NUS National University of Singapore | Social Service Research Centre
Faculty of Arts & Social Sciences

JUNE 2024
ISSUE 2

SNIPPET

CUTTING-EDGE APPLIED RESEARCH

IN THIS ISSUE

EDITOR'S NOTE

by Dr. Rosaleen Ow (Reviewing Editor)

This Issue contains two interesting articles with a focus on the importance of context in the provision and delivery of social services.

First, Seyoung Oh and her colleague, Shantini Sathiyanesan, from the Samaritans of Singapore (SOS) discussed the sensitivity related to providing counselling support to persons who lost a loved one to suicide (i.e suicide survivors). Findings from the funded project Local Outreach to Suicide Survivors (LOSS) provided data on the importance of context sensitive provision and delivery of services in SOS.

Next, the article by Timothy Sim, Singapore University of Social Sciences, is a thought paper on the need to develop a culturally relevant local model for counselling which takes into consideration the multicultural context of Singapore.

Both articles are informative and provide food for thought to readers who are looking for a discourse on the needs and challenges of working in unique contexts.

Sharing from the Local Outreach to Suicide Survivors (LOSS) Programme

By Seyoung Oh, Researcher, and Shantini Sathiyanesan, Counsellor; Samaritans of Singapore (SOS)

Keywords: Suicide, grief, support group, counselling

Background on Suicide Grief

In 2022, there were 476 suicide deaths reported in Singapore which is the highest record since 2000 (Immigration and Checkpoints Authority Singapore, 2022). This staggering number also translates to over 64,000 people in the country exposed to suicide. Cerel et al. (2019) estimates that for every suicide death, about 135 people are affected, but to varying degrees. This “continuum of survivorship” includes people who are exposed to suicide through various ways such as a colleague’s death or even a celebrity’s death reported in the media (Cerel et al., 2014). Exposure to suicide has been shown to affect one’s own suicidal ideation— sub-groups or suicide contagions can emerge (Abrutyn and Mueller, 2014; Gould, 2001). Moreover, Crosby and Sacks (2002) found that those affected by suicide were 1.6 times more likely to develop suicidal thoughts. On the other end of the continuum are suicide survivors, or those who are bereaved by a suicide death, and are experiencing short- or long-term grief.

Unlike other types of bereavement, suicide bereavement is unique and complex. The initial psychological, physical and behavioural reactions to the loss of a significant other may be considered alike in the form of acute grief, which occurs immediately following the death. Under most circumstances, acute grief naturally progresses to integrated grief, or the ongoing, attenuated adaptation to the death. Those bereaved by suicide loss, however, may experience complicated grief due to the nature of the death.

Survivors report higher feelings of rejection, shame, self-blame, denial and need to conceal cause of death (Begley and Quayle, 2007; Sveen and Walby, 2008). Additionally, suicide survivors may grapple with feelings of guilt (“Did I try hard enough to help them?”) or the need to understand (“I thought they were getting better so why did they do that?”) (Tal Young et al., 2017). Furthermore, suicide loss survivors are also at risk of developing prolonged grief disorder (PGD) which is associated with major health problems, such as sleep disturbance, substance abuse, abnormalities in immune function, increased risk of cardiovascular disease and cancer as well as suicide ideation and behaviour (Buckley et al., 2015; 5th ed.; DSM–5; American Psychiatric Association, 2013; Shear, 2015).

Compared to other groups experiencing bereavement, suicide survivors may be more prone to developing depression and suicidal ideation. (Tal Young et al., 2017). A national telephone study of US adults by Crosby and Sacks (1994) found that for individuals who lost someone to suicide in the past year, they were 1.6 times more likely to have suicidal ideation and 3.7 times more likely to have made a suicide attempt. Kinship also plays a role in influencing the effects of suicide grief. For example, survivors who lost their partners were found to be at increased risk of suicide in the 2 years after their partner’s death compared to those with partners who died by non-suicide causes. The suicide risk is significantly higher for surviving mothers of children who died by suicide compared to bereaved mothers by non-suicide causes (Qin and Mortensen, 2003).

With the added factor of stigma associated with suicide, suicide grief may be harder to address as it discourages suicide survivors from seeking help or dissuades others from offering help (Han et al., 2018). There may even be a perceived need for the survivor to deny that the death was a suicide, especially if there are additional layers of stigma due to cultural or religious beliefs (Wu et al., 2021). Considering the racial and religious diversity of Singapore, there are likely a variety of reasons for the lack of disclosure of suicide loss by survivors. In Singapore, eight in ten individuals associate suicide with stigma according to a study conducted by Professor Rosie Ching at the Singapore Management University (2022). Zhang et al., (2019) found that there is also stigma associated with seeking treatment for mental health problems in Singapore. It is evident that stigma remains a hindrance to help-seeking.

Suicide grief is also challenging for families to handle collectively. Compared to other types of grief, suicide grief commonly entails instances of blaming, and existing tensions or difficulties within familial relationships may be brought to the forefront because of the shock and trauma (Lyu et al., 2018). Even fleeting moments of joy or enjoyable family activities can trigger a profound sense of guilt, leading them to question whether they are betraying the memory of their loved one. Family members may find themselves torn between embracing signs of moving forward in life and fearing they are dishonouring the memory of the deceased. The sudden loss of a family member, moreover, may lead to changes in family member roles in the household and thus, negatively affect communication and hinder their coping as well (Provini, Everett, & Pfeffer, 2000). Furthermore, different family members may be at varying stages of grief and employ diverse coping mechanisms, adding another layer of complexity to the situation. Such inter-familial conflict could lead survivors to feeling further isolated from their family and friends, which may be further exacerbated by the stigma surrounding suicide.

Within families grappling with the aftermath of suicide, a complex spectrum of emotions often emerges. Survivors may confront a tumultuous mix of conflicting feelings, including confusion and guilt. While there are some similarities between suicide bereavement and other kinds of grief, individuals mourning the loss of someone who died by suicide may require specific intervention and support to meet their distinctive needs and issues. According to the “shattered assumptions” theory, suicide can also shatter an individual’s assumptions about the self, others, and the world (Carnelley and Janoff-Bulman, 1992). In the aftermath of a suicide loss, survivors often find their once-solid beliefs shattered, leading to significant changes in their thoughts and behaviours. They may grapple with guilt, self-blame, and a diminished sense of self-worth, questioning their ability to prevent the loss or provide adequate support. Moreover, survivors may become hyper-aware of life's fragility, resulting in heightened anxiety and vigilance for the well-being of others. This can lead to reluctance in engaging in activities related to the deceased or being more dominating over others. Additionally, suicide loss challenges survivors' beliefs about life's predictability and safety, prompting a reassessment of priorities, beliefs, and relationships. Hence, there can be a great need for survivors to make sense of the death through their search for explanations and finding out as much as they can.

There are certain aspects such as stigmatisation and sense of rejection that may make coping particularly difficult for people who have lost a significant other due to suicide, or otherwise known as suicide survivors (Hawton and Simkin, 2003). Survivors are usually significantly distressed and family members who are grieving the loss at the same time are typically unable to provide adequate support to each other (Jordan and McIntosh, 2011).

Grief is complex and unique to everyone; therefore, suicide grief has additional layers that must be handled with care when providing support. As such, skilled professionals have a major role to play in enabling survivors to deal with their experience and find relief from their trauma-based symptoms.

Intervention

The Local Outreach to Suicide Survivors or LOSS Programme is the only suicide postvention program in Singapore that provides targeted and prompt support for people who are experiencing suicide bereavement. Between 2021 and 2022, SOS extended their assistance to over 623 suicide survivors. As of 31 August 2023, an additional 157 suicide survivors were referred to SOS for specialized grief support.

The LOSS programme was first conceptualised by Campbell and colleagues (Campbell, 1997; Jordan & McIntosh, 2011) who advocated for an active postvention model (APM) that offers help proactively to new survivors to ensure easier access to resources. The main aims of the programme are to offer prompt outreach to survivors of suicide; to provide emotional support and assurance; and to provide information and resources to survivors throughout the bereavement period.

The key feature of the active postvention model is the on-site support provided to survivors in the form of *emergency response,* or ER. At SOS, the police have a direct phoneline which is used to call in incidents of suicide deaths. If the next-of-kin are agreeable, then SOS volunteers and staff trained in suicide crisis and suicide loss are deployed to the site and provide emotional support as well as brief psychoeducation to the family of the deceased.

In addition to the emergency response service, clients can utilize our specialist counselling services or join one of our support groups. SOS offers Healing Within, which is a structured, six-week psychoeducation support group. There is also Healing Bridge which is an open support group that meets monthly and is offered in English and Mandarin.

Programme Evaluation

SOS recently measured the impact of the LOSS programme on service users. A total of 6 counselling clients participated in the study (see Table 1). All participants were Chinese, and the average age was 45 years old. The average duration in the programme was 8 months and 27 days. There was one married couple in our sample—Client A and Client C.

Table 1. Demographics of Participants

Participant	Age	Gender	Ethnicity	Religion	Marital Status	Relationship to Deceased	Duration in the programme
Client A	48	Female	Chinese	Christianity	Married	Parent	7 months 13 days
Client B	62	Female	Chinese	Christianity	Married	Parent	5 months 6 days
Client C	50	Male	Chinese	Christianity	Married	Parent	7 months 12 days
Client D	24	Female	Chinese	No Religious Affiliation	Single	Friend	13 months 25 days
Client E	19	Female	Chinese	No Religious Affiliation	Single	Child	13 months 11 days
Client F	65	Male	Chinese	Buddhism	Divorced	Parent	6 months 2 days

Methods

The questionnaire captured the survivor's grief (Grief Experiences Inventory Questionnaire, GEQ, Barrett and Scott, 1989), post-traumatic stress disorder symptoms (Impact of Event Scale Revised, IES-R, Weiss, 2007), and social functioning (Social Adjustment Scale, SAS, Weissman et al., 1976, 1981, 2001). Participants were also interviewed to better understand their involvement in the LOSS programme.

Descriptive statistics were performed to assess the mean and standard deviation scores. Pre-and post-intervention scores were analysed using paired-samples t-tests on Microsoft Excel to obtain descriptive statistics and global and dimensional scores for each questionnaire (e.g., GEQ, IES, SAS).

Interviews were coded using thematic analysis (Clarke, Braun and Hayfield, 2015). Open-coding and line by line coding was conducted to identify themes or interesting features from the participants' narratives. To ensure rigor and trustworthiness of the data, the transcripts were coded by two research team members.

Results

Findings from Questionnaires

The GEQ measures various components of grief. The total score range is 55-275 (or 5-25 for each subscale), with higher scores indicating a greater likelihood that the specific grief reaction has been experienced (Barrett and Scott, 1989). There was no significant difference in the GEQ scores pre-intervention (M = 131.83, SD = 29.16) and post-intervention (M = 119.67, SD = 26.42; t(10) = 0.691, p=0.505). Overall, most clients had decreased GEQ scores at the end of their participation in the programme except for two clients whose GEQ scores increased after the programme (see Table 2). The average GEQ score for all clients before any intervention was 131.83, which later decreased to 119.67 after the completion of the programme. The top three dimensions of grief were: "Search for Explanation", "Guilt" and "Unique Reactions" at both the pre- and post-measurements.

Table 2. GEQ Scores

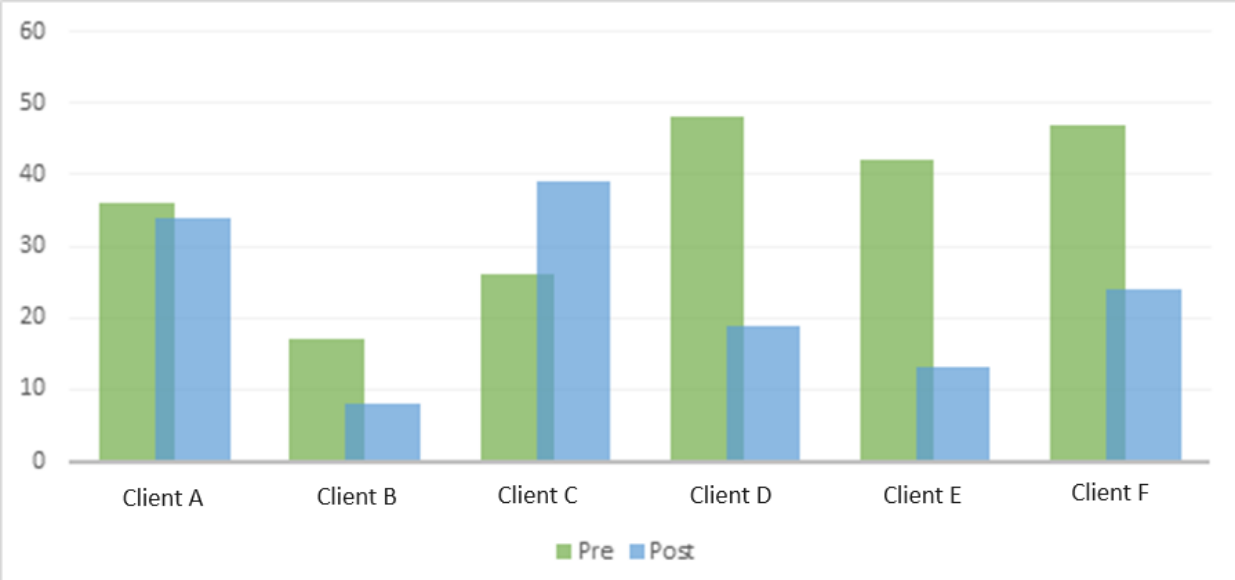
	GEQ – Total		
	Before	After	Difference
Client A	132	145	-13
Client B	75	82	-7
Client C	119	103	16
Client D	148	97	51
Client E	155	146	9
Client F	162	145	17
M	131.83	119.67	12.17
SD	29.16	26.42	20.64

Note. M = mean; SD = standard deviation.

There was a significant difference in the IES scores pre-intervention (M = 38.17, SD = 128.57) and post-intervention (M = 20.17, SD = 70.97; t(10) = 3.12, p = 0.010). As for the Impact of Event (IES) scores, only one client reported an increased score after the completion of the programme (see Figure 1). The rest of the clients had decreased IES scores with some scores below the cut-off for a probable PTSD diagnosis. The most reported symptom was intrusion with an average pre-intervention score of 17.83. Intrusion refers to intrusive thoughts that are repeated and involuntary and possibly distressing

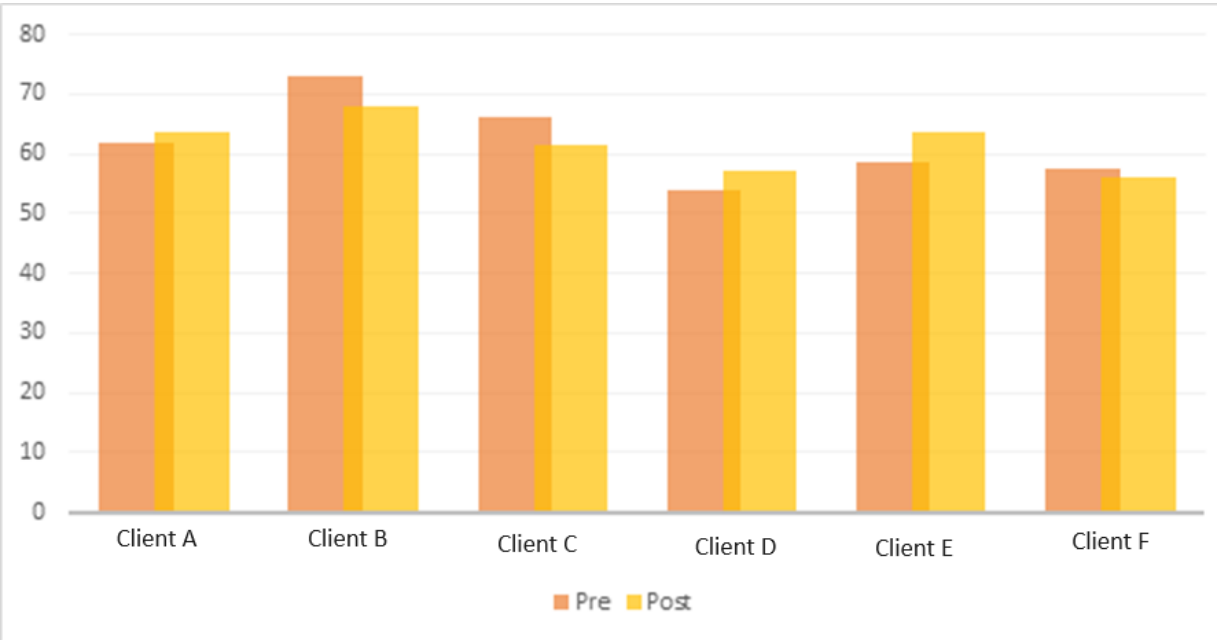
in nature. The average post-intervention score decreased to 12.33, but the intrusion score remained higher than avoidance and hyperarousal.

Figure 1. Individual Pre- and Post-Scores of IES



The third measure, Social Adjustment Scale (SAS), looked at clients' general adjustment and functioning within their daily lives such as perceived quality of work, home, and social life (see Figure 2). There was no significant difference in the SAS scores pre-intervention (M = 61.83, SD = 46.67) and post-intervention (M = 61.20, SD = 24.07; t(10) = 0.17, p = 0.866). All clients reported above average scores (x > 40) indicating excellent functioning. Three clients had decreased SAS scores with one client reporting a decrease of 5 points.

Figure 2. Individual Pre- and Post-Scores of SAS



Findings from Interviews

Denial

When clients were asked about their initial reactions upon finding out about the suicide death, they expressed varying degrees of denial which is a typical part of the grieving process (Kubler-Ross and Kessler, 2005). Client E who lost a parent to suicide shared that she felt "like I'm in an illusion or like I'm not; this is not actually my reality kind of thing." Another client who lost her child shared that she "could not believe it all. [She] thought it was not possible. [She] thought it could be due to a crime that it happened." Client A expressed not understanding why her child had died by suicide and that she blamed herself: "Both sadness and self-blame took turns to appear and they got worse over time. I was not able to sleep because of that."

Self-blame and guilt were common sentiments shared by all clients and is characteristic of suicide bereavement (Schneider et al., 2011). Client F who lost her child reflected on her initial reaction after the death: "Then grief. Then start to question, then start to ask a lot of questions. Why? Trying to find out the fact, actually what's happening?" Similar to Client A and Client E, Client C seemed desperate to confirm that her reality was not true which was apparent in her saying "actually what's happening" compared to "what's happening." Her choice of using "actually" evoked a sense of denial which was also reflected in Client A's thought that her child's death was not by suicide, but a crime.

Feelings of anger and betrayal are typical of suicide bereavement as well (Young et al., 2022). Client D shared that she and her friends felt angry with their friend who had passed because "she was always the one that was cheering us on, like you know 'go for therapy, get your meds, don't commit suicide…' Then it's like, okay, 'you hypocrite how dare you.'" Client E also felt angry towards her parent who had died by suicide. She clarified that her anger was complicated by layers of "large amount of sadness and worry revolving around how I wasn't able to say my goodbyes."

Beyond their emotional reactions to the suicide deaths, clients reported somatic symptoms as well. Client A stated that she was unable to sleep. Her husband shared similar concerns. It is worth noting that on the IES instrument, Client C's hyperarousal score was the highest among the group. The hyperarousal questions on the IES ask about trouble with sleep, feelings of irritation, getting startled, and difficulty concentrating. Previous research on Asian-American mental health has shown that Asian and Asian-American individuals typically focus on their physical symptoms (Lin and Cheung, 1999; Tseng et al., 1990; Kleinman, Good and Good, 1985). These findings add nuance to the claim that Asian patients tend to overly focus on somatic symptoms for their emotional distress by asserting that patients choose to withhold discussing their emotional problems based on what they deem as appropriate for each health care setting.

Social Support

Some clients found support from their friends and family as well as their faith. Client B shared that her coping was supported by her faith and her friends from church. Client D was appreciative of the agency's counselling services as it was an alternative outlet to her friends since she was worried about burdening others with her distress. The perception of burden may exacerbate survivor's emotional pain and interfere with the grieving process (Levi-Belz and Ben-Yaish, 2022). Furthermore, perceived burdensomeness was found to affect survivor's guilt, meaning a survivor's guilt may be offset by reduced levels of perceived burdensomeness which in turn offers "the healing qualities of a sense of belonging and togetherness and the opportunity to share the distressing guilt they carry in their hearts with those around them." (Levi-Belz and Ben-Yaish, 2022).

Support Group

The two support groups within this postvention LOSS programme are unique as they are the first support groups in the country for suicide survivors where suicide is still heavily stigmatized. As Client J puts it, “In Asia, our Chinese the local context, when they talk to counsellor it is always something bad, something negative.” Client A was curious to know “how other people cope with the same loss.” She wanted to learn how other peopled coped so that they could “be together, to help each other.” Client C was not confident in sharing about his experiences because he views himself “not as a professional” who does not have “the skills to help on these things.” Future research on this postvention programme should focus on the impact of the programme on an individual’s self-capacity and empowerment.

Managing Grief

When clients were asked about their grief sometime after the initial period of bereavement, there was a shared sense of acceptance. Client A remarked that “what passes has become the past [so] being anxious won’t help.” Client F was straightforward. His advice to other survivors was to “face it” because according to him: “I told you I don’t accept it, I have to face it. I have to face it every time for the rest of my life. I know. I gonna face it for the rest of my life.” He acknowledged that the grief may lessen over time, but since it does not disappear his way of managing is to “Take it day by day lor, what to do?”

Conclusion

Our findings highlight the complexity of suicide grief and the various challenges that clients navigate following the loss. While suicide grief is also shown to be an individualised and multifaceted experience, in our sample the most reported grief dimensions are Search for Explanation, Guilt and Unique Reactions. An example statement of a ‘unique reaction’ is: “Tell someone that the cause of death was something different than what it really was.” This finding concurs with current literature on suicide survivors’ experiences where guilt is found to be more severe and an integral part of the grief process, as in “what if” questions and when counterfactual thinking can arise (Jordan, 2001). In the context of a suicide, these questions tend to be extreme and self-punishing, condemning the survivor for failing to predict or prevent the death. Overall, clients seemed to have had positive experiences with the LOSS programme. Through counselling and support groups, survivors had the opportunity to weave their grief into their life story and help them find solace despite the loss. The chance to connect with other survivors also helped to empower them to keep their loved one's spirit alive while navigating their grief alongside others. It is especially heartening to see how forthcoming the clients were in sharing about their experiences and supporting one another especially given the stigma of suicide. As one client put it, “I try lah. I mean, I want to get better and I wanna, if I can, I’d like to help others as well.” Instead of evading their experiences and pain, the suicide loss survivors were empowered to cultivate presence within absence and directly confront them, unveiling meaning and strength along their journeys.

Acknowledgements

The LOSS evaluation project was funded by the Mrs. Lee Choon Guan Endowed Research Fund, National University of Singapore (NUS) and approved by the IRB (NUS) with appreciation to Dr. Jungup Lee, Department of Social Work, NUS, who was the Academic Principal Investigator of the project. The authors would also like to thank the staff and clients at SOS who made this project possible.

References

Abrutyn, S., & Mueller, A. S. (2014). Are suicidal behaviors contagious in adolescence? Using longitudinal data to examine suicide suggestion. American Sociological Review, 79(2), 211-227. https://doi.org/10.1177/00031224135

American Psychiatric Association, D. S. M. T. F., & American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5 (Vol. 5, No. 5). Washington, DC: American psychiatric association.

Barrett, T. W., & Scott, T. B. (1989). Development of the grief experience questionnaire. Suicide and Life-Threatening Behavior, 19(2), 201-215. https://doi.org/10.1111/j.1943-278X.1989.tb01033.x

Begley, M., & Quayle, E. (2007). The Lived Experience of Adults Bereaved by Suicide. Crisis, 28(1), 26–34. https://doi.org/10.1027/0227-5910.28.1.26

Buckley, T., Spinaze, M., Bartrop, R., McKinley, S., Whitfield, V., Havyatt, J., ... & Tofler, G. (2015). The nature of death, coping response and intensity of bereavement following death in the critical care environment. Australian Critical Care, 28(2), 64-70.

Campbell, F. R., Cataldie, L., McIntosh, J., & Millet, K. (2004). An active postvention program. Crisis: The Journal of Crisis Intervention and Suicide Prevention, 25(1), 30-32. https://doi.org/10.1027/0227-5910.25.1.30

Carnelley, K. B., & Janoff-Bulman, R. (1992). Optimism about love relationships: General vs specific lessons from one's personal experiences. Journal of Social and Personal Relationships, 9(1), 5-20.

Cerel, J., Brown, M. M., Maple, M., Singleton, M., Van de Venne, J., Moore, M., & Flaherty, C. (2019). How many people are exposed to suicide? Not six. Suicide and Life-Threatening Behavior, 49(2), 529-534. https://doi.org/10.1111/sltb.12450

Cerel, J., McIntosh, J. L., Neimeyer, R. A., Maple, M., & Marshall, D. (2014). The continuum of “survivorship”: Definitional issues in the aftermath of suicide. Suicide and Life-Threatening Behavior, 44(6), 591-600. https://doi.org/10.1111/sltb.12093

Clarke, V., Braun, V., & Hayfield, N. (2015). Thematic analysis. Qualitative Psychology: A Practical guide to Research Methods, 222(2015), 248. https://doi.org/10.4135/9781526405555.n2

Crosby, A. E., & Sacks, J. J. (2002). Exposure to suicide: Incidence and association with suicidal ideation and behavior: United States, 1994. Suicide and Life-Threatening Behavior, 32(3), 321-328. https://doi.org/10.1521/suli.32.3.321.22170

Gould, M. S. (2001). Suicide and the media. Annals of the New York Academy of Sciences, 932(1), 200-224. https://doi.org/10.1111/j.1749-6632.2001.tb05807.x

Han, J., Batterham, P. J., Calear, A. L., & Randall, R. (2018). Factors Influencing Professional Help-Seeking for Suicidality. Crisis, 39(3), 175–196. https://doi.org/10.1027/0227-5910/a000485

Hawton, K., & Simkin, S. (2003). Helping people bereaved by suicide: Their needs may require special attention. Bereavement Care, 22(3), 41-42.

Immigration and Checkpoints Authority Country C. (2022). Report on Registration of Births and Deaths 2021. Retrieved from https://www.ica.gov.sg/news-and-publications/statistics

Jordan, J. R., & McIntosh, J. L. (2011). Suicide bereavement: why study survivors of suicide loss? In Grief after suicide (pp. 33-48). Routledge.

Kleinman, A., Good, B. J., & Good, B. (Eds.). (1985). Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder. University of California Press. https://doi.org/10.1525/9780520340923-fm

Kübler-Ross, E., & Kessler, D. (2005). On grief and grieving: Finding the meaning of grief through the five stages of loss. Simon and Schuster.

Levi-Belz, Y., & Ben-Yaish, T. (2022). Prolonged grief symptoms among suicide-programme Bsurvivors: The contribution of intrapersonal and interpersonal characteristics. International Journal of Environmental Research and Public Health, 19(17), 10545. https://doi.org/10.3390/ijerph191710545

Lin, K. M., & Cheung, F. (1999). Mental health issues for Asian Americans. Psychiatric Services, 50(6), 774-780. https://doi.org/10.1176/ps.50.6.774

Lyu, J., Wang, Y., Shi, H., & Zhang, J. (2018). Early warnings for suicide attempt among Chinese rural population. Journal of Affective Disorders, 238, 353–358. https://doi.org/10.1016/j.jad.2018.06.009

Provini, Jessica R. Everett, Cynthia R. Pfeffer, C. (2000). Adults mourning suicide: Self-reported concerns about bereavement, needs for assistance, and help-seeking behavior. Death studies, 24(1), 1-19.

Qin, P., Agerbo, E., & Mortensen, P. B. (2003). Suicide risk in relation to socioeconomic, demographic, psychiatric, and familial factors: a national register–based study of all suicides in Denmark, 1981–1997. American journal of psychiatry, 160(4), 765-772.

Shear, M. K. (2015). Complicated grief. New England Journal of Medicine, 372(2), 153-160.

Schneider, B., Grebner, K., Schnabel, A., & Georgi, K. (2011). Is the emotional response of survivors dependent on the consequences of the suicide and the support received? Crisis: The Journal of Crisis Intervention and Suicide Prevention, 32(4), 186. https://doi.org/10.1027/0227-5910/a000081

Sveen, C. A., & Walby, F. A. (2008). Suicide survivors' mental health and grief reactions: A systematic review of controlled studies. Suicide and Life-Threatening Behavior, 38(1), 13-29. https://doi.org/10.1521/suli.2008.38.1.13

Tal, I., Mauro, C., Reynolds III, C. F., Shear, M. K., Simon, N., Lebowitz, B., ... & Zisook, S. (2017). Complicated grief after suicide bereavement and other causes of death. Death studies, 41(5), 267-275. https://doi.org/10.1080/07481187.2016.1265028

Tseng, W. S., Asai, M., Jieqiu, L., Wibulswasdi, P., Suryani, L. K., Wen, J. K., ... & Heiby, E. (1990). Multi-cultural study of minor psychiatric disorders in Asia: Symptom manifestations. International Journal of Social Psychiatry, 36(4), 252-264. https://doi.org/10.1177/002076409003600403

Weiss, D. S. (2007). The impact of event scale: Revised. In Cross-cultural assessment of psychological trauma and PTSD (pp. 219-238). Springer, Boston, MA. https://doi.org/10.1007/978-0-387-70990-1_10

Weissman, M. M., & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. Archives of general psychiatry, 33(9), 1111-1115. https://doi.org/10.1001/archpsyc.1976.01770090101010

Weissman, M. M., Sholomskas, D., & John, K. (1981). The assessment of social adjustment: An update. Archives of General Psychiatry, 38(11), 1250-1258. https://doi.org/10.1001/archpsyc.1981.01780360066006

Weissman, M. M., Olfson, M., Gameroff, M. J., Feder, A., & Fuentes, M. (2001). A comparison of three scales for assessing social functioning in primary care. American Journal of Psychiatry, 158(3), 460-466. https://doi.org/10.1176/appi.ajp.158.3.460

Wu, Y., Chen, Z., Batterham, P. J., & Han, J. (2021). Perceived Suicide Stigma and Associated Factors in Chinese College Students: Translation and Validation of the Stigma of Suicide Attempt Scale and the Stigma of Suicide and Suicide Survivors Scale. International Journal of Environmental Research and Public Health, 18(7), 3400. https://doi.org/10.3390/ijerph18073400

Zhang, Z., Sun, K., Jatchavala, C., Koh, J., Chia, Y., Bose, J., ... & Ho, R. (2020). Overview of stigma against psychiatric illnesses and advancements of anti-stigma activities in six Asian societies. International journal of environmental research and public health, 17(1), 280.

Growing Cultural Competence in Counselling and Social Work

by Timothy Sim, Head of Master of Counselling programme, Singapore University of Social Sciences

Keywords: Counselling, local, multicultural competence, respect, social work, transdisciplinary collaboration

Abstract

This paper provides an overview of key concepts and theories of cultural competence in counselling and social work, including a review on the evolution of the development of cultural competence internationally and locally. The paper articulates recommendations for the systematic application of cultural competence concepts and frameworks/models within the unique socio-cultural context of Singapore. By proposing strategies tailored to the local landscape, this paper aims to establish Singapore as a beacon of excellence in fostering cultural competence and embracing diversity in counselling and social work practice.

Overview of Cultural Competence (CC)

Cultural competence in counselling and social work has emerged as a crucial aspect of professional practice in diverse societies worldwide. This paper article endeavors to serve as a catalyst for advancing the discourse on cultural competence in counselling and social work practice, with a specific focus on charting a progressive course for Singapore. By synthesizing theoretical insights with practical recommendations, it aspires to contribute to the ongoing efforts aimed at enhancing the quality and efficacy of professional practice within multicultural contexts.

To commence, drawing from established literature, this paper elucidates the definition and significance of cultural competence in effectively addressing the needs of diverse client populations within counselling and social work settings

Defining Cultural Competence

Cultural competence is increasingly recognized as essential for effective counselling and social work practice, particularly in multicultural societies like Singapore. But what is cultural competence? In 1989, Cross et al. provided one of the most universally accepted definitions: “A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations.” (p. 13) The Cross framework (1989) emphasizes that the process of achieving cultural competency occurs along a continuum and sets forth six stages including:

a. Cultural destructiveness. Involves overt discrimination of certain people based on their differences such as age, gender, ability, sexual orientation, religion, ethnicity, race, and political affiliation.

b. Cultural incapacity or incompetence. Reflects covert forms of discrimination.

c. Cultural blindness. When professionals assume that they are unbiased but believe that dominant ideologies and ways of living are universally applicable.

d. Cultural precompetence. Signifies movement along the continuum, when professionals might attempt to serve minority groups, but lack relevant knowledge about various possibilities and procedures.

e. Cultural competence. Characterized by acceptance and respect for differences, self-assessment of professionals, consideration of the dynamics of difference, expansion of cultural knowledge and resources, and a variety of adaptations to the helping models to provide sensitive and appropriate services.

f. Culturally proficient. Professionals add to their knowledge base through research and experimentation. They establish positive helping relationships with their clients and enable them to help themselves.

In my view, this framework has thoughtfully articulated what is cultural competence, and it is useful for helping professionals and social service agencies to gauge their level of competence, including within the context of Singapore.

International Development of Cultural Competence in Social Work

In Social Work, Kohli, Huber & Faul (2010, p.257) took reference from the work of Cross (1989) and defined cultural competence as the ability of professionals to function successfully with people from different cultural backgrounds including, but not limited to, race, ethnicity, culture, class, gender, sexual orientation, religion, physical or mental ability, age, and national origin (Council on Social Work Education (CSWE), 2008). They elaborated that cultural competence in social work should:

a. Engage the development of abilities and skills to respect differences and effectively interact with individuals from diverse backgrounds.

b. Involve awareness of one's own biases or prejudices and is rooted in respect, validation, and openness toward differences among people.

c. Begins with an awareness of one's own cultural beliefs and practices, and the recognition that others believe in different truths/realities than one's own.

d. Imply that there is more than one way of doing the same thing in a right manner.

There have been significant theoretical paradigm shifts in the cultural competence social work training internationally. In the 1950s, the concept of melting pot was used, which emphasised assimilation. Social work educators focused on the cultural deficit model or mainstreaming "others" into the dominant ideological perspectives. By the 1960s, minorities articulated their needs and decried prior exploitation. Efforts were made to integrate the content on ethnic minorities and women into the social work curriculum. In the 1970s, the promulgation of minority perspective resulted in a unidimensional view that was somewhat paternalistic. This limited social workers and social work students rather than fostering respect and sensitivity. The promotion of cultural pluralism in the 1980s broaden the focus on other vulnerable and oppressed groups are important and was also included, not limited to race, ethnicity, and gender, and broadened to include sexual orientation and other cognitive and physical differences. Subsequently, diversity issues encompass not only ethnic and racial issues in the 1990s, but also variables such as age, sex, gender, physical and mental abilities, sexual orientation, religious affiliation, and political

affiliation. CSWE mandated that content on human diversity be included as one of the nine core areas of study in accredited schools of social work (CSWE, 2008). By the turn of the millennium, social constructionist approaches begin to recommend that an either/or approach should not be used when teaching students about sensitive issues; rather, a reflexive-dialectic stance (or a combination of appropriate approaches) should be employed. This is predicated on the notion that no one is born culture-less or identity-less; therefore, a humanistic approach that values and encourages the narratives of all social workers and social work students should be fostered.

Social work scholars and practitioners have in the past developed at least 10 different cultural competence frameworks (Kohli et al., 2010), which could be classified using three major perspectives (Anderson and Carter (2003):

- Ethnocultural: sensitise social workers to the relationship between ethnicity and culture
- Environmental: examine ecological & systems interaction
- Vulnerable life situations: consider how practitioners can learn from clients about the impact of different vulnerabilities and strengths

At the heart of these diversity perspectives are the strengths and empowerment frameworks. Moreover, four basic assumptions can be derived from the synthesis for all the frameworks from a postmodern paradigm:

- Reality is socially constructed
- Diverse worldviews need to be appreciated
- Multiple realities affect individual personalities, and
- Diversity education has a positive impact on the journey to cultural competency.

However, whilst the constructionist perspective is useful in synthesizing a constructed reality, we need to be mindful that abuses, biases, discriminations, and the like are real and not ‘constructed’ sufferings and must be confronted and have consequences. Moreover, while the various cultural competence frameworks can be useful, we also need to be cognizant of their limitations. First, literature on cultural content is diffuse and there is no consensus on a theoretical framework in social work. Several models have been adapted to effectively integrate human diversity content into the social work curriculum. However, only Lum (2000) has detailed a process stage approach for developing culturally competent practitioners. Last but not the least, many of these frameworks focused on individual professionals and not on organization and related macro processes and policies governing the services and organisations.

What can we do to promote cultural competence among social workers? Historically, little attention was given to providing culturally sensitive social services, and emphasis was placed on fitting clients into available service categories (Harper & McFadden, 2003). The focus has now shifted with the increased awareness about diversity issues and understanding that no particular race or culture’s way of seeing and interpreting events is superior to others. Rather, the social-political-economic-cultural situations in which people are embedded often define or color their perceptions of reality. There are at least two-fold efforts to produce culturally competent social workers. First, social workers and social work students need to be educated to become self-aware and have an appreciation of their own value systems. Miller and Garran (2007) also contend that social workers need to first look at and confront racism inside us before looking outside. Second, professionals

need to be immersed in cultural experiences where they observe the uniqueness of every individual. Various “isms” (i.e., ageism, racism, sexism, and homophobia) are still a reality in today’s society. Social workers at times have limited awareness of manifestations of such discriminations and many at times do not act on them professionally in field settings (Garcia & Van Soest, 1997). This leads to potential harm—both for social work students, practitioners, and for the clients whom they will later serve.

Local Development of Cultural Competence in Social Service

While limited literature exists on cultural competence in Singaporean social work, efforts have been made to address cultural diversity through publications and research initiatives. Let us review what has been done to develop and discuss cultural competence in social work

In social work, Ow (1999; 2019) is probably one of the forerunners who focused on developing cultural competence in social work field locally. She and her colleagues (Ling, Martin & Ow, 2013) co-authored a book that included a collection of works by contributors from different practice settings and different countries which facilitates the development of 'cultural competence' among social work students and educators, practitioners, and researchers. More recently, she presented some thoughts on the Malay Muslim worldviews (Ow & Saparin, 2014), and developed a research project with colleagues in assessing the needs and well-being of 17 Malay carers of people with mental illness in Singapore (Poon et al., 2020).

In the field of counselling, some local researchers adopted Sue et al. (1992)’s Multicultural Competencies (MCC) model, comprising three aspects of awareness, knowledge, and skills, to examine cultural competence in counselling. While research suggested that MCCs are positively associated with therapy outcomes, there were only a few studies that looked at cultural competence specifically within the local context (Ow & Osman, 2003; Wong, 2022). At the turn of the Millennium, Earley and Ang (2003) developed a conceptual framework called cultural intelligence (CQ), which examined individuals’ aptitude to effectively interact with people from different cultural backgrounds. Goh, Koch and Sanger (2008) described examples of the way CQ may manifest in psychotherapy situations and outline possible applications for clinical psychology with a focus on four facets:

- Strategy (Conscious awareness in monitoring)
- Knowledge (Cultural norms, practices, values etc.)
- Motivation (Learning and intrinsic interest)
- Behaviour (Verbal and nonverbal actions)

Jennings et al (2012) conducted a qualitative investigation on the multicultural competencies of 6 Singaporean master therapists. 8 themes within 2 categories emerged.

- Multicultural Knowledge
    i. Self-knowledge
    ii. Cultural immersion
    iii. Cultural knowledge
    iv. Knowledge of systemic/historic oppression
- Multicultural Skills:
    i. Respect
    ii. Cultural misunderstandings lead to humility & growth
    iii. Ask, don't assume
    iv. Suspend judgement & avoid imposing values

However, specific discussion on multicultural competence related to working different ethnic groups, issues or settings are not highlighted by the master therapists in this study.

Developing Social Work Cultural Competence in Singapore

What may be next for Singapore social service sector in developing cultural competence? Personally, I have four suggestions. First, constantly reviewing and learning in specific service domains is a first step to understanding and knowing about a complex domain like cultural competence. Second, continual assessment and reflection on our current cultural competence at both individual and organisational level is crucial locally. Third, I am of the persuasion that it is crucial to adopt a transdisciplinary approach to develop a locally salient model to develop cultural competence for the sector is urgently needed (Sim et al., 2019). Last but not the least, the adoption of boundary-crossing learning is instrumental in developing cultural competence in Singapore. Let me elaborate.

Reviewing Literature in specific service domains

As we continue to serve diverse clientele that are different from us and what we know, professionals must continue to increase their understanding of the specific clientele who are different culturally. Take for example, being a Chinese couple and family therapist, I often wonder: What works for Muslim couples? With the help of librarian in SUSS, Ms. Manimekalai Thirumalai, we conducted a search on couple therapy with Muslims, and found at least 20 items internationally. I was rather surprised by the limited literature available, but it was a good place to start with. And it is indicative to me there is a huge gap in this critical area of work for us in Singapore.

In exploring diverse tools and processes for review, the incorporation of a comprehensive literature review is paramount, including black literature (e.g., peer reviewed journals) and grey literature (e.g., government reports, books, and journals),

quantitative and qualitative and mixed methodologies. From an extensive review of review methods from 2009 to 2019, Sutton and colleagues (2019) delineated 48 methods into seven distinct families of reviews and compiled 15 methods accompanied by official guidelines. We should note that a meticulously executed literature review can serve as an independent research endeavor, characterized by profound synthesis and interpretation of all pertinent research pertaining to the identified research inquiry (Munn et al., 2018). Hence conducting a rigorous review is undoubtedly a useful strategy for the field to increase our cultural competence, particularly in increasing our knowledge and values on the cultural diversity of our service users.

Assessing Individual and Organisational Cultural Competency

To assess cultural competence, both at individual and organization levels, we could use Cross (1989) six-stage framework, or we could use the core competence of social work comprising values or awareness, knowledge, and skills to conduct the assessment. There are currently at least seven instruments available in assessing professional cultural competencies (Jani et al., 2016):

- Cross-Cultural Competency Inventory
- Multicultural Awareness-Knowledge-Skills Inventory
- Multicultural Counseling Awareness Scale
- Multicultural Counseling Inventory
- Quick Discrimination Index
- Miville-Guzman Universality-Diversity Scale
- Ethnic-Competence-Skill Model in Psychological Interventions With Minority Ethnic Children and Youth

Although the latter four have been recommended for use in social work (Krentzman & Townsend, 2008), there is yet sufficient validation of these instruments to justify their application to the assessment of clinical outcomes or educational goals (Boyle & Springer, 2001). Moreover, these instruments need to be further validated in our local context.

At an organisational level, cultural competence is a dynamic, ongoing process that begins with awareness and commitment, hence evolves into culturally responsive organizational policies and procedures. A commitment to improving cultural competence must include resources to help support ongoing fidelity to these policies and procedures along with an ongoing process of reassessment and adaptation as client and community needs evolve (Substance Abuse & Mental Health Services Administration (SAMHSA), 2014, p. xix). An organizational self-assessment prioritises the steps needed to improve culturally responsive services. The plan should address strategies for:

- Recruiting, hiring, retaining, and promoting qualified staff members;
- Diverse staff members;
- Use of interpreters or bilingual staff members;

- Staff training, professional development, and education;
- Fostering community involvement;
- Facilities design and operation;
- Development of culturally appropriate program materials;
- Incorporate culturally relevant treatment approaches; and,
- Development and implementation of supporting policies and procedures, including reassessment processes.

Transdisciplinary Collaboration: Pursuing a Multi-Dimensional Cultural Competence Framework for Case Work and Counselling in Singapore

To conceptualise a cultural competence framework relevant to Singapore, I think it is important to engage the different stakeholders of different field and sectors using a transdisciplinary collaboration approach, i.e., across disciplines and sectors, involving different stakeholders, including our clients (Sim et al, 2019). Having reviewed several frameworks and models the counselling, education, medicine, psychology, and social work, I find the Multidimensional Model for Developing Cultural Competence, developed in 2014 by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) to be one of the most comprehensive models. The SAMHSA model has three dimensions:

- Dimension 1: Racially & Culturally Specific Attributes. This dimension includes of African & Black, Asian, Hispanics & Latinos, Native and White Americans. It also includes other multiracial and culturally diverse groups and can also include sexual orientation, gender orientation, socioeconomic status, and geographic location.
- Dimension 2: Core Elements/Competencies of Cultural Competence. This dimension includes cultural awareness, cultural knowledge, and cultural skill development. There is a 341-page “Treatment Improvement Protocol (TIP)” that articulates meticulously what they are specifically.
- Dimension 3: Foci of Culturally Responsive Services. This dimension targets key levels of treatment services: the individual staff member level, the clinical and programmatic level, and the organizational and administrative level. Interventions need to occur at each of these levels to endorse and provide culturally responsive treatment services, and such interventions are clearly addressed.

2. Looking at our field and local contexts, I would like to suggest adding a sub-dimension to each. A sub-dimension to be added for the first dimension on “Racially & Culturally Specific Attributes” entails focus on Chinese, Malay, Indian, and other cultural/ethnic groups (including LGBTQIA2S) specific to our context. We could consider elaborating on the specific cultural competencies for working with children, couples and families, older adults, and others in Singapore. This could be achieved through a literature review, as previously mentioned.

Next, I would suggest adding a sub-dimension to the second dimension on Core Elements/Competencies of Cultural Competence by integrating the counselling and social work process model, related to engagement, assessment, contracting,

interventions, and evaluation. For example, during the stage of engaging different clientele, we should learn about the necessary awareness, knowledge, and cultural skills. Specifically:

- What are the help seeking behaviours of a particular culture group?
- Who and how should we address or greet for a start?
- What are the common issues experienced by this community?

For the third dimension on "Foci of Culturally Responsive Services", I would like to suggest adding a sub-dimension on core competencies in working with specific issues related to mental health and illnesses and challenges issues. This includes but not limited to issues related to critical incidence, death and dying and so on, particularly considering the different manifestations commonly adopted by different cultures.

Boundary-Crossing Learning

My last suggestion is predicated on the earlier three suggestions on promoting boundary-crossing learning and leadership development. What is boundary-crossing learning? It is the competence to learn from and co-create with others outside one's own scientific domain, institute, culture, or context. Incidentally Singapore University of Social Sciences recently launched a master degree in boundary crossing learning and leadership.[1] This is a novel, transdisciplinary-focused, cutting-edge, and innovative programme which is created to accelerate the capacities of Training and Adult Education (TAE) sector professionals and leaders, and those who function as organisational change-makers, to cope with, strategise within and lead in a highly disruptive world. On a dynamic and diverse topic such as cultural competence, I believe a boundary-crossing approach to learning and leadership development would be one of the most poignant approaches as we come together to learn from one another.

Conclusion

I have been privileged to work in a post-earthquake situation in China in 2008 to 2016, where at least 50% of those affected were minority (i.e., Qiang and Zang minorities) in the epic centre, where 9000 out of 12000 perished. The moment I arrived at the epic centre, one thing was evident, the rural setting did not know what social work or psychotherapy was. In fact, there was dictum: run away from dogs, run away from fire, and run away from psychotherapy, where counselling and social work was unknown (Sim, 2009; 2015).

There is much to do in developing the cultural competence of social work both internationally and locally. I recently met my Clinical Supervisor Professor Ivan Eisler from King's College London since I graduated in 1997. Having visited Singapore, he reminded me that Singapore is one of the best "labs" where there are so many possibilities and capacities, including the multi-cultural context that we are so proud of. I believe, Singapore can play a part in developing and promoting cultural competencies in business, counselling, political studies, and definitely social work. This is especially so many social policies are already in place to foster cross cultural interactions and learning from one another, and the challenge is not just to counsellors and social workers, but also educators and policy makers (Ow & Osman, 2003).

[1] See here: https://www.suss.edu.sg/programmes/detail/master-in-boundary-crossing-learning-and-leadership

In closing, may I quote Cross et al (1989) as we contemplate in what we could do to increase the cultural competency of counselling and social work in Singapore:

> "Becoming culturally competent is a developmental process for the individual and for the system. It is not something that happens because one reads a book, or attends a workshop, or happens to be a member of a minority group. It is a process born of a commitment to provide quality services to all and a willingness to risk." (p.21)

In the dynamic fields of counseling and social work, the journey toward cultural competence is undeniably intricate. Too often, institutions and systems crave easy fixes, hoping for textbook solutions or step-by-step guides to navigate the complexities of cultural understanding. This inclination is not unfamiliar to us. Yet, the truth remains: achieving genuine cultural competence transcends mere formulas or quick fixes. It demands a fervent commitment to delve deep, to grapple with nuance, and to embrace the profound complexities inherent in bridging diverse cultural landscapes.

References

Anderson, J., & Carter, R. W. (2003). Diversity perspectives for social work practice. Boston: Allyn & Bacon.

Boyle, D. P., & Springer, A. (2001). Toward a cultural competence measure for social work with specific populations. Journal of Ethnic and Cultural Diversity in Social Work, 9(3-4), 53–71. https://doi.org/10.1300/J051v09n03_03

Council on Social Work Education (CSWE). (2008). Educational Policy and Accreditation Standards. Retrieved on April 27, 2024 from: http://www.cswe.org/Accreditation/2008EPASDescription.aspx

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). Towards a culturally competent system of care, Volume 1. Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

Early, P. C., & Ang, S. (2003). Cultural intelligence: Individual interactions across cultures. In S. Ang & L VanDyne (Eds.)., Handbook of cultural intelligence (pp. 257-270). Armonk, NY: M.E. Sharpe.

Garcia, B., & Van Soest, D. (1997). Changing perceptions of diversity and oppression: MSW students discuss the effects of a required course. Journal of Social Work Education, 33(1), 119–129. http://www.jstor.org/stable/23043022.

Goh, M., Koch, J. M., & Sanger, S. (2008). Cultural intelligence in counseling psychology: Applications for multicultural counselling competence. In S. Ang & L. VanDyne (Eds.), Handbook of cultural intelligence (pp. 257-270). Armonk, NY: M.E. Sharpe.

Harper, F. D., & McFadden, J. (2003). Culture and counseling: New approaches. Boston: Allyn & Bacon.

Jani, J. S., Osteen, P & Shipe, S. (2016). Cultural competence and social work education: Moving toward assessment of practice behaviors. Journal of Social Work Education, 52(3), 311–324. http://dx.doi.org/10.1080/10437797.2016.1174634

Jennings, L., Gulden, A., Oien, M., D'Rozario, V., Goh, M., & Skovholt, T. (2012). Multicultural knowledge and skills of Singaporean master therapists. Journal of Asia Pacific Counseling, 2(2), 133–146. https://doi.org/10.18401/2012.2.2.1

Kohli, H. K., Huber, R., & Faul, A. C. (2010). Historical and Theoretical Development of Culturally Competent Social Work Practice, Journal of Teaching in Social Work, 30(3), 252-271. https://doi: 10.1080/08841233.2010.499091

Krentzman, A., & Townsend, A. (2008). Review of multidisciplinary measures of cultural competence for use in social work education. Journal of Social Work Education, 44(2), 7–32. https://doi:10.5175/JSWE.2008.200600003

Ling, H. K., Martin, J., & Ow, R. (2013). Cross Cultural Social Work: local and global. Palgrave MacMillan.

Lum, D. (2000). Social work practice and people of color: A process stage approach. Belmont, CA: Wadsworth.

Miller, J., & Garran, A. M. (2007). Racism in the United States: Implications for the helping professions. Belmont, CA: Thomson

Munn, Z., Stern, C., Aromataris, E., Lockwood, C., & Jordan, Z. (2018). What kind of systematic review should I conduct? A proposed typology and guidance for systematic reviewers in the medical and health sciences. BMC Medical Research Methodology, 18(1), 5-14. https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/s12874-017-0468-4

Ow, R. (1999). Social work in a multicultural context. International Social Work, 42(1), 7-14. https://doi.10.1177/002087289904200102

Ow, R. (2019). Cross cultural social work practice. In Munford & O'Donoghue (Eds.). New theories for social work practice (pp. 231-247). Jessica Kingsley Publishers

Ow, R. & Osman, M. M. (2003). Issues and Challenges of Cross Cultural Counselling in Singapore. Asia Pacific Journal of Social Work and Development 13(1):81-98. https://doi.10.1080/21650993.2003.9755914

Ow, R., & Saparin, N. H. B. (2014). Malay Muslim Worldviews: Some Thoughts for Social Work Practice in Singapore. Journal of Religion & Spirituality in Social Work: Social Thought, 33(1), 73–94. https://doi.org/10.1080/15426432.2014.874261

Poon, A. W. C., Wahab, N. A. Salim, R., & Ow, R. (2020). Well-being and needs of Malay carers of people with mental health in Singapore, Health and Social Care, 29(1), 164-174. https://doi.org/10.1111/hsc.13079

Sim, T. (2009). Crossing the river stone by stone: Developing an expanded school mental health network in post-quake Sichuan. China Journal of Social Work, 2(3), 165–177. https://doi.org/10.1080/17525090903211713

Sim, T. (2015). Building back better in disaster management. Making knowledge sexy. https://vimeo.com/128756640

Sim, T., Young, J., Lau, J., & Cui, K. (2019). Initiating transdisciplinary research in China: A case study. International Journal of Environmental Sciences & Natural Resources. 22(1). IJESNR.MS.ID.556080. https://odi: 10.19080/IJESNR.2019.22.556080

Substance Abuse and Mental Health Services Administration (SAMHSA) (2014). A treatment improvement protocol: Improving cultural competence. US Department of Health and Human Services. Retrieved on November 6, 2022 from: https://store.samhsa.gov/product/Improving-Cultural-Competence/sma16-4931

Sutton, A., Clowes, M., Preston, L., & Booth, A. (2019). Meeting the review family: Exploring review types and associated information retrieval requirements. Health Information & Libraries Journal, 36(3), 202–222. https://doi.org/10.1111/hir.12276

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. Journal of Multicultural Counseling and Development, 20(2), 64–88. https://doi.org/10.1002/j.2161-1912.1992.tb00563.x

Wong, S. S. (2002). Multidimensional clinical interviewing (MCI): An integrative approach. In A. G. Tan & L. C. Law (Eds.)., Psychology in context: A perspective from the Southeast Asian societies (pp.232-249). Singapore Lingzi Media.

The Snippet Team

Check out other Snippet publications **here**!

Editorial Team

Review Editor: Dr. Rosaleen Ow
Executive Editor: Dr. Xu Jianbin
Editorial Assistant: Nurul Fadiah Johari

Questions for us? Want to write for us?

Contact us at:

NUS Social Service Research Centre

Faculty of Arts and Social Science
National University of Singapore
The Shaw Foundation Building, Block AS7,
Level 3, 5 Arts Link,
Singapore 117570

Email: ssr@nus.edu.sg
Phone: 6601-5019
Website: https://fass.nus.edu.sg/ssr/

Upcoming SSR Events

SSR Training:
Introduction to Realist Evaluation for Social Services (July 2024). Click **here** for more information.

Critical Discourse Analysis for Social Services (August 2024). Click **here** for more information.

SSR Seminar Series:
Research Ethics for Social Services. Click **here** for more information.

Connect with Us

Check out updates on SSR events and more on our social media!