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Cultural Competence in Clinical Psychology Training: A Qualitative Investigation of Student and Academic Experiences

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Objective: Recent years have seen a marked increase in attention to cultural competence in clinical psychology practice in Australia. While the body of literature on the need for cultural competence is expanding, this is the first study that analyses how cross-cultural training and practice is experienced and related to standardised models of cultural competence.

Method: Twelve participants (8 students and 4 academics; 9 females and 3 males, ages 22–57) in two Australian universities were interviewed on their experiences with cultural competence during clinical psychology training. Each semi-structured interview took about 30 min and focused on identifying the training experiences and needs for cultural competence.

Results: Interpretative Phenomenological Analysis of the transcripts delivered three master themes: experiences of culture, strategies for culturally competent practice, and experiences of cultural competence development.

Conclusions: Students and academics experienced a "western" bias in training, and consequently adopted a variety of strategies to adapt their practice with culturally non-western clients. These findings draw attention to the need for structured cultural competence development in professional training programs.

Key words: clinical psychology education; cultural competence; cultural diversity; Interpretative Phenomenological Analysis (IPA); professional psychology.

What is already known on the topic

1 The importance of cultural competence as a key attribute of clinical psychologists practicing in multicultural Australia has been widely acknowledged by professional organisations, tertiary education institutions, and in the academic literature.
2 There is uncertainty about what cultural competence entails for clinical psychologists in Australia. Different models for cultural competence are used by professional organisations and are integrated in tertiary clinical psychology curricula, including Cross, Bazron, Dennis, and Isaacs' (1989) cultural competence and Sue et al.'s (1982) tripartite model.
3 More systematic cultural competence training of clinical psychologists is needed. However, in order to determine how this need can be met, more knowledge is needed into what cultural competence entails, and how it is developed.

What this paper adds

1 The struggle to adjust western-biased clinical psychology models and methods with culturally non-western clients shapes the strategies for cultural competence.
2 Strategies for cultural competence used by students and academics in Queensland are consistent with theoretical models for cultural competency, and with strategies reported in research from other geographic and cultural localities in Australia, which suggests that standardised models may be useful to guide more formalised cultural competency training.
3 Cultural competency training needs to be systematically addressed in clinical psychology programs. The building and maintenance of cross-cultural professional and personal collaborations is important as a means for developing cultural competence.

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Clinical psychologists in Australia are required to practice in culturally diverse settings. Australia is home to diverse communities, including Aboriginal and Torres Strait Islander peoples, and a large migrant population, with almost half of Australia's population being born overseas or being offspring of an

overseas-born parent (Australian Bureau of Statistics, 2012a, 2012b). However, clinical psychology training and practice remain strongly oriented towards models for mental health and therapy that were largely developed for European and North American populations (Geerlings, Thompson, & Lundberg, 2014). This raises concerns about the applicability of these "western" models in multicultural settings, especially in Indigenous contexts (e.g., Ford, 2013; McConnochie, Ranzijn, Hodgson, Nolan, & Samson, 2012; Ranzijn, McConnochie, Clarke, & Nolan, 2007; Vicary & Bishop, 2005). Consequently, psychologists need to culturally adapt the practices of clinical psychology (Khawaja, McCarthy, Braddock, & Dunne, 2013; Nelson et al., 2014; Ranzijn et al., 2007) in order to provide "cultural safety" when practicing cross-culturally (Walker & Sonn, 2010). Cultural competence is thus an essential attribute of clinical psychologists in Australia.

The call for culturally competent clinical psychology practice has been met with training and research initiatives. The Psychology Board of Australia lists cultural competence as an ethical guideline and requirement for practice endorsement (Psychology Board of Australia, 2011). In addition, the Australian Psychological Society's (APS) Code of Ethics states that psychologists need to "have a high regard for the diversity and uniqueness of people and their right to linguistically and culturally appropriate services" (APS, 2014, p. 11). The APS has also provided specific ethical guidelines for the provision of psychological services for, and the conduct of research with Aboriginal and Torres Strait Islander people (APS, 2015). Moreover, the Australian Indigenous Psychologists Association promotes the cultural competency of psychologists in Australia through workshops (Australian Indigenous Psychologists Association, 2016). Finally, the Australian Psychological Accreditation Council (APAC), the body that accredits Australian psychology university degrees, requires professional programs to focus on developing students' familiarity with cultural issues and their interpersonal professional skills for cross-cultural practice (APAC, 2010). More specifically, APAC standard 5.1.12(b) requires graduates to demonstrate familiarity with legal and professional matters, including cultural issues, and issues for minorities and marginalised groups. APAC standard 5.1.12(c) draws attention for psychologists to be aware of limitations of psychological tests in relation to cultural issues, and standard 5.1.12(f) stipulates that oral communication and interpersonal skills should include groups and agencies from varied cultural backgrounds (APAC, 2010). While the standards for curricula make explicit reference to cultural awareness and competence, there are no specific guidelines as to how these standards should be met in formal clinical psychology training.

The concept of cultural competence was introduced in Australia to guide initiatives in multicultural clinical psychology practice and research (e.g., McConnochie et al., 2012; Ranzijn, McConnochie, Day, Nolan, & Wharton, 2008; Walker & Sonn, 2010). Several models of cultural competence are currently used, including Cross et al.'s cultural competence (1989) and Sue et al.'s (1982) multicultural counselling competency (MCC).

Cross et al.'s (1989) cultural competence model is used by the Australian Indigenous Psychologists Association in their cultural workshops for non-Indigenous psychologists (Australian Indigenous Psychologists Association, 2015). The model depicts cultural competence as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross et al., 1989, p. iv). On the level of the individual, culturally competent psychologists value diversity, are culturally self-aware and reflective, are aware of the dynamics in multicultural interactions, possess cultural knowledge, and are able to adapt culturally (Cross et al., 1989).

Sue et al.'s (1982) tripartite model of MCC asserts that culturally competent psychologists have developed *awareness*, *knowledge*, and *skills* (Sue et al., 1982). Multicultural awareness refers to practitioners' consciousness of their own biases, beliefs, and values, and how these may affect clients. Multicultural knowledge refers to familiarity with cultural groups and social and political systems in practitioners' own country and the client's country of origin. Finally, multicultural skills refer to the ability to communicate adequately and appropriately with a variety of cultural groups, and to exercise adequate intervention skills on behalf of culturally diverse clients (Sue et al., 1982). Although Sue et al. (1982) and Cross et al. (1989) define the construct and offer a method of measurement for cultural competency, these models do not offer any guidance as to how training programs can develop these competencies in students.

There is a growing interest in the study of multicultural practice in Australia through the analytical lens of cultural competence. The MCC model has been applied to Australian psychologists working with culturally and linguistically diverse communities (Khawaja, Gomezi, & Turner, 2009) and it was shown that psychology students' MCC is partly related to multicultural clinical experience and supervision (Lee & Khawaja, 2012). Vicary and Bishop (2005) interviewed 70 members of various Aboriginal communities on culturally competent mental health practice. They noted a misfit between "western" clinical psychology and Aboriginal communities' conceptualisations of mental health and approach to treatment, and stressed the importance of cultural competency training in curricula of clinical psychology degrees (Vicary & Bishop, 2005). More recently, O'Connor, Chur-Hansen, and Turnbull (2015) analysed interviews with eight psychologists on the professional and personal competencies they used when practicing with Indigenous youth. The psychologists emphasised the importance of cultural knowledge, observing cultural norms, and adaptive practice, in addition to basic psychotherapeutic skills. The authors also argued for the need to include cultural competency training in clinical psychology degrees (O'Connor et al., 2015). The call for more systematic cultural competency training was also made in another study based on interviews with 23 non-Indigenous psychologists working in Indigenous contexts, who reported gaining cultural competency on a "trial-and-error basis" (McConnochie et al., 2012). Taken together, these studies demonstrate the need to include cultural competency training in tertiary curricula.

Yet, to date, no research has been conducted on the perspectives of students and academics about acquiring cultural competence in clinical psychology training. This indicates a lack of

knowledge in how well students' and academics' experiences actually map on the standardised models for cultural competence, and how well-prepared graduates feel for cross-cultural practice after their professional clinical psychology training programs.

The present study addresses this gap using a qualitative research approach, which is especially suitable for exploring and understanding individual experiences. It focuses on the question: how do students and academics of clinical psychology experience preparation for culturally competent clinical psychology practice? This question is explored through interviews with students and academics in two universities based in Queensland, a northern Australian state which is home to different communities of populations of Aboriginal and Torres Strait Islander people (Australian Bureau of Statistics, 2012a), multiple migrant groups with ancestry from the United Kingdom, Europe, Asia, the Pacific, Middle-East, and Africa, and former refugees from various parts of the world (Australian Government, 2012). Interviews are explored through Interpretative Phenomenological Analysis (IPA).

Method

Participants

Twelve participants were interviewed, including eight students (age $M = 26.3$, range: 22–31 years) and four academics (age $M = 50.3$, range: 45–57 years). Nine participants were female, and three were male. Seven of the 12 participants self-identified as Caucasian Australian. No participants identified as Aboriginal or Torres Strait Islander, which could reflect the low number of Indigenous professionals and students of clinical psychology (Australian Indigenous Psychologists Association, 2016). Further demographic information is not reported in order to maintain confidentiality.

Procedure

After institutional ethics approval, students and academics of clinical psychology in two universities that provide 2-year masters and 3-year doctoral programs in clinical psychology were invited to participate. Recruitment took place via emails to staff and students ($n = 6$) and through snowball recruitment ($n = 6$). Eleven semi-structured interviews were conducted face-to-face on-site at the participating universities; one interview was conducted by telephone. All interviews were conducted by the same interviewer and took an average duration of 30 min (range: 20–41 min). Interviews were audio-taped and were transcribed verbatim with NVivo analysis software. Participants were invited to check the transcripts for accuracy and sufficient de-identification, and those who did this approved of the transcripts. After the interview, one participant provided additional information by email.

An interview outline of open-ended questions inviting participants to describe and reflect upon their experiences of studying, teaching, or practicing clinical psychology (see Appendix). The interview was piloted with a clinical psychologist not otherwise involved in the study (data not included) then used in a flexible manner with interviewees encouraged to introduce thoughts related to the research topic.

Data Analysis

Qualitative analysis used an IPA framework to gain insights into the lived experiences of events from the perspective of the participant (Larkin, Watts, & Clifton, 2006; Smith, Flowers, & Larkin, 2009). This procedure begins with data familiarisation, and with noting descriptive, linguistic, and conceptual comments on the transcripts. All comments were categorised based on similar meaning into themes that focused on the participant's experiences of preparing for multicultural practice. In turn, these themes were organised into superordinate themes based on similarity in meaning, thereby generating a list of superordinate themes for each of the 12 transcripts. One analysis was independently audited by an IPA expert and generated high similarity of the researcher's and auditor's interpretations, thus it was decided that no further auditing was required.

To form homogenous samples for IPA, student and academic interviews were then analysed in two separate groups. Group analyses focused on identifying patterns and constructing master themes that summarised the experiences of each group: students and academics. The superordinate themes demonstrate the strength of the qualitative method as they provide insights into the lived experiences of teaching and studying clinical psychology using the voices of individual participants, rather than predefined constructs in a survey. There was considerable overlap in superordinate themes between the groups. Therefore, superordinate themes were collated into three shared master themes, which are presented in Table 1. Superordinate themes were included in shared master themes if they were present in half of the interviews of that group (students, academics) or more (Smith et al., 2009).

Results

The themes (see Table 1) cover experiences of culture, strategies for multicultural practice, and teaching and learning experiences of multicultural practice. The themes are discussed below for students and academics together. Participant quotes are italicised, and brackets are used to identify material that was omitted, added, or changed in the participant quotes for clarification and confidentiality.

Experiences of Culture

The first theme covers the context of multicultural clinical psychology practice, which shapes how cultural competence is experienced and practised. It shows that students and academics of clinical psychology experienced cultural influences in clinical psychology training and practice in three important ways. First, clinical psychology theories, knowledge, and practices taught in the training programs were perceived as culturally "western," particularly during clinical practice. Second, and relatedly, participants felt they exert cultural influence through clinical judgement. Third, culture was experienced as a factor in professional relationships in cross-cultural teaching or practice.

Table 1 Distribution of Master- and Superordinate Themes per Participant Group

Master theme	Superordinate theme	Type[a]	Students								Academics			
			S1	S2	S3	S4	S5	S6	S7	S8	A1	A2	A3	A4
Experiences of culture	Western "feel" to training	J	X	X	X	X	X	X	X	X	X	X	X	X
	Exerting cultural influence	J	X	X	X		X	X	X	X	X	X		X
	Cultural relationships	J	X	X	X	X	X	X	X	X	X	X	X	X
Strategies for cross-cultural practice	Adaptive practice	J	X	X				X	X		X	X		X
	Cultural dialogue	S	X	X	X	X	X			X	X			X
	Cultural knowledge	S	X	X	X	X	X			X	X			
	Cultural self-awareness	A			X							X	X	
Learning/teaching cultural competency	Personal interactions	J	X	X	X	X	X	X		X		X	X	
	Professional training curricula	J	X	X	X	X	X	X		X	X	X	X	X
	Personal dedication	S		X	X	X	X	X		X			X	
	Role modelling	A					X				X		X	

[a] Type of theme: A = theme identified in at least half of the academic interviews; S = theme identified in at least half of the student interviews; J = joint theme, identified in at least half of the student and half of the academic interviews

"Western feel" to training

Students and academics experienced their clinical psychology training and practice as culturally "western" and thus felt well prepared for practicing with culturally western Australians, but felt less confident in practicing with culturally non-western clients, including Indigenous Australians:

> *I'm going to be replicating things, you know, especially at the beginning, from what I've been taught which may be flawed or very Western or Australian kind of biased…*

This participant, situated at the beginning of clinical psychology training, expressed a thirst for didactic knowledge or tools for cross-cultural practice, which stemmed from an awareness of cultural bias in clinical psychology. This suggests for this participant, cultural competence training should focus mainly on training in knowledge and skills. However, while participants acknowledged the attention for cultural issues in their clinical psychology curricula, especially for practice with Aboriginals, Torres Strait Islanders, and Asian clients, these components were considered as an "add on" to the curriculum, rather than an adequate preparation for working with these diverse clients. Consequently, being aware of these limitations, students experienced a sense of insecurity and inadequacy when they started to practice cross-culturally:

> *I suppose a lot of our concepts that we learn about and our techniques […] have a very western feel to it. […] When you are training, you don't really consider it. It is only when you actually go out and have more of a multicultural clientele or client-base, that you then realise—oh, how do I actually, you know, adjust my way of thinking or even my way of talking to people to fit with their, I guess.... just to be more culturally appropriate.*

Participants rationalised that the "western feel" to clinical psychology training may be related to the discipline's historical development in the west and its continued reliance on research from "western" countries. Participants identified "western" cultural values, such as individualism and self-actualisation, in therapeutic models.

Exerting cultural influence

A second way in which culture was experienced was through clinical judgement: participants reported experiences of exerting cultural influence through diagnosing mental disorders. These experiences relate to the previous theme in that classification systems and theories of psychopathology taught during training programs were considered to be western biased, and perhaps not cross-culturally applicable. Consequently, participants considered clinical diagnosis as judgements based on "western" cultural values.

Participants feared that their narrow norms for behaviour and western-biased models for psychopathology could lead them to "erroneous assumptions," or to mistakenly regard culturally informed behaviour as psychopathology. A frequent example of this fear for doing cultural damage provided by participants related to psychosis and belief in spirits:

> *Trying to separate what is cultural and what is a mental health issue… I guess we don't realise how difficult it can be until they're there in front of you and they're speaking about hearing people from their family talking to them… But for an Indigenous Australian it is actually culturally appropriate for them to feel spirits of their family, their ancestors.*

Furthermore, some participants considered diagnosing psychosis a problematic act of favouring of the western culture propagated by clinical psychology over Indigenous Australian cultures. Therefore, participants faced the difficult task of balancing clinical categorisation and openness towards clients' cultural experiences:

> *I'm trying to be open towards other people's experiences, but having your own idea of what you think and what you think pathology is and what psychology is and how it works—that can be difficult sometimes.*

Thus, having gained some awareness of diversity, beginning practitioners struggled with finding the tools for cultural competence.

Cultural relationships

A third way in which participants experienced culture was through professional relationships. Students and academics experienced cultural impacts on their professional relationships, and their enactment of their roles as students, academics, or practitioners. Culture was experienced as "influences" on values and beliefs, ideas about psychology, communication styles, and behaviour. In multicultural clinical psychology practice, such influences were regarded as factors that practitioners should engage with in order to establish rapport and an effective professional relationship: "I'm more effective [practicing] with someone from my own culture, […] because then you just don't have to address these other things that may come up." This participant quote illustrates that for some participants, culture was regarded as a factor present in a different "other," rather than in all clients and practitioners. It also demonstrates a pathway of developing cultural competence in which awareness of diversity has developed ahead of sufficient cross-cultural practice skills.

Consequently, some participants experienced culture as a barrier in building effective professional relationships. For example, practicing academics recalled experiences in which clients had difficulty disclosing personal information in a cross-cultural practice setting. Culture was also experienced as a barrier in establishing personal connections between supervisors and clinical psychology trainees:

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

This quote draws attention to the difficulty of cross-cultural engagement and understanding that was experienced at times. According to this participant, learning how to practice and while simultaneously learning how to understand aspects of Australian culture presented by clients, was a struggle for international students. The participant, in turn, expresses a lack of effectiveness in engagement for cross-cultural supervision.

Cultural differences between practitioners and clients, or between academics and students, could thus complicate therapeutic and supervisory relationships. However, according to two participants, being personally different from the cultural mainstream could benefit therapeutic relationships. These two participants discussed their status as cultural minorities in Australia as an aid to rapport building with other cultural minority clients.

Strategies for Multicultural Practice

The second theme conveys four strategies identified for culturally competent practice. Both participant groups emphasised the importance of adaptive practice. Students identified strategies of talking about cultural differences and applying cultural knowledge, while academics identified the need for practitioners to be reflective of their own culture.

Adaptive practice

The adaptability of the psychologist's behaviour and communication styles, therapeutic approach, and application of clinical psychological models and procedures was considered an important strategy for multicultural practice. Participants recalled examples of a wide range of adaptations in their cross-cultural practice: from making less eye contact, to adopting a more hierarchical therapeutic approach to suit a client seeking expert advice, or modifying therapeutic procedures or test protocols.

Participants' experiences suggest that adaptive practice is facilitated by practitioners' critical reflection on their practice. Students and academics reported enhanced self-awareness and situational awareness during sessions with culturally different clients:

> *I felt like I was more aware of […] how I was sitting, how I was talking, my tone of voice, whether I was making eye contact. […] And being aware that there could have been a cultural bias in test results due to the setting, and even [due to] the fact that I am a female talking to a male client. So I guess going into it with a sort of a filter of: 'this is a culturally different situation, these are all the things I need to keep thinking of,' whereas if it was [a client] who was of a non-Indigenous background I wouldn't have as strong as a feel for that.*

For this participant, cultural awareness and knowledge helped with developing a sense of cultural competency. The quote illustrates that for commencing practitioners cross-cultural practice requires a conscious application of cultural competencies and continuous monitoring.

Ongoing critical reflection helped especially new practitioners to adapt to culturally different clients. Academics expressed more confidence than students in their ability to practice adaptively. Academics perceived cultural differences as "just another difference" between clients that they should work with, and considered their basic therapeutic skills sufficient for adaptive practice. Students, however, reported relying on additional strategies for adaptive practice: talking about differences and using cultural knowledge.

Cultural dialogue

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

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

A few students recalled their positive experiences of such feedback sessions in building rapport with their clients and gaining cultural knowledge. Cultural dialogues helped students to develop the knowledge and skill to bridge cultural distance. The cultural dialogue was also considered a preferred strategy for cross-cultural practice to some students who did not yet have any multicultural practice experience. For these students with a baseline level of cultural awareness, the cultural dialogue relieved their fears of doing cultural damage.

Some participants maintained a cultural dialogue throughout cross-cultural clinical practice, instead of solely the start or end of a session. These students, and some academics, consulted clients' on cultural issues whenever necessary: "When I'm not sure about something I would ask them 'okay, is this usual practice in your culture?' and sometimes they would just tell me." This skill of continuous cultural dialogue helped participants to adjust their behaviour to the expectations of their clients, and helped them gain more insight and empathy for their clients' perspectives. Thus, the cultural dialogue was aimed at understanding differences between practitioner and client, rather than similarities.

Cultural knowledge

Students identified the need for being knowledgeable of different cultural groups in Australia and their values and beliefs, and of cultural influences on psychopathology and practice. Students experienced that cultural knowledge helped them to develop empathy for culturally different clients, to manage their expectations of their clients' behaviours, and assisted in clinical judgement. In these ways, cultural knowledge positively influenced students' self-perceived cultural skills as it eased the uncertainty of how to practice in a cross-cultural setting and relieved the fear for doing cultural damage:

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

Cultural self-awareness

Academics identified the need for practitioners to be culturally self-aware and to be conscious of how their own cultural backgrounds, values, beliefs, behaviours, and expectations influence their clinical psychology practice:

> *You need to know who you are first and you need to know your worldviews, how it is that you come to be who you are, before you can even begin to understand someone else. If you don't know yourself, you can't know someone else.*

This participant quote suggests that development of cultural self-awareness needs to precede the development of cross-cultural knowledge and skills. In addition, this quote highlights that according to academics, culture is not exclusive to an exotic "other," but that culture is in any person—including oneself.

Thus, cultural self-awareness was considered a basic requirement for good clinical practice, regardless of whether practice is cross-cultural or not. Combined with unconditional positive regard and open-mindedness, culturally self-aware practitioners would be able to connect with clients from any cultural background: "Essentially people are people. […] We all want a connection with someone else, any cultural group in the world." Academics thus emphasised similarities between people, seemingly universal needs and, accordingly, self-awareness and clinical skills that are likely to be applicable in any practice.

Teaching and Learning Cultural Competence

All participants stated that future clinical psychologists need to be especially prepared for multicultural practice in Australia. The final theme conveys three important learning experiences for cultural competency. Both students and academics experienced personal interactions and cultural training in professional clinical psychology programs as important pathways for developing cultural competence. In addition, students felt that personal dedication, initiative, and transformation are key to cultural competency learning.

Personal interactions

Looking back at how they learned to practice cross-culturally, participants felt that "you can learn only that much from a book." All participants recalled personal interactions with clients, lecturers, supervisors, peers, or colleagues of different cultural backgrounds as key learning experiences for cross-cultural understanding and ability. Such interactions were usually informal, and took place in the corridors at the work place or in the private sphere. Importantly, cross-cultural social interactions provided participants with more understanding and sympathy for different perspectives, knowledge on cultural practices and beliefs, and a feeling of competency in maintaining cross-cultural relationships.

Some participants considered cultural training programs to be especially helpful when they were delivered by cultural minority facilitators:

> *And I think it was that personal experience [shared by the Indigenous workshop facilitator] that really made it for me, made me understand what… like what, sort of those, what they experience, whereas I don't think, I don't think a Caucasian person can give me that. They can teach me all the skills and tell me: 'so if they are not looking at you they are not being disrespectful, and blah, blah, blah'—but I think it means more and I get a better understanding of the culture and of the experiences of the person when it's coming from someone who is coming from that culture.*

Personal experiences shared by academics or practitioners of a cultural minority made long-lasting impressions on this participant, and this was echoed by other participants. It helped participants to gain more understanding of experiences of cultural minority persons. In addition, cultural information coming from a person of cultural minority background was also

considered to be more reliable and trustworthy. One participant added that, especially in relation to Indigenous Australians, it may be more respectful to address cultural questions to a cultural insider instead of to an outsider.

Professional training curricula

Most students and academics experienced a shortage of attention to cultural issues in training curricula, and identified the need for more cultural components in their professional training programs. The need to integrate cultural issues in curricula is especially pertinent as the majority of academics and trainees are part of the cultural majority group in Australia. Culturally mainstream students and academics were conscious of their limitations in cultural awareness:

> *It is kind of like: does the fish know that it is swimming in water? […] It is really hard to see which aspects we are learning are really exaggerated western components that to someone who is not Caucasian will be 'oh my God, that's so western!' To me, I'm not going to be sensitive to that material, so it is hard for me to know how western it is because I* am *western.*

Participants thus experienced clinical psychology curricula as an important means to provide culturally mainstream students and academics with the necessary exposure to cultural issues to enhance their cultural awareness. This was also expressed by participants of cultural minority backgrounds: "I do worry about my peers, especially the white ones […] who have not much exposure to different types of culture." The need to include cultural competency training in clinical psychology degrees is thus very pertinent.

Nearly all participants opined that clinical psychology curricula should include components that help raise awareness and knowledge of cultural issues, as well as help students develop skills required for cross-cultural practice. When such cultural components were included in clinical psychology curricula, they were experienced as beneficial for cultural awareness: "I definitely appreciate it… It provides a different way of viewing the world, it is helpful for me to see that there are different ways of viewing things."

Personal dedication

Students experienced their training in cultural competency as an important personal development journey. Learning how to practice cross-culturally was experienced as a transformation on professional and personal levels. Students felt they learnt to "realise that you don't know everything" and needed to "learn new perspectives" and to "think outside the box." At times, this learning process was overwhelming and anxiety provoking: "I feel a bit overwhelmed thinking about how much practice I am going to need to feel competent in working cross-culturally." Consequently, students experienced that their cultural competency learning required personal dedication and perseverance. Learning how to practice cross-culturally is a personal learning process, and needs intrinsic motivation.

Some students expressed feeling responsible for their cultural competency learning as part of an ethical obligation to reconciliation, and equality in Australia. These students were motivated to work cross-culturally, and were frustrated with the lack of attention to cultural issues in their training programs: "There are so many issues and such huge misunderstandings. So you've got the whole gap thing, and there's the Stolen Generation. So [academics] completely ignore all that, all those cultural aspects! I think that is ridiculous!" These students actively sought supplementary learning experiences, such as extracurricular workshops and cross-cultural social interactions, to help their learning process.

Discussion

We have explored experiences of students and academics of preparing for culturally competent clinical psychology practice. Overall, the findings demonstrate that students and academics experience a "western" bias in training and practice, which highlights the need for developing cultural competence. While acknowledging the efforts made by their universities to address cultural issues, students struggled to apply their "western" knowledge and practices when working with Aboriginal and Torres Strait Islander clients, or with clients from other cultural groups, such as Asian clients. Participants' experiences of clinical psychology as "western" ethnocentric are consistent with other Australian and international literature (Ford, 2013; Henrich, Heine, & Norenzayan, 2010; McConnochie et al., 2012; Nelson et al., 2014; Ranzijn et al., 2007; Vicary & Bishop, 2005; Walker & Sonn, 2010).

Students expressed a willingness to adapt their practice when working cross-culturally, but did not clearly know how to do this due to a lack of experience, knowledge, and confidence in their own clinical and cultural competence. This indicates a pathway of acquiring cultural competence in which the development of awareness of cultural diversity precedes the development of cross-cultural knowledge and skills. Commencing practitioners articulated what Westerman (2010, p. 213) termed a "dual struggle": the need to simultaneously gain clinical and cultural competence. Students need more support in this process: some experienced cultural difference as a barrier to clinical practice and expressed a preference to practice only with culturally western Australians.

Participants identified a variety of strategies to adapt their practice with culturally non-western clients, many of which are consistent with those outlined in the literature. For example, the strategy of adaptive practice identified by participants in the present study encompassed communication styles, therapeutic approach, and application of clinical psychological models. Similarly, McConnochie et al. (2012) reported that non-Indigenous psychologists adapt their communication strategies, assessment and therapeutic tools, and diagnostic models during practice with Indigenous Australians. Likewise, O'Connor et al. (2015) described client-focused communication, flexibility in the delivery of services, and adaptability in assessments, interventions, and evaluations as strategies for practice with Indigenous youths. In addition, other strategies identified in this study, including cultural self-awareness, being culturally knowledgeable, and consulting clients about culture, were identified previously (McConnochie et al., 2012; O'Connor et al., 2015; Vicary & Bishop, 2005). The consistency of the strategies

identified in the present study with those outlined in the literature suggests that some strategies for cultural competency are applicable across geographic and cultural localities in Australia.

The strategies for culturally competent practice identified in the present study reflect theoretical cultural competency models. Both Cross et al.'s (1989) cultural competence and Sue et al.'s (1982) MCC list cultural awareness, cultural knowledge, and cultural skills as essential attributes of culturally competent practitioners, although interpretations of the components vary slightly and Cross et al. (1989) added a value component. In the present study, academics identified the competency of being culturally self-aware, and both participant groups emphasised awareness of cultural differences during practice, showing participants' appreciation of cultural awareness. Students also identified cultural knowledge as important. The strategy of adapting professional behaviour as well as clinical psychology practices and theories in cross-cultural practice shows the importance of cultural skills. Also, the theme "personal dedication" identified by students highlights the importance of valuing diversity for cultural competency learning and reflects Cross et al.'s (1989) value component of cultural competence.

The consistency of the reported competencies with Cross et al.'s (1989) cultural competence and Sue et al.'s (1982) MCC suggests that standardised models may be effective in guiding initiatives for more formalised cultural competency training and practice in Australia. However, the present study also identified issues of cross-cultural practice that are especially pertinent in Australia, including considerations for practicing with Aboriginal and Torres Strait Islander clients. Thus, an Australian model of cultural competence and competency training may be needed. For example, qualitative research such as the present study could be used to develop an Australia-specific measure of cultural competency, which could then be used to guide specific training targeted to cultural competencies, with ongoing measurements of progress. Current APAC standards for professional psychology training require consideration of cultural diversity and such a model could operationalise the standard into training objectives.

Interestingly, the present findings suggest a particular pathway for cultural competency development. Academics, who were generally older than students, expressed more confidence in their cultural competence than students, perhaps a result of their greater level of life experience and clinical practice. Academics' and students' strategies for cultural competency differed: academics emphasised cultural self-awareness and reflection, regarding culture as an inherent characteristics of their clients *and* themselves. On the other hand, students expressed insecurity and a fear for doing cultural damage. They focused on cultural knowledge and discussions of culture with clients—focusing on the cultural "other." This focus on self-awareness for seasoned practitioners, rather than on cultural knowledge for beginning practitioners, suggests a pathway that starts with developing awareness of cultural diversity (a cultural "other" awareness), then cultural knowledge and skills leading to increased cultural self-awareness. The possible benefits of tailoring cultural competency training to practitioners' level of experience and confidence certainly merit further research.

Cultural competence training needs more specific attention in clinical psychology curricula in order to prepare graduates to meet the mental health needs of their culturally diverse communities. Given the impact of personal interaction identified by this study's participants, this training should involve members of Aboriginal and Torres Strait Islander peoples and other cultural groups. It is especially necessary to collaborate with Indigenous populations, as the unique history and cultural politics demand recognition and sensitivity. Such training needs to begin at the start of the clinical training program as these cultural competencies underlie all coursework, research, and practicum components. Open discussion of cultural diversity at the start could then be followed up with better informed consideration of cultural elements of all subsequent aspects of the program. While the need for cultural competence in direct clinical work with clients is most apparent, cultural diversity should also be considered as a part of training in formulating, treatment planning and evaluation, as well as research. Specific attention to the Cultural Formulation Interview, which was introduced in *DSM-V* to improve clinicians' understanding of a client's distress from a cultural perspective, may provide one way to increase trainee skill in this area (American Psychiatric Association, 2013).

Formal training focusing on cultural knowledge and skills should be balanced with immersion in multicultural experiences and self-reflection. The present research highlights the significance of cross-cultural social interactions and personal involvement for developing cultural competency, in addition to formal training. The value of cross-cultural engagement, especially with cultural minorities, has previously been identified in the literature (e.g., Dudgeon, Kelly, & Walker, 2010; McConnochie et al., 2012; O'Connor et al., 2015; Vicary & Bishop, 2005; Westerman, 2010), and is recognised by governmental and professional organisations (Australian Indigenous Psychologists Association, 2016; Australian Psychological Society, Reconciliation Australia, & Australian Indigenous Psychologists Association, 2012; Mental Health in Multicultural Australia, 2014). For example, establishing "respectful relationships" was one of the four targets listed in the *Australian Psychological Society's Reconciliation Action Plan* (Australian Psychological Society, Reconciliation Australia, & Australian Indigenous Psychologists Association, 2012). Building cross-cultural collaborations is important, and such engagement could improve cultural competence at an individual level.

However, the experiences of participants also demonstrate the difficulty of establishing and maintaining cross-cultural relationships. Cultural differences can be perceived as barriers that impede connection and mutual understanding between clients and practitioners, or students and supervisors. Thus, research into "rules of engagement" (Vicary & Bishop, 2005) in cross-cultural relationships merits attention. Research has indicated the importance of the cultural appropriateness of processes of engagement for establishing professional relationships between clients and practitioners. For example, Westerman (2004, 2010) argued that engagement processes are one of the two factors that determine the quality of cross-cultural professional relationships. This suggests a useful direction for further research, to determine the possible benefits of training clinical psychology students in processes of cross-cultural engagement for enhancing cross-cultural relationships.

In addition, the perception of cultural differences as barriers for establishing connections cross-culturally also points out to the need to highlight similarities. While lack of competency at managing cross-cultural differences was a common concern of participants, similarities between trainees and clients (including social class, gender, sexuality, and age) were essential to making a therapeutic "connection" For example, it has been argued that many current practices of culturally sensitive psychotherapy, with its emphasis on cultural difference, run the risk of having culture become the source of the problem and thus, issues of difference take on a significance over and above the intended psychological meaning for the client and every utterance of the client is interpreted according to a fixed cultural context (Moodley, 2009). Thus an emphasis on similarity rather than cultural difference could facilitate therapeutic connection, and enhance understanding of the client in ways that prevent cultural stereotyping.

Some limitations must be acknowledged. All interviewed participants were aware of cultural issues in clinical psychology and this may be the result of a self-selection bias: those with strongest opinions may be more likely to volunteer to be interviewed. Consequently, more research is needed on experiences of students who are less engaged with diversity. We note that none of our participants identified as being from Aboriginal or Torres Strait Islander origin, and this research would have benefitted from their experiences and perspectives, along with those of other cultural minority groups in Australia (Dudgeon et al., 2010). Finally, it is doubtful whether the present findings are generalisable to students and academics in universities other than the ones where these interviews were conducted. Generalisability of the findings outside Queensland is particularly questionable. In Queensland, cross-cultural issues tend to be related to working with Indigenous Australian clients, whereas in other parts of Australia may be related to other culturally or linguistically diverse groups, where issues of immigration and resettlement, and loss of established social networks may be more prominent. As a result of these limitations, the present findings are best considered as preliminary, and merit additional research to identify implications and directions for practice.

In conclusion, this study showed that students feel unprepared for cross-cultural clinical psychology practice which led to a drive to acquire cultural competency. This drive is contextualised by the complications of applying "western" clinical psychology among non-western cultural groups in Australia. There were some similarities in the competencies used by students and academics across cross-cultural practice situations, which suggests that standardised models may help to guide formal training in cultural competency. Ways forward include the development of standardised theoretical models of cultural competency tailored towards training initiatives in Australian contexts, as well as providing training tailored to practitioners' levels of experience and practice in specific cultural settings. We note the need for more systematic cultural competency training in clinical psychology curricula, as well as the importance of encouraging cross-cultural collaborations and social encounters.

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Appendix

Interview questions

(1) What made you decide to participate in this interview?
(2) Let's talk about your clinical psychology training program. What do you know of the origins of the curriculum that you are studying/teaching?
(3) Clinical psychology has been critiqued for being mainly of western origin. What do you think of this critique? Why?
(4) How much consideration for culture or cultural issues is included in the program?
    (a) Is there any course, or specific knowledge or skill that you are being taught (or: teach) at your university that is specific for Australia, or specific cultural groups in Australia?
    (b) Are there any alternative, non-western models of psychology taught at your university?
(5) Now let's focus a bit more on your clinical practice experience. Have you ever practiced in a setting that focused on cultural issues?
    (a) What made this a cultural setting for you?
    (b) Were there any special competencies required for you to practice adequately?
    (c) Can you give an example?
(6) Have you come across clinical practice situations in which you used specific cultural or cross-cultural skills?
    (a) How often does this happen?
    (b) Could you describe these skills?
    (c) How did you learn these skills?
(7) Have you come across cultural or cross-cultural situations in which you did not know how to respond?
    (a) How often does this happen?
    (b) What made this a cultural situation?
    (c) What did you do?
    (d) What would you have needed to help you in this situation?
(8) Is your clinical psychology training adequate preparation for practice in Australia? Why?
    (a) Do you have any ideas on how to improve clinical psychology training to better fit the cultural context?
(9) What advice would you give to a foreign university, or an academic from a foreign country, that would start to teach clinical psychology in Australia?
(10) Is there anything you wish to add, highlight, or emphasise?