshire Health, Science, Engineering & Technology Ethics Committee with Delegated Authority (**UH Protocol number:** LMS/PGT/UH/04737).

Name and contact details of Principal Researcher:

Caleb Wong, Trainee Clinical Psychologist, University of Hertfordshire
hw19abb@herts.ac.uk

Department:

School of Life and Medical Sciences, Doctorate in Clinical Psychology, University of Hertfordshire

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time up until the end of the interview without disadvantage or having to give a reason.

3 In giving my consent to participate in this study, I understand that voice or video recording will take place and I have been informed of how/whether this recording will be transmitted.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

5 I understand that I may meet familiar people in the focus groups. I agree to maintain the confidentiality of other participants, and have been assured that all participants would also have agreed to maintain my confidentiality as well.



6 I understand that information provided for this research may be published in a journal, Web site or other form of publication without my name attached, and that efforts will be made to conceal my identity, but that anonymity cannot be guaranteed.

7 I understand that my participation in this study may reveal findings that could indicate that I might require medical or mental health advice. In that event, I will be informed and advised to consult relevant third parties such as my GP.

8 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

9 I have been told that I may at some time in the future be contacted again in connection with this or another study.

I, the undersigned *[please give your name here, in BLOCK CAPITALS]*

.....

of *[please give contact details here, e.g., a mobile number or email address]*

.....

hereby freely agree to take part in the study entitled

Decolonizing Clinical Psychology Training in Singapore: Trainee and Recently Qualified Psychologist views about diversifying therapeutic models

(UH Protocol number: LMS/PGT/UH/04737)

Signature of participant.....Date.....

Signature of (principal) investigator.....Date.....

Name of (principal) investigator*WONG HONG QIANG, CALEB*.....

Appendix O

Example of Transcript Coding

Ben: I wanted to – Sorry, I wanted to add on and I was waiting for Diane to respond first la, cuz she haven't say anything (laughs). But, but actually you know when Ella and Chende, and then Amelia was talking about um, how they uh, in terms of like spiritual aspect right, so it got me thinking about the kind of clients that I'm seeing and so in one of the particular sites – this is post training, uh, but a lot of the clients that I was seeing came from, uh, they were using substances and uh, they.. most of them are stigmatized minorities. So they may be diagnosed with HIV, most of them are gay, um, and the idea of uh, the spiritual, uh religion can be actually very traumatic for them. A lot of them had undergone some kind of religious trauma. So speaking of spirituality was quite challenging. Uh, with the exception of those people who were part of like Narcotics Anonymous. So a lot of them saw that spiritual element to it la. Um, but then it got thinking right, which is because you asked a question which is, um, what about your client that influenced the kind of modality or orientation that you go towards. What kind of demographic. And I realized that even though the clients, um, uh, were of a similar demographics, so substance use, gay, um, HIV, had underwent various form of abuses in their lives, uh, their – the way I can actually see myself conceptualizing each of them in a different modality. Like psychodynamic framework, or like ACT framework, and then, which got me thinking right – I mean what is it about training, right, that perhaps predisposes us to choose particular or favour particular orientations more than the others. But then as I was thinking I was like actually during the training, I wasn't trained in psychodynamic work, I wasn't trained in – ok maybe ACT, but a lot of things that I'm using today was not necessarily provided for in the 2 years that I was in NUS, if we focus on the academic training, right? Then, um, but at the same time I think something about training that what it gave us was perhaps, or rather what it gave me was perhaps a healthy respect for different modalities. That each of them have their utilities in various contexts. And I remember one thing my lecturer really emphasized was the idea of evidence, like, there needs to be evidence - that kind of evidence that's involved, is there evidence? Um, Which I think, for, it still now it still colours my lens, like when I look at different modalities the first thing I think of is how much evidence is there, right? But then... increasingly I also doubt that as well? Because some modalities just tend to produce evidence. (laugh) SO then I start to question myself. So so I guess I guess to some extent the training that we provided, provided me with that kind of appreciation for evidence and the importance of that, but it also allowed me - it's kind of like a starting point for me to start exploring what the meaning of evidence and what's the applicability of different orientations for people, not necessarily learning that that orientation. Yeah, that's from what I'm thinking.

CODE STRIPES

Coding Density

- Clients' preferences and expectations shaped by social media
- Academic teaching influences the me
- Systemic therapy is culturally relevant
- CBT may not be as effective for all groups of Singaporeans
- Using too many models may be confusing
- ACT is culturally relevant
- Impact of interviewer & topic on participant responses
- Spiritual models may not resonate as well with some clients
- Singaporeans tend to be more cognitive and less in tune with emotions
- CBT provides concrete, goal-directed focus
- Not wanting to have to use clients as learning opportunities
- Generational differences
- Educated and psychologically minded
- Socioeconomic status
- Older generation hold more cultural and spiritual beliefs
- Intergenerational differences in explanatory models may lead to distress
- Matching models to formulation
- DBT can be too airy-fairy for some Singaporeans
- Academic teaching focused on CBT
- Borrowing ideas but using CBT as a base
- Course could be lengthened if trainees were paid
- Learning from work experience that spiritual factors may also contribute to distress
- Roleplays with different cultures
- Increased diversity in client populations on placements
- Academic focus pro
- Focus on one model provides groundwork to apply other models more rigorously in future
- Mandating personal therapy for trainees
- Cultural competence involves staying curious about differences
- Experience post-training has eno
- Worry about reinforcing stereotypes and assumptions
- Academic teaching on culture was broad and generic
- There is limited time on courses to focus specifically on diversity
- Clients from other countries may hold different cultural values
- Focus on CBT hones expertise in one modality
- More training in working with clients from other countries
- All somewhat resonate with me
- Academic teaching did not encourage

Interviewer: Interesting. Do you mind if I ask, so you, you were sort of speaking a little bit about how evidence was kind of a big focus on training and you find yourself sort of moving a little bit away from that. Is that something that happened during training as well, or was it something that happened mostly after training?

Ben: I think it's umm, after um, perhaps more after training, um, because the kind of client population that I was exposed to, um, a bit of context – so, uh, out of sight out of mind, main line of work. Uh I volunteer at primarily for stigmatized minorities, so uh, LGBTQ+ queer folks, um, sexual health, uh, substance use, and I found that the.. the traditional uh, oh, you know CBT gold standard, go for it kind of thing may not necessarily apply too well for that, and I, I start to wonder whether or not it's because these kinds of populations are not being captured within that kind of discourse in Singapore, right? And does that mean that other modalities which may perhaps have a little bit more research, uh, may not be seen so much, uh, it may not be the kind of you don't really learn how to work with that so much? So, so, my thoughts are a bit jumbled up, so I mean for the others, if you echo anything, or you disagree please tell me – it's.. it's I just had my first cup of coffee so... (laughs) not yet, not yet. Ya.

Ella: Uh, I actually agree with what Ben said. So I think when I graduated, especially – actually during training I was very strict in sticking to all the evidence based practice, you know, follow the manual and things like that. But after that when I work, I started to realize like some things just didn't seem to work very well with the clients we're seeing. And like Ben said I also started to wonder if it's just that, you know, the – like some subset are not captured right? Some subset of clients are not captured, and it makes me wonder – if we only stick to the evidence-base, is it also a bit unfair to these other clients for whom other types of therapies may be more suited? So like, for example, like uh, existential therapy (laughs) – it's really very, it's not super evidence-based compared to like CBT or something but I found that a lot of the people especially when they've been stuck in residential homes for like 20-30 years and they have – they feel like they don't really have a lot of hope, um, talking to them about things like meaning – more meaning-based work has been a lot more helpful, especially with substance-use also. I find that when you just teach them the typical strategies, it might not be as helpful as if you help them to find some purpose – more like they want to move towards. Ya, and ya, something that guides them overall. And before I start rambling on, I'm gonna stop. (laughs) And have more coffee.

Chende: I think my perhaps I feel like I'm a bit like in the early stages of what Ella and Ben is going through now. Which I think, um, I guess I am I think as what they have shared la and then... I think, um, yeah, I think our course kind of very much, just very heavy on CBT, but I think the – the nice thing is also, I think over the different modules they kind of always kind of always augment a bit of – ok like, CBT but you can do a bit of narrative, you can do a bit of motivation interview. So I think that kind of slowly shifted our lens la. From OK, since I have evidence base, since I see this is the way to go, but kind of I guess get us, uh, starting to explore a bit “eh maybe something, uh, is not quite fully targeted area that's why we kind of need to combine something.” Eh maybe that's why we are all searching for some other random – not random, sorry (laughs), I mean searching for other modalities and kind of other (inaudible) eh – what's this thing that's lacking or missing. Um, but I thought at the same time, I guess, uh I think that's kind of what I guess that's what helped me. I think also because of my academic-wise cuz I think my professors, my research professors are also the kind that kind of have at different points tells me that “eh CBT is kind of the whole group right, but you know, there may be people sometimes in the middle that – like one or two, that kind of drop out, or kind of not quite respond. Maybe they are the ones that actually potentially need some alternative, um, therapy la. Which I think then my prof is very also very UK trained very hardcore CBT, so she kind of said, “But NICE guidelines they talk about second alternative”, and bla bla bla – so I think that's where I kind of “OK, sounds like this is really not just the only to go-to kind of thing.” Um, um, but ya. I think that's my experience. I mean I spoke to a friend from, uh, colleague who's actually trained in JCU. So she interestingly, she was telling me that at her course they are taught – I'm not sure, maybe Diane can kind of share a little bit if that's the same experience – but she kind of said that what was very different in JCU, they are basically taught “eh we are going to teach you 3-4 modalities at one shot, see which one fits with your client then use that with the client.” But I think for us, at least in my experience, it's kind of academic, it's “ok CBT is the best evidence. Use CBT first – all else fails, and then kind of then see what you do – you adjust, or you kind of combine with other thing, but CBT is the base. Something like that – that's my feel la. That's my experience. Ya. Maybe Amelia and Diane can share whether that's kind of similar experience, and maybe Diane can – I don't know, hear from you about JCU training?

CODE STRIPES

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- Clients' preferences and expectations shaped by social media
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- ACT is culturally relevant
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- Singaporeans may not resonate as well with some clients
- CBT provides concrete, goal-directed fixes
- Not wanting to have to use clients as learning opportunities
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- Clients from other countries may hold different cultural values
- Focus on CBT hones expertise in one modality
- More training in working with clients from other countries
- All somewhat resonate with me
- Academic teaching did not encourage reflections on evidence base

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- More training in working with clients from other countries
- All somewhat resonate with me
- Religiousity and traditionality
- Academic teaching did not encourage reflect

Appendix P

Initial Thematic Diagram

