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"CULTURED CLINICIANS": THE RHETORIC OF CULTURE IN CLINICAL PSYCHOLOGY TRAINING

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Abstract.
The article examines the vexing question of the status of "culture" in contemporary clinical psychological training in South Africa. The interest in this topic arises out of some puzzlement and frustration in attempting to engage with "cultural" critiques of clinical practice and the slippery, contested and idealized elements of the construct. The article is particularly interested in the rhetorical power of the term and the discursive functions it performs as spoken by different speakers in different contexts. Rather than rehearsing the many anthropologically based debates about the scope and definition of the term culture, the focus is on how the term is employed in arguments about the nature of clinical practice/s in South Africa. Several authors (for example, Dawes, 1998; Hayes, 1998; Gibson, Sandenbergh & Swartz, 2001; Moll, 2002) have engaged in related discussions pertaining to ethnicity, "africanisation" and appropriate theory and training models as they relate to psychology in post-colonial and post-apartheid South Africa. Such writing reflects the widespread contestation concerning the adoption of so-called Western and Eurocentric theories and practice and the basis on which these should be ousted or retained. Whilst the content of such arguments will be addressed to some extent, the focus of the article is on the multiple meanings served by the term culture and on some of the politics entailed in speaking about culture in clinical training settings. The discussion is based both on naturalistic observation in a university environment as well as upon formal interviews with a range of psychologists of different levels of experience, from different training backgrounds and from varied "race" and class origins, all engaged in clinical psychology training. The article examines how culture is framed and employed at a point in South African history when transformation is part of the national educational and political agenda. Although the issues raised relate to a particular training context, it is hoped that the discussion will stimulate wider debate about the "rules of engagement" in relation to sensitive topics in contexts of old and new power relations.

INTRODUCTION.

The motivation to write this article came out of a number of developments and conversations taking place in a South African university unit over the time period from 2001 up until the present. In my role as a senior staff member involved in the training of clinical psychology masters students I have found myself grappling with a range of political issues that tend to pass under the guise of academic transformation. In reviewing elements of the clinical training process, including selection procedures, course content, theoretical orientation, use of resources, skills prioritization and student evaluation, critique has often been framed in terms of cultural bias, insensitivity or relevance. The term "culture" has taken on a loading that is important to interrogate in relation to the rhetorical and other functions it performs. To offer a hypothetical example, a statement such as: "Introspection is not part of my culture", volunteered by an African colleague, and particularly a senior staff member, tends to carry a particular weight in the critique of current selection procedures. The pronouncement seems to preclude further discussion, even if this were warranted. Not only is the reference to cultural practices as unquestioningly inclusive or exclusive, interesting, but in addition, the authority of the speaker in this regard is also worth exploring further as a discursive practice.

The invocation of cultural knowledge as something sacrosanct is not limited to the academic domain. In a recent newspaper article dealing with male initiation among Xhosa communities, the journalist, a black woman herself, writes: "Some defend the practice, and outrage has been expressed. The very idea of a discussion is offensive to some because it is 'our culture'. Unfortunately, these positions do not help us much in understanding the practice and its meanings." (**The Sunday Independent**, 3rd August, 2003:17). The article addresses both the historical origins and contemporary practices pertaining to initiation, including recent reports of some deaths and injuries amongst initiates. However, it is the reference to the immutability of "our culture" that resonated with my frustration with the terms of debate within the clinical training context.

Recognizing my own location within an historical axis of power associated with being white, middle-class, well-educated, English-speaking and probably western (as the term is commonly employed), engagement with the terrain of culture in contemporary South Africa becomes particularly fraught. Similar sentiments have been expressed by other privileged psychologists attempting to engage with the transformation agenda. In debating the Africanisation of psychology Dawes (1986:6) writes: "Given the overdetermination of 'race' in South Africa, I am aware of how delicately the white English South African identity, into which I am cast by my location in the political history of South Africa (and into which I inevitably cast myself), shapes both my contribution to this debate, as well as potential responses. These facts should not I believe, render this voice illegitimate. While I cannot and do not wish to speak on behalf of anyone, or expropriate black South African experience, I believe that as an academic in this country at this time, it is necessary to engage with the issue of Africanisation and its implications for psychology." Implicit in this carefully framed qualification of position is the need to justify one's right to engage in this kind of debate given one's historical and present social position. This is an aspect of positioning that the article seeks to engage with further.

In her research work on teenage pregnancy and its discursive construction in South Africa, Macleod (2002) notes similar tensions. She observes that the characteristics associated with her status as a well-educated, middle-class white woman are contradictory in their "interactive positioning" (the discursive positioning assigned by others) at this time in South Africa. Whilst increasing the validity of her findings from an academic perspective, she writes: "On the other hand, in a time when there is increasing 'Africanisation' both within educational institutions and elsewhere, 'whiteness' becomes equated with 'imperialism' and 'oppression'. In my interviews with service providers, only one of whom is 'white', the racialised positionings of myself as 'white' and the majority of service providers and patients as 'African', 'Black' or 'Zulu' seemed to translate into a space for the invocation of culture as an explanatory tool. Virtually all the service providers utilized phrases equivalent to 'in our culture' … in describing teenagers' and their parents' behaviour." (Macleod, 2002:19-20). Although Macleod refers to this interactive dimension of her scholarship in order to illustrate aspects of reflexivity in the research process and does not unpack these observations about the invocation of culture any further in this paper, it is apparent that she is also mindful of a strategic employment of the term. It is also worth noting that although such usages are very much part of the political fabric of contemporary South Africa, researchers conducting an investigation into minority women's experiences of domestic violence and service delivery in the United Kingdom also struggled with the contradictory ways in which culture appeared to be invoked and the constraints associated with what they term "cultural privacy", associated with "cultural respect" (Batsleer et al, 2002). It would seem that observations concerning the degree to which culture is a loaded term carrying strategic, inter-personal and rhetorical weight, are quite widespread.

Having begun to frame the questions that I was invested in exploring with regard to negotiating the terms of reference informing the transformation of clinical psychology training in contemporary South Africa, I was confronted with my own biases early in my reading. In his book, **Elite discourse and racism**, van Dijk (1993) makes a cogent point that it is often only when their position is under attack that elites begin to engage critically with the power of language and discursive strategies. "As a rule, we may assume that as soon as elite interests are challenged, as in the domain of ethnic affairs, such elites will quickly forget the norms of tolerance and the values of equality that they supposedly espoused." (van Dijk, 1993: 9). Although I hope that this article is written in a spirit of tolerance and equality, it is important to acknowledge that part of the motivation for addressing these issues stems from an experience of being marginalized or dis-voiced, an uncomfortable and unfamiliar feeling. From this perspective I was interested in looking at how some rules of engagement might be possible that would allow for fruitful participation from a range of actors in debates about cultural sensitivity.

In addition to this interest in the context of debate and discussion, with the inevitable acknowledgement of the role of identity politics, the article is also focused on the range of meanings that have become constellated around the word *culture*. Culture appears to have become a code for a range of other terms and issues, carrying multiple implicit associations. In contemporary South Africa, *culture* is employed by many different groupings with different rhetorical objectives, including those of dominance, assertion, resistance and subversion. A second aim of the article is to explore some of the agendas served by the term culture in conversations about clinical training.

The article thus aims to address two related themes, the first pertaining to the codes related to the term culture and the second to the interactive dynamics involved in making claims about culture and associated debate or contestation. Since these topics are very broad and have been addressed within a range of other disciplines and theoretical contexts, the discussion will be focused on the field of clinical training, the domain with which I am most familiar. The exploration of these issues will draw on written material as well as on participant observation and semi-structured interviews with colleagues who have been, and are involved in clinical masters training at the University of the Witwatersrand (Wits). It is anticipated however, that the discussion may reflect more generally on politics in academia, professional training and psychology in contemporary South Africa.

To clarify the basis for the discussion further it should be acknowledged that the article is primarily theoretical in emphasis. However, in order to broaden the basis for discussion empirical data was generated by means of semi-structured interviews that were conducted with clinical training colleagues at Wits. Formal, audio-taped interviews of about 60 minutes duration were conducted with 6 colleagues, 2 of whom were white and 4 of whom were black. Five of the interviewees were male and 3 had trained at Wits, one at Rhodes and 2 at the University of the Western Cape. (My own training took place at the [former] University of Natal). The interviews centred around questions concerning what people understood by the term “culture” in the context of clinical training, what aspects of culture they felt confident or comfortable to comment upon, what bestowed the right to speak about culture with authority, what a culturally-sensitive clinical training programme would look like, and what issues might be delicate in interpersonal engagement about culture within the university context. It was conveyed that the aim of the conversation was ultimately to develop a better understanding of what cultural sensitivity entails and to establish some potential guidelines for meaningful dialogue around such issues.

A range of themes and content areas were identified during the interviews and then confirmed and elaborated in playing back the audio-tapes to allow for further analysis. A copy of the first draft of the article was circulated to all colleagues who had been interviewed with a specific request that they assess the veracity of the reported material and offer any necessary clarification or further insights they felt might be useful. Beyond some commentary that they had found the exercise engaging, thought-provoking and helpful, there were no concerns requiring modification of the reported content. In addition to this formal exercise, the discussion also draws upon the author’s experience of working in clinical training teams and in the South African clinical training field over some 20 years and in this respect is based on personal reflection and what could be understood as “participant observation”. The article should thus be understood as reflecting the views of the author rather than the Wits clinical training staff, unless otherwise indicated.

A BRIEF CONTEXTUALIZATION OF CLINICAL PSYCHOLOGY TRAINING.

Clinical psychology training in South Africa began in the late fifties and early sixties and was heavily influenced by British training models in its scope and orientation. Following training on an accredited programme offered by one of a range of universities, trainees have registered with some form of medical or health profession’s council in order to gain sanction to practice. Clinical psychology training has generally incorporated the core

elements of psychological assessment and clinical intervention, the latter being associated strongly with training in the theory and practice of psychotherapy. In addition, training in research theory and skills, in psychopathology or abnormal psychology and in professional practice ethics, has also been common to all clinical courses. The Professional Board for Psychology has specified parameters such as minimum training hours, supervision requirements, acceptable internship sites, key outcomes and has responsibility for reviewing accredited programmes. Although there is a degree of consistency across clinical training courses, there is also room for variation across institutions. This variation emerges significantly in the theoretical orientation of courses (most particularly in their approaches to psychotherapy), in the balance between theory and practice, in the emphasis on tuition or self-guided learning, in the nature of practicum sites and in what auxiliary courses are offered. For example, many training programmes incorporate training in neuropsychology, others emphasize systemic interventions and yet others developmental concerns. Without extending the discussion into an alternate focus on clinical psychology training in South Africa in general, what this summary seeks to emphasize is the historical influence of British training models, the medicalization associated with registration with a health related board or council and the centralized regulation of training, along with some space for differentiation across institutions.

Critiques of clinical psychology training in South Africa are not new. Given the fraught political history of the country with its legacy of colonialism and inter-group conflict, apartheid and state repression, capitalist exploitation and extreme wealth disparities, it is not surprising that clinical psychology, along with other professions, has been challenged in terms of its legitimacy within this context. Criticisms have been levelled at the elitism of clinical practice, at the limitations of psychological intervention in the face of material deprivation and at the western biases of existing training models. During the 1980s the central critiques of clinical training and practice constellated around notions of “relevance”, reflecting the political discourse of the day. Such arguments were captured in a range of papers published in **PINS (Psychology in society)**, including those by Dawes (1985), Anonymous (1986), and Perkel (1988). As Dawes (1998) suggests in a more recent article, the “relevance” arguments pertain to the utilitarian value of (clinical) psychology in Africa and South Africa, challenging the discipline at this level rather than in terms of overarching theoretical orientation. However, the relevance debates reflected not only a concern with the usefulness of clinical interventions in the South African context, but also both explicitly and by implication, a concern with the importation of what was generally referred to as Eurocentric or Western theories and models of training.

One pathway that emerged to address the relevance question was the integration of community psychology premises and orientations into clinical training. In the early 1990s Eagle and Malcolm (1991) conducted a survey of South African clinical training programmes focusing on the degree to which they incorporated aspects of community psychology, arguing that this was a potential solution to some of the debates about relevance and economies of scale of service delivery. Many training courses continue to attempt to straddle aspects of both clinical and community theory and practice, with varying degrees of success. A recent article by Gibson, Sandenbergh and Swartz (2001) raises some of the tensions that arise in demanding that students master two very broad areas of practice with different paradigmatic bases.

The focus of this article is on an associated but different set of debates that have been heralded by the national agenda of transformation. Although cultural biases and limitations have been part and parcel of the ongoing debates about relevance and about community/clinical practice, they have come to the fore again in the imperatives of transformation. Universities are facing a range of challenges including broadening access, mergers, massification, increasingly strained resources and the incorporation of business models of management. Departments of Psychology and their professional training programmes are not immune to these pressures for change. In addition, in recent years, the Professional Board for Psychology has also pursued the agenda of transformation, introducing new training dispensations and criteria, specifying demographic targets for trainees and subjecting existing programmes to review. One of the central themes of this transformation has been that of cultural sensitivity, fairness, appropriateness, embeddedness or the overcoming of cultural bias. Be it in selection procedures, theoretical models, assessment practices, supervisory relationships and/or practicum experiences, trainers have been compelled to examine and critique existing practices in terms of possible cultural assumptions and biases. Whilst few would question the laudable pursuit of cultural sensitivity in clinical psychology training, attempting to engage with this imperative becomes much more complex in execution. Similar concerns about the difficulties of applying desirable theoretical models in practice are identified in a recent text on engaging with cultural differences in liberal democracies (Shedder, Minow & Rose, 2002). As suggested in the introduction, not only is culture a slippery and multifaceted construct, but the politics inherent in assertions and discussions about culture are also particularly loaded. The rest of the paper seeks to grapple with this complexity with a view to creating some space for debate and a climate in which an ethical engagement with clinical psychology training issues may take place at this particular historical juncture.

THE MEANINGS OF THE TERM "CULTURE": WHAT IS BEING SPOKEN ABOUT?

Culture is recognized as a term that is difficult to define carrying multiple meanings (Geertz, 1973; Lee, 1991; Carter & Qureshi, 1995; Lago and Thompson, 1996; Swartz, 2001). It has been included in texts designed to interrogate the semiotics of words and their potential usages (Williams, 1987; Boonzaier and Sharp, 1988). In addition to the notion of cultivating or growing something, Williams (1997:90) identifies three broad active categories of usage: "(i) the independent and abstract noun which describes a general process of intellectual, spiritual and aesthetic development from C18; (ii) the independent noun, whether used generally or specifically, which indicates a particular way of life, whether of a people, a period, a group, or humanity in general …(iii) the independent and abstract noun which describes the works and practices of intellectual and especially artistic activity." As suggested by the title of the paper, several of these associations carry some relevance for clinical training, however, it is category (ii), stemming from a primarily anthropological perspective, that characterizes the manner in which culture is understood in discussions about "cultural sensitivity". Offering some operational definitions of culture in the context of counselling relationships, Lago and Thompson (1996:35) quote Valentine's assertion that "the culture of a particular people or other social body is everything that one must learn in order to behave in ways that are recognizable, predictable and understandable to those people". It seems a tall order to attempt to master culture in this manner in the course of multicultural clinical training, but this definition reflects an important recognition of the degree to which culture (used

in this sense), is something that is socially acquired. For Lago and Thompson it is important to recognize "that culture is socially transmitted and profoundly affects our ways of seeing and thinking about the world, of understanding relationships amongst people, things and events, of establishing preferences and purposes, and of carrying out actions and pursuing goals." (1996:33).

Thornton (1988) makes the point that given that culture is socially constructed and historically located, varying and transforming across context, groupings and historical epochs, it is more appropriate to speak of cultures than culture. He asserts that notions of culture constitute a particular kind of resource, a resource that has been utilized in complex ways in the South African context: "the concepts of 'different cultures' and 'own culture' have become central to the political thought of most South Africans. For the most part, these political uses of the word 'culture' are not about culture at all, as we shall use the term here, but about cultures. In this case it is the final 's' that makes all the difference. For while there are differences in the way people behave, think and live, this reflects their differing access to cultural resources, as well as their use of these resources to make statements to each other and about themselves." (Thornton, 1988:24). Given when this piece was written, one can speculate as to what kinds of political processes and resources Thornton was referring, however, it is also interesting to apply his argument to contemporary usages of the term. Thornton also makes the point that culture *does* something. "One thing that culture does is to create the boundaries of class, ethnicity (identification with a larger historical group), race, gender, neighbourhood, generation, and territory within which we all live … These boundaries come to seem uniquely real and permanent. Their creation through cultural means is only obvious when we step outside of our normal day-to-day interactions." (Thornton, 1988:27). He thus asserts that invoking culture is a powerful political resource and tool and that culture is a loaded term with particular sets of connotations within the South African context.

Having addressed some of the definitional complexity of the term culture, how is this reflected in conversations with clinical trainers, asked to consider their understandings of the term in the context of rendering programmes more culturally sensitive?

In the main, my colleagues' appreciation of culture resonated with the kinds of definitions outlined in the theoretical literature. With varying emphases culture was associated with: sets of practices and customs; communicative repertoires, including language; a person or group's worldview; the product of one's family origins and rearing; and as an aspect of identity acquired from one's personal history, including for example one's ethnicity, religion, social status and place of upbringing. In unpacking the construct further, almost all the trainers understood culture to reflect the contextual location of individuals. Cultural identity was viewed as something that varied considerably for each person and was subject to different interpretations and operationalization. Thus for example, these academics suggested that there might be distinctions between people brought up in an urban, Zulu cultural environment as opposed to a rural one, and that there were also further distinctions within these communities as reflected for example in language usage, some rural groupings speaking what is referred to as "deep Zulu", a form of spoken language that might be difficult for Zulus from other environments to understand. Culture was generally viewed as a product of "lived experience", hence people spoke of being a product of "township

culture", of "a Jewish/Christian upbringing", of "coming from royal lineage" or of "growing up in a 'coloured' area". There was clearly an appreciation of the difficulties entailed in describing and discussing culture and an awareness that many uses of the term were/are overly reductionistic. In the course of the semi-structured interviews it became apparent that talking of making training multicultural or culturally sensitive is more easily said than done, given the contested and relativist nature of the term. If we cannot easily operationalize a common understanding of what we mean by culture, then it is difficult to proceed with an interrogation of the limitations of existing training. Also inherent in the more complex appreciations of the term and its usage; for example, culture as reflecting contextual location, as malleable and as open to personal interpretation; lay an awareness that engaging meaningfully with a client or clinician's culture is an open-ended project. The more carefully one engages with the construct the more intangible it becomes.

Despite acknowledgement of this tension in dialogues about culture and clinical training, it was interesting that it was nevertheless possible to proceed with an "as if" understanding of the domain being spoken about. Culture clearly stands in for a number of dimensions and in this respect could be understood as a kind of code for a range of other concerns, several of which emerged in the interviews. On the basis of this data and personal observations, some of these alternative signifieds are explored further.

"Race".

The most obvious categorization that culture stands in for is that of "race". Although there are sometimes specific references to "Black culture" or "White culture", racial categorization and associated differences are more often implicit in references to culture. Van Dijk (1993) points out that much talk about race and racial differences within academia and other elite domains has become subsumed under discussions of culture and cultural practices, watering down the politics implicit in discussion of the former. "In more respectable mainstream thinking, where white supremacy has largely been declared obsolete, however, we find similar ideological orientations, formulated in the less crude terms of 'cultural difference', which is the seemingly neutral façade of what is usually meant; cultural incompatibility, if not white/Western superiority." (van Dijk, 1993:160).

Whilst van Dijk is writing about the obfuscatory use of the term culture in the service of elites, in contemporary South Africa the use of culture in place of "race" appears to be associated with a politics of resistance or new assertions of dominance. References to culture are more tempered than those to race and seem to serve less confrontational objectives. For example, I would suggest that it would create more tension to assert that something offends me because I am black (or white) than to refer to cultural alienation. Nevertheless, the implicit reference to "race" and the politics inherent in this usage at this point in South African history, are usually appreciated by the actors concerned. "Race" is the less acceptable sub-text of culture, disguised in this veil in academic circles in order to allow for more 'civilized' kinds of dialogue. Discussions of race carry more stark political connotations and also potentially raise painful feelings associated with devaluation and oppression on the one hand and exploitation and guilt on the other, given the publicly shameful history of racially based *apartheid* in South Africa.

The implications of such understandings of culture for clinical practice tend to involve considerations of cross-race pairings in the clinical or therapeutic dyad and the power relations inherent within this. Although there is a substantial body of South African work on this topic, much of it remains unpublished in university libraries as student research reports and dissertations and South African conversations about inter-racial clinical exchanges are heavily reliant on American research that is not always contextually relevant. For example, minority vs. majority relations in terms of population demographics and the different kinds of political power wielded by American and South African black citizens contribute to distinct sets of dynamics. Considerations of culture in this respect tend to represent concerns about past and present relations of power, discrimination, stereotyping, oppression and trust. For example Lago and Thompson assert that cross race therapeutic encounters almost inevitably exaggerate the existing power differentials in the therapeutic relationship. “From the perspective of power, this combination of white counselor with black client has a potential danger, namely a perpetuation of the notion of white superiority. The white person as the counselor in this situation has the power.” (1996:27). Such agendas are not always apparent in cultured conversations about cultural difference/s.

The issue of “race” in South African clinical training is also reflected in professional board directives about selection and admission of candidates into programmes. From 2004 all programmes are expected to aim to ensure that at least 50% of any class is black. Although often spoke of in terms of contributing to diversity, this target quota is also clearly about redress and puts issues of “race” squarely on the agenda. However, it raises debates about what constitutes “black”, whether people of African origin who speak African languages should be given preference, and how to deal with black applicants who may not be South African citizens. Each university seems to engage with these issues differently, although those that emphasize diversity as enriching clinical training programmes may understand “black” more broadly and may invoke notions of cultural difference and breadth to justify selection choices.

Ethnicity.

Despite describing culture as multifaceted in relation to identity and identity formation, it was interesting to observe how quickly discussion of culture and culturally-sensitive training became focused on aspects of ethnic identity. Thus for example, references were made to distinctions between Zulu and Xhosa culture and to aspects of Jewish identity (as an ethnic as much as religious identification). In talking about culture it seems that one of the most salient categorizations is that of ethnicity. Stevens (1998) notes a similar elision between discussion of differences in “*culture*” and “*ethnic*” differences (p210), as well as notions of race. Again, debates about the generality of such categories and the boundaries they assume tend to be less problematised when discussed as aspects of culture. Within clinical training an awareness of ethnicity has been at the forefront of many texts on inter-cultural and multicultural interventions. There is a large body of literature on multicultural aspects of training, much of it published in the counselling theory literature and again heavily American biased (e.g., Ivey, 1987; Sue & Sue, 1990; Lee & Richardson, 1991; Ponterotto et al, 1995). Such texts tend to focus on issues such as communicative repertoires including language, the worldviews of clients and therapists, and sets of customs and practices that might introduce possible points of tension or disrespect into interchanges between people from different cultural backgrounds. The centrality of the extended family in Hispanic

communities or the ways in which personal achievement is understood in Asian-American "culture", might form the basis for these kinds of discussions. In the South African literature, Swartz (1998) has focused particularly on the problems introduced when counsellors do not speak the same language and are required to make use of the services of interpreters.

In South Africa, ethnicity is often associated with "tribal" origins (such as whether one views oneself as Sotho or Zulu or Xhosa), or with language or religious affiliation and has some problematic associations with forms of nationalism. Culture as code for ethnicity thus also introduces complex political tensions that are not necessarily disguised or circumvented by references to cultural sensitivity or respect.

Afrocentricism.

The political project of an African renaissance is part and parcel of the transformation agenda in contemporary South Africa. Discussions about culture thus often inherently represent discussion about that which is African. As opposed to "tradition" (discussed next), African-ness may be associated with a particular kind of mentality or personality orientation, with "an indigenous, African psychology rooted in the continents' own, unique epistemologies, knowledge systems and identities" as Holdstock and others (cited in Moll, 2002) would argue. Moll's paper entitled "African psychology: Myth and reality" (2002) presents a sophisticated debate on African scholarship reflecting the tensions arising out of relativist and universalist positions as regards psychological theory. He quotes Mashogoane's reservations about a relativist "African" psychology: "any emphasis on difference in Africa is a racist, colonialist or *apartheid* 'game plan'", and, "Indigenization does not have to invoke and adopt the ethnocentrism that it seeks to destroy" (quoted in Moll, 2002:10). Similar reservations could apply to the considerations of the cultural appropriateness of the more restricted domain of clinical psychology. Afrocentricity in clinical practice and training might imply the adoption of alternative models of personality, abnormal psychology and therapeutic goals and interventions. This would entail a radical shift in the ontology of clinical psychology and would have implications for international recognition of qualifications. It also assumes the establishment of an Afrocentric body of knowledge to which clinicians could refer, a project that many see as still in the making, or as contestable from the outset.

Nevertheless it is apparent that some debates about the cultural relevance of clinical psychology are essentially debates about its Euro or Afrocentricity and what this implies.

The traditional.

Culture is also often associated with historical tradition, that which existed before colonization, modernization or Westernization. In this sense culture may refer to something inherent or supposedly indigenous to a group or community. Culture in this sense signifies a romantic conception of sets of practices and ways of being that represent something pure or uncontaminated, culture as primordial. Culture as it existed before it became polluted, diluted or eradicated, tends to be idealized and is very often compared unfavourably with present developments. Such discussions of culture speak to a hankering for the pre-modern.

In the context of clinical training, the pull or push towards that which is/was traditional is viewed as an impossibility or as a project that is constrained by the scientific or

ontological basis of the discipline of psychology. The compromise seems to be that clinicians recognize the limits of their own practice frameworks and learn to work in harmony with other kinds of healers whose knowledge base and practices are steeped "in tradition". Clinicians should respect the traditional orientations of clients, where these are in evidence, and should refer to alternative practitioners where suitable. The complexity of such referrals and the potential confusions and conflicts this may introduce for clients are not always addressed. Far from being vilified as was previously the case, traditional healing tends to be idealized in these kinds of discussions. In some instances, clinical psychologists have attempted to straddle cultural divides by training to become traditional healers (*isangomas*, *inyangas* or diviners) themselves. This decision introduces ethical dilemmas in terms of clinical practice (for example, which accreditation body one is responsible to) and presents potential difficulties in terms of reconciling theoretical orientations and accepted clinical practices. Although in some instances presented as a post-modern stance, embracing a pastiche of methods and orientations, embarking on such a course of training could also be considered an attempt to return to the pre-modern, a turn incompatible with mainstream clinical psychological epistemology. Culture as the turn to tradition thus also introduces a range of critical considerations.

Material deprivation and poverty.

Culture is also sometimes the code word for poverty or class exploitation, used in the sense of township culture or working class culture. The "cultural" constraints of working with such clients are essentially the constraints of working with materially, economically or socially deprived clients. For example, the difficulties of working with illiterate clients, with clients who cannot afford services or transport to services and with people who tend to think "concretely", constitute this arena of concern. These aspects of a person's culture might cut across some of the other dimensions referred to previously, such as ethnicity. Clinical practice concerns about this kind of "culture" centre around the suitability of clinical interventions at all, the need for psycho-education about services and their limits and potentials, worries about dependency and inequality of relations, mismatched expectations and possible patronization or further inferiorisation of clients. Solutions are sometimes sought at material levels, for example subsidization of transport, reduction of fees and networking with other agencies that provide material resources. These also tend to be the kinds of cases that lead to discussions about the superiority of community interventions and instantiate debates about modifications to practice that appear designed to "meet the client at his or her level". There is thus considerable contestation around this dimension of culture too.

That which is not eurocentric / western.

Finally (although probably not exhaustively), culture is also often used to signify that which is other than Western or Eurocentric. Culture in this respect represents that which is marginalized. This is possibly the most difficult cultural referent to describe since it is constituted in opposition to something else, as that which it is not. Such a use of the word may in fact represent an agglomeration of all the kinds of categories mentioned thus far. That which is cultural is that which cannot be assumed, that which is not normative in relation to the hegemony of dominant categories of identity - white, middle-class, consumer-orientated, westernised (or now globalised), etc. It is also probably predicated on the association of culture with the exotic, an association that has been problematised as carrying voyeuristic connotations. In the very act of dissociation from

the mainstream such references to culture may lay themselves open to more prurient interpretations. Allusions to culture as "other than" may thus be construed both as a form of resistance and as a form of co-option in relation to that which is hegemonic and may have different discursive outcomes to those intended or understood.

This tendency to view culture as a property of those who differ from the norm has also been introduced into debates about clinical psychology. Cultural considerations of case material tend to be raised in relation to some groups of clients and not in relation to others, i.e. not in relation to clients who fall into normative categories of identity. Although this observation will be elaborated in further discussion, this employment of culture as entailing "in opposition to" poses almost insoluble problems for clinical psychology training, given the latter's origins and base in Western frameworks of scholarship and practice. Such concerns take us into the terrain of debates about radical versus moderate forms of transformation and the emic/etic divides associated with psychological theory on culture. Again these issues are introduced to flag the complexity of debates they institute, rather than to discuss the full implications of such contestation, a topic that this article cannot do justice to and has been raised with considerable sophistication in other writings (for example, Dawes, 1998; Hayes, 1998; Painter & Theron, 2001; Moll, 2002).

Having addressed the first agenda of the paper, i.e. to explore some of the aspects of identity and issues that culture stands in for, the discussion now turns to some of the social practice or interactive dimensions involved in a discursive understanding of the term.

CULTURAL AUTHORITY AND WARRANTS: WHO IS ALLOWED TO SPEAK?

Implied in some of the previous discussion is the idea that the legitimacy of assertions about culture is tied up as much with the authority of the speaker (or writer) as it is with the content of what is being asserted. The notion that speaking or writing carries strategic weight is an accepted premise in critical psychological theory. For example Macleod cites Fairclough's (1992) conceptualization of a "discursive event" as encompassing "simultaneously a piece of text … an instance of discursive practice, and an instance of social practice" (2002:18), and van Dijk (1993) argues that it is as important to study social interaction and sociocultural contexts as it is to study structures and strategies of text in analyzing the operation of racism. Both authors thus affirm that conversations about particular topics have interactive or social meanings in the sense that speakers position themselves and are positioned in the process of dialogue. Discursive power may be reflected as much in how and when things are said, as in what is said.

A second central issue explored in the semi-structured interviews with colleagues was their views on what gave them the confidence or authority to speak about aspects of culture and how they perceived such warrants to operate in interaction, for example in interchanges with colleagues about aspects of clinical training.

An interesting exchange took place in the process of setting up the interviews. One of my white colleagues noted somewhat wryly that he had not expected to be interviewed about culture as those with privileged knowledge about culture and cultural sensitivity were the black staff involved in training. Although this initial assumption may have

reflected an association of culture with that which is not normative or hegemonic, it also points to a politics of deference, an implication that white people are not in a position to usefully make contributions about the cultural relevance of training. Most colleagues found it rather difficult to identify or explain what bestowed the authority to speak about culture, suggesting that such rules tend to operate implicitly. Having firstly asserted the modesty of their contentions by specifying limits to generalization, they generally said that their knowledge claims about culture would be based on their personal experience. By personal experience was understood “lived experience”. For example, salience was attached to place, persons, milieu and circumstances of upbringing. It was recognized that in talking about culture and cultural forms, experiential knowledge was privileged over other sources of information, for example, hearsay, reading (be this academic or popular texts), or even observation, (although direct observation carried some weight). To talk about culture with authority one has to have “lived it”. One colleague made a distinction between knowledge and experience, the latter being privileged in exchanges about what is or is not part of a particular culture.

As discussion on this issue became extended, further qualifications were elaborated. Some colleagues added that it was not just immersion in culture that bestowed authority, but that in addition some process of reflection was required. Thus in order to be able to speak about a cultural form, one needed to paradoxically be both “of it” and “outside it”. Without some process of reflection or temporary disengagement, it seemed difficult to observe what was “cultural” about one’s lived experience. In addition, if there were recognized avenues for indirectly learning about culture, these seemed to be predicated on the kind of effort expended to engage with groupings other than one’s own. Anthropologists’ attention to length of time spent in the field would dovetail with this kind of evaluation of people’s credentials to speak about a culture or cultures. A colleague illustrated the distinction in the following example. He had observed as a child that a particular white man who spoke an African language fluently was very willingly given access to a township community and reflected in the interview that such incorporation would have been much more difficult for an academic with extensive formal knowledge of aspects of African culture. Different means and points of entry carry different weightings and reflect some of the debates about service provider credibility that surface in the community psychology literature. However, for people outside of a culture it seems that immersion in the culture and a minimum (if not easily specified) amount of effort, is required before they may be allowed to speak with any weight about that culture.

In order to speak with authority about a particular aspect of culture, especially in dialogue, several colleagues indicated that it was important to qualify the limits of one’s exposure or knowledge base, further reinforcing the observation that assertions may be graded in terms of their force or credibility. This in turn of course, also depends on the audience to whom comments are being addressed. Thus in the company of international scholars South African speakers might assume greater authority in describing aspects of “African culture”(irrespective of the “race” of the participants) than they would in a South African forum. One colleague ventured that one gauges one’s knowledge base relative to other participants in any discussion and that based on this unofficial assessment one then speaks more or less openly and confidently about aspects of culture. Such covert assessment also seemed to determine under what circumstances it was possible for people to challenge each other’s assertions. It was

generally acknowledged that it was much easier for someone ostensibly from the same cultural background to enter into debates about the interpretation of culture than it was for even a very well informed person outside of that category.

As suggested in the introduction, people are possessive and protective of their cultural knowledge claims. Having experienced the frustration of being the outside observer on many occasions, I caught myself having an antagonistic reaction to an American speaker who was presenting her work on the South African Truth and Reconciliation Commission at an international conference. My automatic response was to assume superior knowledge as a South African, to be jealous of any insights she might have to which I was not privy and to become defensive about any critical commentary. I do not believe that I would have felt such a strong response towards a fellow South African or to hearing such work presented in a South African forum. This experience and my reflection upon it, was salutary in gaining a deeper understanding of people's antagonistic responses to interrogation of cultural forms with which they identify by people who they perceive to be other. Such sensitivities are exacerbated when the positions of power of the speakers are unequal or there is a history of discrimination or devaluation. In acknowledging the delicacy of these issues, the wish to engage meaningfully in critical dialogue with others about cultural interpretations of clinical psychology and its limitations and strengths becomes rather perilous and anxiety-provoking. Nevertheless such an ongoing project seems crucial if we are to participate in transformation and consider its implications for clinical training.

One further point of reference for making claims about culture in clinical practice contexts was somewhat tentatively put forward. A few colleagues recognized that extensive experience with a particular client group or in a particular setting, for example several years of practice in a township clinic, might also bestow the warrant to speak on such an actor. Whilst this might be considered a variant on the "effort expended equates to authority" premise, it is important to note that clinical experience might be sanctioned in a distinct way in the context of clinical training debates. For example, a white therapist with extensive experience of working with a particular form of pathology might be allowed to speak with more authority about cultural presentations of such pathology than a less experienced clinician who was from the same cultural background as a client. Once again, however, the politics of such interchanges are fluid and complex.

In sum, it seemed that the implicit rules for making assertions about culture were well-understood but difficult to define, in part because of the politics surrounding such usages and the fluidity of parameters introduced by contextual variations. Talking about talking about culture seems to be as difficult to get a handle on, as is the actual talk about culture. The interactional dimensions are as complex as the definitional ones. Stemming out of this exploration it seemed useful to flag some critical points for further debate or engagement.

IMPLICATIONS FOR TRAINEES AND TRAINING.

The potential reification of culture/s.

Emerging from discussions and observations and raised in the section on the difficulties of defining culture and its variations, is the recognition that rendering culture sufficiently tangible to teach people about it, is a difficult project. In many instances it seems that

attempts to apply what is understood by cultural sensitivity are reduced to discussions of cultural practices and possible mis-communication that may occur in such instances. For example, in South Africa a well-used illustration is that of a white therapist's possible misinterpretation of lack of eye-contact on the part of a black client, viewing this as some kind of avoidance rather than as a sign of respect. The turn to examples to illustrate what is problematic in multi-cultural interchanges often leads to a superficial appreciation of issues. The origins of behaviour and their full implications are often not unpacked or discussed. To continue with the example of eye-contact, this is seldom extended into a discussion of gender and age dynamics and relations, into discussions about westernization and urbanization and the dis/continuity of practices, into considerations of issues of personal boundaries and how these might in turn be influenced by notions of how distress is appropriately communicated and to whom, etc. Jackson and Meadows (1991) argue that despite historical transitions in the conceptualization of culture, counselling programmes have tended to employ surface rather than deep understandings of culture. "Culture must not be treated as a loose agglomeration of customs, as a heap of anthropological curiosities," (ibid:74). "The values that give meaning to behaviours become lost through inattention to an understanding of the deep or core structure of particular cultures" (ibid:73.). The discussion of cultural meanings may need to go beyond even the level of elaboration suggested above, extending into a deeper discussion of the philosophical assumptions embedded in a particular culture, the ontology, cosmology, epistemology, axiology, logic and processes "underpinning and reflected in the culture's worldview, ethos and ideology" according to Jackson and Meadows (1991:74).

However, whilst such an approach is certainly preferable to a superficial appreciation of cultural forms, it still tends to present culture as something unchanging and as a reified, seamless entity or property of groups and individuals. Despite their assertion that "Culture is alive, dynamic, and all its elements are interconnected," (ibid:74), Jackson and Meadows in part conclude their article by offering a summary of three conceptual systems: the European, Asian and African (their categorization), becoming guilty of the same reductionism that they accuse others of. Getting a handle on culture almost inevitably entails the trap of essentialising, reducing or reifying the phenomenon under study, a trap that is not escaped by attention to deep rather than surface levels of cultural understanding (although the former is certainly an improvement on the latter). This is clearly a tension that trainers have to negotiate in introducing cultural considerations into the curriculum. It is important to remind students that culture is not static but constantly undergoing transformation, even if in some instances such change is gradual and subject to very slow processes of evolution.

How does one learn to become culturally sensitive?

If the full appreciation of a particular cultural form is dependent upon 'lived experience', how can this possibly be approximated in the course of training? Unlike anthropology students who may be able to spend extended time in the field studying a particular cultural group or form, clinical psychology trainees are expected to master a range of theory and skills in working with a deliberately broad population in respect of demographics such as age, race, ethnicity, gender, class, religious orientation, and type of pathology. Knowledge of the cultural background of every client they come into contact with can neither be obtained from some sort of manual nor from direct immersion in the client's culture, as this would be logistically impossible. The default

position has sometimes been to assert that clinicians should only work with those clients whose backgrounds they are reasonably familiar with. The problem with this solution is that it instantiates a never-ending kind of factionalism. To follow such arguments to their logical extension, only disabled people should be allowed to work with the disabled, only those who are parents themselves, with children, and so on. Such an approach would also potentially contribute to elitism and further unevenness in accessing services, and would mean for example, that refugee populations and the illiterate could not be assisted, since there would be no trained personnel available from such backgrounds.

Multicultural and intercultural training models offer the alternative solution of attempting to train people in awareness and sensitivity. There is a vast body of literature on the subject (including training manuals), that has been evolving over several decades (Lee & Richardson, in Lee & Richardson, 1991; Jackson, in Ponterotto et al, 1995). As noted previously much of this literature is American in origin and not always easily applicable to South African dynamics. Without claiming to do justice to such literature, some issues are worth noting. One debate (similar to that around gender issues) is whether multiculturalism is something that should be confined to or highlighted in (depending on one's perspective) a particular course, or whether it should be integrated throughout training modules. My colleagues' preference seemed to be for the latter approach, a framework apparently adopted by many South African clinical training programmes. The rationale for such an approach is that if culture is an important and universal element of every individual's presentation and way of being, if culture infuses people's lives and is also open to individual interpretation, it is important to be observant of possible cultural dimensions in each and every interchange with each and every client. However, it is worth noting that there may be some merit in foregrounding "cultural" issues in a specific module or workshop to introduce the very kinds of more complex considerations that this paper raises, rather than to teach people about different aspects of culture per se.

It is also worth noting that some models of multicultural training may involve more experiential methods than others. Practical placements based in settings unlike one's own, for example on the Phelophepa train that travels to rural areas in South Africa, may assist students to appreciate aspects of people's "lived experience" in a more immediate way. Care needs to be taken to address the questions and anxieties that such placements might throw up for students (Gibson et al, 2001) in order that their learning experiences deepen engagement rather than encourage withdrawal. Pedersen's Triad model of training (1977; 2000) attempts to operationalise covert aspects of inter-cultural counseling in interesting ways, involving role-playing and discussion. Lago and Thompson (1996) present simulated counseling interchanges, including video footage, as a basis for discussion and further role play. These models, amongst others, might usefully be extended for application in South African training.

One colleague suggested that the diverse nature of the candidates who come in for training might also be viewed as a resource for enhancing multi-cultural sensitivity. Many professional training courses facilitate some sort of group introduction process at the outset of their courses, often focused on sharing of biographical information, prior clinically related experience/s and sometimes personality attributes. It was proposed that this induction process could usefully be expanded to include a deeper exploration of aspects of cultural background and identity. This might help to clarify what range of

cultural knowledge/s and expertise the group would have to draw on during their training. For example, a candidate might claim knowledge of aspects of urban, gay men's culture or of what it was like to be brought up in an extended family system with strong rural ties. (Such an exercise could also usefully be extended to the training team, either in or outside of the presence of the trainees). This kind of approach, viewing diversity as potentially enriching group resources rather than as a source of potential tension, would seem to resonate with what has been termed the "Value-added" model of engaging with diversity (Plaut, 2002:381). Such an orientation celebrates differences in contrast to the "Sameness" model (Plaut, 2002:372) that advocates a form of "colour-blindness" and emphasizes similarity in an attempt to downplay cultural differences.

Theoretical frameworks or orientations.

Although this was not a central preoccupation for colleagues during the interviews, but was rather an issue that I introduced, there was some interesting debate about theoretical frameworks. That people did not spontaneously raise such considerations in the context of discussing culturally sensitive training seemed to reflect a perspective that cultural concerns were metatheoretical. Most models of intervention could be tailored to be more or less culturally sensitive in the course of training and cultural sensitivity or insensitivity was not seen as a property of theoretical frameworks themselves. This was in contrast to discussions raised in other contexts, for example in critiquing psychodynamic orientations to training or praising ecosystemic frameworks in terms of their cultural appropriateness. Where colleagues did venture evaluative comments about particular orientations when nudged to do so, the following observations emerged: psychodynamic theory is useful in that it takes seriously the individual's subjective interpretation and translation of experiences, thus allowing for a complex appreciation of cultural influences in their lives; cognitive-behaviour therapy may be helpful for those whose cultural modus includes expectations that professionals should demonstrate expertise and take control of treatment, however, it was also perceived as a framework that over-emphasized normative values and behaviour and as most likely to disempower clients due to the directive nature of interventions; whilst disclaiming detailed knowledge of ecosystemic or ecological theory it was acknowledged that these models were perhaps specifically designed to take account of social context and hence of cultural influences, however, these models were questioned in terms of over-mapping the social onto the individual and in terms of possible de-politicization of power issues by collapsing social relations into ecological metaphors; aspects of psychodynamic theory, such as boundary maintenance, were viewed as potentially problematic if interpreted too narrowly; the necessary and basic conditions associated with Rogerian or client-centered therapy were viewed as helpful as a basis for most interpersonal interchanges, although authenticity was flagged as potentially problematic in contexts in which there might be intercultural tensions; narrative therapy was seen as enabling work within the client's cultural framework and as closest to appreciating the personal translations of culture by individuals and its malleability, however, colleagues were also concerned about the disguised nature of power relations that might emerge in the co-construction of narrative versions by clients and therapists. Thus it seemed that most of the major approaches to psychotherapy or intervention were perceived as having both potential weaknesses and strengths in terms of cultural sensitivity. No one framework was seen as ideal in this respect. As yet there seems to be contestation about whether any therapeutic approach can successfully embrace the impact of culture in all its complexity.

IMPLICATIONS FOR WORKING IN A TRAINING TEAM.

Not only has the discussion raised questions about the induction and education of trainees with respect to culture, but there are also clearly implications for training teams who seek to engage co-operatively around such an endeavour.

Uneven problematisation.

An observation made by colleagues was that there appeared to be some discrimination operating in the consideration of culture as significant in relation to case material. For example, in case conferences, if the client presented was white and middle-class there was less likelihood of their cultural background being reviewed as part of the case formulation. In addition, some references to cultural attributes or forms are unpacked in case discussion whereas as others are not, the latter predictably being those cultural forms that might be considered dominant or hegemonic. There appeared to be some unconscious bias in what is construed as normative in case discussions. Several black colleagues ventured that the equal problematisation or consideration of the role of culture in every appropriate case discussion would go a considerable way towards creating a more open and balanced forum for the discussion of cultural issues. This observation resonates with the recent problematisation of whiteness in social science literature (e.g. Seshadri-Crooks, in Lane, 1998) based on the realization that as an identity category whiteness has seldom been made salient in and of itself, for a variety of political reasons.

Some black colleagues also ventured concerns about opening aspects of African and non-dominant cultural practices and beliefs to criticism. They argued that because of the devaluation of blackness and the African continent by colonialist and neo-colonialist forces, criticism was likely to be particularly sensitively received. Against such a backdrop, even minor criticisms might be viewed as reinforcing pejorative stereotypes and therefore be rejected. One colleague reflected that he might even defend aspects of culture of which he himself was critical in some contexts, particularly if the speaker was perceived to be denigrating. Thus not only is there a need to examine cultural influences even-handedly across all social groupings, but there also needs to be considerable sensitivity around the critical interrogation of previously marginalized or denigrated cultural forms. The politics of such interactions cannot be evaded and require ongoing reflexive examination.

Cultural interpreters / brokers.

During the course of clinical training it is not uncommon for particular staff or students to be referred to as experts when discussions around culture take place. This is more likely to be the case for African staff or students who become what Swartz refers to as “cultural interpreters” (1998) or cultural brokers. During the interviews with colleagues I asked how people perceived and understood this practice.

Again the issue of unevenness came up. It was felt that all those present should be viewed as potential contributors to discussions about aspects of culture. Several colleagues also felt uneasy about the degree to which they could be considered experts on phenomena under discussion, indicating that their knowledge of aspects of culture needed to be recognized as discrete. Behind assumptions about their cultural expertise seemed to lie the overgeneralization often associated with racism. Some staff perceived

the practice as patronizing and were concerned that they might be considered experts on their culture/s to the exclusion of being considered experts about other aspects of clinical practice. One colleague suggested that he had some reluctance in writing about aspects of culture in relation to clinical practice lest he should be characterized as only capable of writing about such parochial kinds of issues. There was some debate about whether such interchanges were motivated by political correctness as opposed to genuine interest. However, it seemed that colleagues still recognized some merit in such practices, or even perceived the deference to others whose cultural identifications with clients might be strong, as a necessary act of respect. Political sensitivity as opposed to political correctness was seen as desirable, although these might be difficult to distinguish on the parts of various actors. It was suggested that more overt attention to the cultural knowledge of both trainers and trainees as an explicit resource, in the same way that expertise in case formulation, group work or research skills might be perceived, might lead to more relaxed cultural interpreting.

Past and present power relations.

The need to recognize historical repression and devaluation of particular groups and "cultures" by outsiders has already been acknowledged. This history is still clearly part of the present as is the tendency for individuals to feel some sense of ownership or loyalty to aspects of their cultural identity. Within the clinical training team it was recognized that multiple and fluid forms of power were operative, associated with a range of identifications and signifiers. Not only were demographic features such as age, gender and race salient, but in addition, features such as longevity of registration, extent of clinical experience, rank of university post, facility in the dominant theoretical paradigm, perceived clinical expertise, alliances with significant players outside of the immediate training team (e.g., university authorities, internship staff, past and present students), and personality style; all contribute to team members variable authority and influence. Such complex power dynamics make it very difficult for any such team to function consistently and underpin any discussions that might take place about the cultural properties of the training. Since these potential sources of tension cannot be wished away, and indeed could potentially contribute to an enriched engagement with cultural issues, again it seemed important to attempt to render such dynamics more transparent and to engage with them rather than covertly exercising or resisting these multiple forms of power.

Given the historical power relations associated with whiteness and the legacy of colonial domination, it may also be appropriate to ask whether there should not be some inversion of relations in who is currently given more space to speak. In the course of the interview discussions a spectrum of opinions were ventured. Some people argued that given the particular historical moment, white trainers should recognize their dominance precisely by stepping back and allowing previously disadvantaged or dis-voiced colleagues to dominate discussion. Paralleling some of the separatist trends in the feminist movement, what was implied was that until previously marginalized groups obtained greater confidence and more enduring influence, previously dominant groups should be silent. Others felt that this stance would be patronizing and would perpetuate existing divisions, preferring to attempt to create a context for constructive dialogue by less radical or oppressive means. Given the group identities of participants in training it is difficult to escape the social positioning that this entails. My white colleagues and I recognized our interpolation as those associated both with oppression and exploitation,

in keeping with Macleod's (2002) understanding of her role as white researcher. In academia these associations translate into concerns about silencing and expropriation of knowledge, issues that are very much part of the debate about how cultural appreciation can be broadened and incorporated into curricula. There are no simple answers to the politics of negotiation around curriculum reform. However, the silencing of any party with a vested interest in contributing to effective and responsive clinical training seems problematic.

CONCLUSION.

The paper has raised many questions in the course of discussing what is and may be understood by culture and the complex social interactions that are involved in debating the cultural appropriateness of clinical psychological training curricula and practices. As a consequence of the multi-pronged and complex nature of many of the concerns raised it has not been possible to suggest many answers to these questions.

I would contend that part of the difficulty lies in attempting to engage in debates without a common understanding of precisely what it is that is being contested. One recommendation therefore would be that academics attempt to be more specific about their understandings of culture and what this entails, in introducing particular critiques of clinical psychology training/s. As has been illustrated in prior discussions, it may be more useful to unpack what is being referred to in order to engage in constructive debate. For example, it would be less opaque to argue that something is not part of Xhosa culture, or is problematic in terms of replicating prior relations of oppression, or is insensitive to the fact that some people do not have access to computers, than to assert that something is "alien to my culture". In an academic setting one should be able to explore what precisely the 'my culture' being referred to entails and in what sense that which is being critiqued is alien. It would then be possible to debate the relative merits and demerits of this assertion in the light of training requirements and possibilities. Beyond this, it would be useful for those engaged in a common training endeavour to develop a more coherent understanding of different conceptualizations of "cultural" transformation.

Carter and Quereshi (in Ponterotto et al, 1995) propose a useful model for distinguishing between different theoretical or philosophical premises that underpin multicultural counselling. Having surveyed the American multicultural or diversity counselling literature, they propose a typology of critical approaches that includes five orientations: Universal; Ubiquitous; Traditional (Anthropological); Race-based; and Pan-national. Each of these approaches makes certain assumptions that have implications for approaches to and methods of multicultural training. They provide a useful summary of some of the kinds of concerns that distinguish typologies: "Several factors differentiate the various categories identified. In no specific order, they are: Does the conception of culture concern itself exclusively with intergroup differences, intragroup differences, or both? Does the conception of culture situate culture in ascribed (i.e., already given) or chosen loci of identity? Are multiple identities (cultures) possible within the conception of culture? Does the conception of culture thematize sociopolitical or power dynamics? Is culture understood as a self-contained construct, or is it deemed to develop dialectically or interactively? And finally, does the perspective on culture raise questions about the status quo? That is, does effective multicultural counseling one way or the other thematize social change?" (Carter & Quereshi, 1995:257-258).

These are the kinds of questions we need to be asking each other in order to develop a more sophisticated understanding of what it is we really mean when each of us talks about culturally attuned clinical training. From this base we need to establish whether we can agree on some over-arching or common framework from which to approach curricula and practices. The lack of clarity around what is understood by culture; both represented in and by the text of this article, may be at the heart of much misunderstanding and contestation. While it would be naïve not to recognize that there might be some investment in the mystification of what is meant by culture, it is also the case that meaningful discussion and consequent practice implications, cannot be pursued without acceptance of some common parameters.

In addition, in order to deal with the politics associated with the relativity of various cultural claims and the identities and positionings of the speakers engaged in debate, we also need to seek some reference point against which the integrity of clinical training itself can be assessed. This is a difficult project. In the feminist area it has been possible to contest cultural claims on the basis of highlighting forms of gender oppression and in some instances a discourse of universal human rights has been invoked to challenge the culturally sacrosanct, for example, to challenge the practices of suttee and clitoredectomy. Defining the bedrock or inviolability of clinical training, what might be termed its ethical basis, seems a much more mundane, but nevertheless, difficult, project. Although some core elements seem to characterize clinical psychological practice as outlined previously, it is suggested that each training programme needs to extend these and to define their core training principles and goals, against which proposals for change can be assessed. For example, in a hypothetical debate about the cultural bias of role-playing as a teaching medium, we need to be able to assess various cultural claims against some yardstick of the merits/demerits of the practice as a training tool. It may be that criteria such as the importance of experiential learning, client protection and benefit, and training efficacy and ethics, outweigh the demerits of cultural unfamiliarity. In such instances one might look for an accommodation rather than an eradication of components of training that are considered important to the training project itself.

Negotiating a consensus understanding of both the models of culture being employed and of what determines the integrity of clinical psychology training, is an exercise in transformation itself. The research interviews have goaded the clinical trainers involved to grapple with these issues at a deeper level and it is hoped that the paper will provoke further debate and questioning of assumptions. Without greater clarity about what it is that we are contesting and why, transformation in this arena is likely to become ad hoc and subject to the vagaries of individual agendas. Having the debate about the terms of debate is likely to get us somewhere, together.

REFERENCES.

Anonymous (1986) Some thoughts on a more relevant indigenous counselling psychology in South Africa: Discovering the socio-political context of the oppressed. **PINS (Psychology in society)**, **5**, 81-89.

Batsleer, J, Burman, E, Chantler, K, McIntosh, H S, Pantling, K, Smailes, S & Warner, S (2002) **Domestic violence and minoritisation – supporting women to independence.** Special report of the Women's Studies Research Centre, Manchester Metropolitan University. Manchester: Manchester Metropolitan University.

Boonzaier, E & Sharp, J (eds) (1988) **South African keywords: The uses and abuses of political concepts**. Johannesburg: David Philip.

Carter, R T & Qureshi, A (1995) A typology of philosophical assumptions in multicultural counseling and training, in Ponterotto, J, Manuel Casas, J, Suzuki, L & Alexander, C (eds) **Handbook of multicultural counseling**. Thousand Oaks: Sage Publications.

Dawes, A (1986) The notion of relevant psychology with particular reference to africanist pragmatic initiatives. **PINS (Psychology in society)**, **5**, 28-48.

Dawes, A (1998) Africanisation of psychology: Identities and continents. **PINS (Psychology in society)**, **23**, 4-16.

Eagle, G & Malcolm, C (1981) The incorporation of community psychology into clinical psychology training in South Africa. Paper presented at the Annual conference of the Psychological Association of South Africa (PASA), Johannesburg.

Geertz, C (1973) **The interpretation of cultures**. New York: Basic Books.

Gibson, K, Sandenbergh, R & Swartz, L (2001) Becoming a community clinical psychologist: Integration of community and clinical practices in psychologists' training. **South African Journal of Psychology**, **31(1)**, 29-35.

Hayes, G (1998) Editorial. **PINS (Psychology in society)**, **23**, 1-3.

Ivey, A (1987) The multicultural practice of therapy: Ethics, empathy and dialectics. **Journal of Social and Clinical psychology**, **5**, 195-204.

Jackson, M (1995) Multicultural counseling: Historical perspectives, in Ponterotto, J, Manuel Casas, J, Suzuki, L & Alexander,C (eds) (1995) **Handbook of multicultural counseling**. Thousand Oaks: Sage Publications.

Jackson, A P & Meadows, F (1991) Getting to the bottom to understand the top. **Journal of Counseling and Development**, **70**, 72-76.

Lago, C & Thompson, J (1996) **Race, culture and counselling**. Buckingham: Open University Press.

Lee, C (1991) Cultural dynamics: Their importance in multicultural counseling, in Lee,C & Richardson, B (eds) (1991) **Multicultural issues in counseling: New approaches to diversity**. Alexandria, V. A.: American Association for Counseling and Development.

Lee, C & Richardson, B (1991) Promise and pitfalls of multicultural counseling, in Lee, C & Richardson, B (eds) (1991) **Multicultural issues in counseling: New approaches to diversity**. Alexandria, V. A.: American Association for Counseling and Development.

Macleod, C (2002) Deconstructive discourse analysis: Extending the methodological conversation. **South African Journal of Psychology**, **32 (1)**, 17-25.

Mcleod, J (1993) **An introduction to counselling**. Buckingham: Open University Press.

Moll, I (2002) African psychology: Myth and reality. **South African Journal of Psychology**, **32 (1)**, 9-16.

Painter, D & Theron, W (2001) *Heading South*! Importing discourse analysis. **South African Journal of Psychology**, **31 (1)**, 1-11.

Pedersen, P (1977) The triad model of cross-cultural counselor training. **Personnel and Guidance Journal**, **55**, 94-100.

Pedersen, PB (2000) **Hidden messages in culture-centred counseling: A triad training model**. London: Sage.

Perkel, A (1988) Towards a model for a South African clinical psychology, **PINS (Psychology in society)**, **8**, 54-91.

Plaut, V C (2002) Cultural models of diversity in America: The psychology of difference and inclusion, in Shweder, R, Minow, M & Markus, H R (eds) (2002) **Engaging cultural differences: A multicultural challenge in liberal democracies**. New York: Russel Sage Foundation.

Ponterotto, J G, Manual Casas, J, Suzuki, L & Alexander, C (eds) (1995) **Handbook of multicultural counseling**. Thousand Oaks: Sage Publications.

Ridley, C (1995) **Overcoming unintentional racism in counselling and psychotherapy**. London: Sage Publications.

Seshadri-Crooks, K (1998) The comedy of domination: Psychoanalysis and the conceit of whiteness, in Lane, C (ed) (1998) **The psychoanalysis of race**. New York: Columbia University Press.

Stevens, G (1998) “Racialised” discourses: Understanding perceptions of threat in post-apartheid South Africa. **South African Journal of Psychology**, **28(4)**, 204-214.

Strous, M (2001) Therapists’ self talk in interracial counselling contexts. Unpublished doctoral dissertation. University of the Witwatersrand, Johannesburg.

Sue, D W & Sue, D (1990) **Counseling the culturally different: Theory and practice**. New York: John Wiley.

Shweder, R, Minow, M & Markus, H R (eds) (2002) **Engaging cultural differences: A multicultural challenge in liberal democracies**. New York: Russel Sage Foundation.

Swartz, L (1998) **Culture and mental health: A southern African view**. Oxford: Oxford University Press.

Swartz, S, Dowdall, T & Swartz, L (1986) Clinical psychology and the 1985 crisis in Cape Town. **PINS (Psychology in society)**, **5**, 131-138.

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Thornton, R (1988) Culture: A contemporary definition, in Boonzaier, E & Sharp, J (eds) (1988) **South African keywords: The uses and abuses of political concepts**. Cape Town: David Philip.

Van Dijk, T (1993) **Elite discourse and racism**. London: Sage Publications.

Williams, R (1987) **Keywords: A vocabulary of culture and society**. London: Fontana.