A QUALITATIVE STUDY OF PSYCHOTHERAPISTS" APPROACHES TO CROSS-CULTURAL ASSESSMENT, DIAGNOSIS AND TREATMENT OF POSTTRAUMATIC STRESS DISORDER AND MAJOR DEPRESSIVE DISORDER IN KWAZULU-NATAL, SOUTH AFRICA

By

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Declaration

Submitted in fulfilment / partial fulfilment of the requirements for the degree of MSocSci Clinical Psychology, in the Graduate Programme in Applied Human Sciences, University of KwaZulu-Natal, Pietermaritzburg, South Africa.

I, Meggan Slabbert, declare that:

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Abstract

Psychiatric illnesses are a reason for major concern for the health and welfare of people internationally and within the South Africa context (Slone et al., 2006; Stein et al). The rates of specific disorders such as Major Depressive Disorder (MDD) and Posttraumatic Stress Disorder (PTSD) are high within the South African context. This may be attributed to past human rights abuses, and current high rates of poverty, violence and trauma (Edwards, 2005). In South Africa, the process of psychological assessment, diagnosis and interventions can be challenging for psychologists specifically (Knight, 2004), due to the multicultural and multi-lingual contextual nature of the country.

In this study, the relevant approaches used by psychotherapists, when assessing, diagnosing and intervening with clients from different ethno-cultural orientations were investigated from an interpretive paradigm in which a qualitative approach was used. Specific reference was given to the assessment, diagnosis and treatment of Major Depressive Disorder (MDD) and Posttraumatic Stress Disorder (PTSD) across cultures. Psychotherapists whom assess, diagnose and treat within private practice from various areas were selected to represent the broader KwaZulu-Natal area.

Contextual factors are influential in determining multicultural assessment processes and the cultural competency of a clinician. Clinicians maintain that there is a need for different approaches to assessing, diagnosing and treating clients from different ethno-cultural orientations but also highlight that this is not sufficient in determining the approaches that may suit the needs of clients. The findings of this study highlight that the assessment, diagnosis and treatment of MDD and PTSD across cultures within the South African context is dependent on the clinician's perception and awareness of the relationship between culture and pathology. This will ultimately inform the clinician's understanding of the client's problems; the practical work done in relation to these problems; as well as how clients may respond to interventions used. The transition from the use of standard assessment and perception of cultural sensitivity to the use of multicultural assessment and development of cultural competency was prominent in this study. The need for attention to be given to the notion of clinician bias in developing and maintaining cultural competency in assessing, diagnosing and treating client's from multiple ethno-cultural orientations was highlighted in this study.

Chapter 1: Introduction

Background and Outline of the Research Problem

Posttraumatic Stress Disorder (PTSD) can be defined as a condition that is characterised by the development of symptoms that follow post exposure to a traumatic life experience or event (Sadock & Sadock, 2007). Major Depressive Disorder (MDD) is a depressive disorder that commonly presents with changes in affect, cognitions and behaviours. The disorder is related to problems relative to social and cognitive functioning and depressive disorders are characterised by a sense of loss of control and distressing subjective experiences (Slone et al., 2006). The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is the latest version of the manual developed for the understanding of mental disorders, their treatments and for research (American Psychiatric Association [APA], 2013). This is one of the most commonly used manuals or guides for diagnosing mental disorders (APA, 2013). The DSM-5 highlights that a relationship between culture and pathology exists and that it is imperative to be aware of and acknowledge this relationship when assessing, diagnosing and treating MDD and PTSD.

In South Africa, the process of psychological assessment, diagnosis and interventions can be a challenge for psychologists and other mental health care professionals. This is relevant within the context of both training and professional practice (Knight, 2004). PTSD and MDD can be disabling conditions that can cause considerable distress for individuals and have a profound impairment on interpersonal relationships in multiple contexts such as home, work and socially (Blatt, 2004; Edwards, 2005b). High prevalence rates of MDD and PTSD and the disabling and maintaining nature of both conditions within the South African context is well documented in the South African literature.

Also, for the purpose of this study it is important to define the relevant concepts that are under investigation such as psychological "assessment", "diagnosis/diagnoses" and "treatment/intervention/therapy". According to Foxcroft and Roodt (2004) psychological assessment is defined as an activity that is process-oriented and involves gathering multiple types of information from a variety of sources. This includes the use (administration, scoring and interpretation) of psychometric measures (tools/tests) as well as other sources such as interviews with the client or alternatively with collateral sources. According to the DSM-5,

the concept of diagnosis can be defined as the use of clinical expertise to identify "symptoms, behaviours, cognitive functioning, personality traits, physical signs, syndrome combinations and durations" (p. 5) that fit within a classification system relative to mental illness. Lastly, Corey (2009) refers to a broad definition of psychotherapy as a process whereby two or more people engage within a particular process of healing. Within psychology, this process can be informed by multiple theoretical and practical approaches.

Research Aims

The main aims or objectives of this study are:

1. To explore psychotherapists' perceptions and practical experiences of assessing, diagnosing and treating clients from multiple ethno-cultural population groups

2. To examine the methods of assessment, both qualitative and quantitative that psychotherapists use in practice with clients from multiple ethno-cultural population groups to assess for major depressive disorder (MDD) and posttraumatic stress disorder (PTSD).

3. To examine the methods of diagnosis if any, psychotherapists use with clients from multiple ethno-cultural population groups relative to MDD and PTSD.

4. To examine the modes of interventions used for disorders such as MDD and PTSD

5. To investigate whether client's responses to these approaches differ in accordance with their specific ethno-cultural orientation; and lastly,

Research Problems and Fundamental Questions

1. Does a diverse ethno-cultural sample of psychotherapists think there is a need for diverse cross-cultural assessment approaches in their practices?

2. How does a given sample of psychotherapists define major depressive disorder (MDD) and posttraumatic stress disorder (PTSD)?

3. Do the specific approaches for assessment, diagnosis and treatment used by a given sample of psychotherapists for MDD and PTSD differ between the clients ethnic groups?

4. Do the client's responses to assessment, diagnosis and intervention for MDD or PTSD differ according to their ethnic group?

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Purpose and Focus of the Study

The purpose of this study was to explore the similarities and/or differences between psychotherapists" approaches to assessing, diagnosing and treating clients from various ethno-cultural orientations. In particular, the study focused on exploring psychotherapists" perceptions of the role of culture in assessing, diagnosing and treating clients on a daily basis as well as the particular role that these perceptions have in relation to disorders of MDD and PTSD. Also, examining psychotherapists" practical approaches in doing so and whether culture is accounted for in those practices, again, specific to MDD and PTSD.

Rationale

While psychologists are made aware of the challenges they face regarding culture and psychopathology, there are still no clearly defined strategies or approaches particular to and/or stemming directly from the South African context, in terms of how to ensure culturally sound practices. This is supported by Foxcroft, Paterson, le Roux and Herbst (2004) as well as Gentz and Durrheim (2009) who state that psychology has been criticised for its inability to transcend all demographics and for the lack of applicability of its westernised roots in a South African context.

Literature within the South African context highlights that significant changes in mental health care policy, funding and research are needed. This is specifically relevant to factors such as pathogenesis and intervention methods used to treat mental illness in multiple contexts (Stein et al., 2008). Literature based within the South African context that illustrates the relationship between culture and mental health on a practical level is limited. Specifically, regarding the nature of disorders such as MDD and PTSD across cultures and how this may influence treatment outcomes.

In his study on the treatment of Posttraumatic Stress Disorder in South Africa, Edwards (2009), emphasises that modes of treatment developed in first world countries; that are predominantly evidenced-based, do not always require extensive adaption when used in multiple varying cultural contexts. This, however, is based or dependent upon the clinicians" ability to demonstrate adequate responsiveness to the client"s context (Edwards, 2009). Thus, the argument proposed by Edwards 2009, concerning the practical application and effectiveness of currently used intervention/psychotherapy methods across contexts (specifically cultural contexts), forms part of the investigation of the current study.

Therefore, the proposed study sought to explore psychotherapists" approaches to assessment, diagnosis and treatment of MDD and PTSD in private practice. This includes identifying what culturally ethical practices in the private domain in KwaZulu-Natal may entail. It is envisaged that the findings will contribute to the enhancement of knowledge pertaining to cross-cultural assessment, diagnosis and intervention as well as provide broad guidelines concerning culturally-appropriate services rendered by psychotherapists in independent practice.

Chapter Outline

Following Chapter 1, which served as a preparatory chapter for the study, there are five subsequent chapters. Chapter 2 is a comprehensive review of the literature and previous research studies conducted. It highlights specific gaps in the literature and thus provides an argument in support of the current study. Chapter 3 examines a detailed description of the research paradigm – interpretevist paradigm – and specific methodological aspects of the research, including specific reference to the methods used for material collection and analysis. All ethical considerations are also mentioned here. Following this chapter, Chapter 4 is the findings chapter. Here, patterns and themes that emerged from the material data are presented and illustrated with quotes selected. In Chapter 5 the relevant findings and interpretations are discussed in detail in concurrence with the literature presented in Chapter 2.

Chapter 6 is the final chapter in this research study and is predominantly a summary of the salient findings in this research. Limitations to the study and problematic areas are briefly discussed in this chapter and based on these limitations; specific recommendations are provided for future research studies and reports. Following this chapter is the reference list and all appendices consisting of the official documents used in the process of conducting this research.

Conclusion

The celebration of diversity is promoted in South Africa. The South African policies and laws that are pertinent to the practice of psychologists, have been passed for the purposes of certifying unbiased and fair mental health care service provision to all citizens (HPCSA, 2006; Radebe, 2010; RSA, 1996). At the time of this study, minimal studies had been

conducted in South African on the relationship between culture and mental health, and how this relationship may influence the practice of psychologists. It is for this reason that this study was undertaken. The following chapter presents the literature reviewed and the argument for this study.

Chapter 2: Literature Review

Introduction

Psychiatric illnesses are a reason for major concern for the health and welfare of people all around the world (Slone et al., 2006). In South Africa, the process of psychological assessment, diagnosis and interventions can be a challenge for psychologists and other mental health care professionals. This is relevant within the context of both training and professional practice, although attempts are being made to ensure that psychological practices such as testing and assessment, diagnosis and psychotherapy are more meaningful and powerful (Knight, 2004) within African contexts.

In their study on the lifetime prevalence of psychiatric disorders in South Africa, Stein et al. (2008) state that the prevalence of psychiatric disorders in South Africa can be expected to be high because:

"Stressors such as racial discrimination and political violence have been perennial in the past, and high rates of gender inequality and criminal violence are reportedly a feature in the present. Poverty remains a significant problem, and is likely to contribute to vulnerability to common psychiatric disorders in low-income countries" (p. 112).

Research and literature on the relationship between culture and the psychological assessment, diagnosis and treatment of disorders such as major depressive disorder (MDD) and posttraumatic stress disorder (PTSD) within the South African context is limited. Some South African research and literature stems from during the apartheid era and some directly after the instilling of democracy. These studies and literature may therefore reflect a differing social milieu than that which is represented today. According to Edwards (2005) despite the transition to democracy, many people living in South Africa are suffering from PTSD either as a result of past human rights abuses or the current high rates of domestic and criminal violence, making PTSD a significant concern for public health in South Africa (Edwards, 2005).

According to Slone et al., (2006), "because the majority of depression research has been completed in the United States and other developed, Western countries, more extensive cross-cultural research efforts are needed" (p. 159). Internationally, there are significantly

larger areas of research and literature into the domain of culture and psychopathology which is highlighted in this particular chapter as both local and international literature is reviewed here.

Symptomology of Posttraumatic Stress Disorder and Major Depressive Disorder

PTSD can be defined as a condition that is characterised by the development of symptoms that follow post exposure to a traumatic life experience or event (Sadock & Sadock, 2007). These symptoms are broadly characterised by a reaction of fear and helplessness and persistent re-experiences of the event either in dreams or daily thoughts or both. These emotions and thoughts also give rise to avoidant behaviours and the clinical presentation of PTSD can vary between detachment of responses and/or hyper arousal (APA, 2013). It is noted that if the traumatic experience is prolonged, repeated or severe, additional symptomology may include difficulties in emotional regulation and maintaining interpersonal relationships leading to isolation and dissociative symptoms (APA, 2013).

MDD is a depressive disorder that commonly presents with changes in affect, cognitions and behaviours. The disorder is related to problems relative to social and cognitive functioning and depressive disorders are characterised by a sense of loss of control and distressing subjective experiences (Slone et al., 2006). Changes in affect are paired with a particular mood that is sad, empty or irritable. Somatic or neurovegetative functions include changes in appetite and weight, changes in sleep and activity levels, and changes in energy and/or libido (APA, 2013). Behavioural and cognitive changes also occur including feelings of guilt, difficulties with concentration, attention and decision making processes. Recurring thoughts of death and suicide may also be evident and extreme isolation (Sadock & Sadock, 2007). All of the aforementioned changes have a significant impact on an individual's ability to function socially and occupationally. Changes in functioning occur within what is termed a depressive episode where periods of remission are noted between these episodes. Thus, what separates MDD from other depressive disorders is its episodic nature and time criteria (APA, 2013). The time criteria and nature of episodes mentioned in this section for both MDD and PTSD are relative to the criteria stipulated in the Diagnostic and Statistical Manual for Mental Disorders (DSM-5) (APA, 2013).

Diagnostic and Statistical Manual for Mental Disorders Fifth Edition (DSM-5)

The DSM-5 is the latest version of the manual developed for the understanding of mental disorders, their treatments and for research. This is one of the most commonly used manuals or guides for diagnosing mental disorders (American Psychiatric Association, 2013).

There have been some significant changes for PTSD from the DSM-IV-TR to the DSM-5 (APA, 2013). Firstly, PTSD is no longer grouped under the Anxiety Disorder category but rather falls within a new chapter termed Trauma-and Stressor-Related Disorders. This may be relative to criticisms made regarding the need for a broader use and definition of the word *trauma* in order to include events and experiences not necessarily associated with PTSD (Collings, 2004 as cited in Edwards, 2005a). This new chapter gives more consideration to PTSD as an important condition with concomitant, observable factors that require attention (Stetka & Correll, 2013). Criterion A2 (subjective reaction) has been removed from the DSM-5 but Criterion A is more clear on how the individual may have experienced the traumatic event/s. In the DSM-IV-TR there were three major symptom clusters of re-experiencing, avoidance/numbing and arousal. In the DSM-5 there are now four clusters as the avoidance/numbing cluster has been divided into two clusters, namely avoidance and persistent negative alterations in cognitions and mood.

There have also been inclusions of irritable or aggressive behaviour and reckless or self-destructive behaviour in the arousal and reactivity cluster in DSM-5 (APA, 2013). This may assist in focusing clinician‟s attention here (Stetka & Corell, 2013). Lastly, specific developmental thresholds have been included in DSM-5 where thresholds for diagnosis have been lowered for children and adolescents and criteria for children 6 years and younger has been separated (APA, 2013). This may allow for better characterization of PTSD in paediatric and adolescent populations who are often victims of trauma and thus have a high vulnerability to developing PTSD (Stetka & Corell, 2013).

According to the American Psychiatric Association (2013), there have not been many extensive changes to the criteria for MDD from DSM-IV-TR to DSM-5 barring in number arrangement where criterion C is now listed as B. One specific change made is the acknowledgement of manic symptoms (that do not satisfy the criteria for a manic episode) within a major depressive episode with the inclusion of the with mixed features criteria. This was intended to determine the likelihood that the symptoms fall more appropriately within a

Bipolar Spectrum or Depressive Spectrum (APA, 2013). An additional change includes the removal of the bereavement exclusion from MDD. Reasons for this exclusion include, firstly, removing the assumption that bereavement lasts only two months; secondly, bereavement is now noted as a possible severe psychosocial stressor that can provoke the occurrence of a major depressive episode after the loss; third it is noted that bereavement-related major depression may be linked to an individual‟s genetic predisposition, family history and personality patterns such as in non-bereavement related major depression (Sadock & Sadock, 2007). Lastly, both bereavement-related and non-bereavement related major depression respond adequately to similar modes of treatment and intervention (APA, 2013). In response to this, Stetka and Corell (2013) state that this inclusion may have implications for practice, where a seemingly normal process, namely that of bereavement, may be pathologized.

In addition, in the DSM-5, a descriptive section of certain factors or issues that may be associated with culture and how this may be relative to the diagnosis of MDD and PTSD is included (APA, 2013). For MDD, the sub-section highlights that there may be differences in the expression of MDD across cultures, thus acknowledging that a relationship exists between culture and pathology. What the sub-section also highlights is that, the specific association between certain cultures and certain symptoms has not been established. Thus, the sub-section purely notes that the diagnosis of MDD is easily missed across many cultures and that somatic complaints commonly form the presenting complaints in cases of MDD across cultures (APA. 2013).

For PTSD, the sub-section again purely acknowledges that a relationship exists between culture and pathology but does not provide specifics for different cultures. Rather, it highlights, that due to the variations in the type of traumatic exposure, the meaning attributed to the traumatic event, the individual‟s socio-cultural context and factors such as acculturation may influence the risk of onset and level of severity of PTSD across cultures (APA, 2013). Also, it mentions that PTSD signs and symptoms may differ across cultures and that the development of comorbid disorders may also be relative to the cultural orientation of individuals.

Thus, the DSM-5 highlights that a relationship between culture and pathology exists and that it is imperative to be aware of and acknowledge this relationship when assessing and diagnosing MDD and PTSD.

Culture and Psychopathology

The acknowledgement and awareness of the relationship between culture and psychopathology is critical in a South African context. Specifically within a multicultural context such as that found in South Africa where mental health care professionals deal on a daily basis with clients who are racially, ethnically, linguistically and culturally diverse (Sharp et al., 2010).

The relationship between culture and abnormal behaviour is an intricate one and the use of the term *culture* in this regard can be perplexing. This is because the term culture is often used interchangeably to include both the broader dimensions of society, but it can also be representative of the differing compositions of each individual client (Draguns & Tanaka-Matsumi, 2003). Furthermore, clinical interest in the relationships between culture and abnormal behaviour can be examined on a micro-level between interacting cultures sharing the same country or on a macro-level where cultural groups may have unrelated histories and are separated geographically across the world (Draguns & Tanaka-Matsumi, 2003). The current study is particularly interested in the former micro-level of culture with specific focus on examining the relationships between culture and abnormal behaviour within psychological private practice settings and within the particular province of KwaZulu-Natal.

It is important to distinguish between different views of culture as it is often used as a comprehensive term for almost everything relating to the human social world (Spiro, 2001). Drawing on the work of Marsella (1988), Draguns and Tanaka-Matsumi (2003) highlight a comprehensive definition of culture as:

"Shared learned behaviour which is transmitted from one generation to another for purposes of individual and societal growth, adjustment, and adaptation: culture is represented externally as artefacts, roles, and institutions, and it is represented internally as values, beliefs, attitudes, epistemology, consciousness, and biological functioning" (p. 756).

As represented in this definition, culture functions both on a societal level and ideational level. Examining the definition of culture on a societal level, mental illness or psychopathology is seen as socially or experientially caused. According to Spiro (2001), the use of culture in this sense refers to societal culture and "the patterned social relations that

characterize its various institutional domains" (p. 219). This, in relation to the above definition is the external representation of culture.

In contrast to this, the use of the term culture can also refer rather to the „meaning systems" and in relation to the definition above, the values, beliefs, attitudes, epistemology, consciousness, and biological functioning of a societal group (Marsella, 1988 as cited in Draguns & Tanaka-Matsumi, 2003). In the latter sense of culture then, abnormal behaviour or mental disorders are ideationally caused. This supports and aligns with ideas about the cultural relativity of psychopathology (Spiro, 2001).

Philosophically, cultural relativism itself can be viewed in two respects. Firstly, it is viewed from a descriptive or emic sense where particular judgements about mental illness are culturally relevant and dependent on cultural standards of groups. Secondly, it is viewed from the normative sense which maintains that there are no universal judgements regarding psychopathology. Here, Spiro, (2001) highlights two concepts namely pancultural standards which are standards shared by all cultures and extra-cultural standards which are standards determined and established by "a cosmopolitan science that transcends the folk standards of any and all local cultures" (p. 221).

As highlighted above, two approaches are particularly relevant when discussing and attempting to understand orientation of theory and research of psychopathology and the assessment thereof namely the universalistic and cultural relativism approaches (Draguns & Tanaka-Matsumi, 2003). Universalistic approaches are informed by Western constructs of social phenomenon and according to Thakker and Ward (1998) "such systems represent a means of placing together disorders or entities on the basis of their shared attributes or relations" (p. 501). The focus is on universal thinking, standard instruments of measurement, categorisation and classification (Dana, 2005).

The cultural relativist approach on the other hand views culture as having significant influences on manifestations of pathology. This view denies pancultural standards and in staying aligned with the normative sense of cultural relativism, maintains that there are no universal judgements regarding psychopathology. If this is the case, how are psychotherapists then able to assess, diagnose and treat different mental illness and disorders? Hoshmand (2010) argues for a cultural-ecological approach to individual clinical assessment and

intervention. This approach focuses more on the cultural context and ecological settings of the individual. This is supported by Edwards (2005a) who states that "there is considerable cultural variation in the ‚idioms of distress" that govern the expression of emotional states, depending on the overall context of cultural conditioning" (p. 119).

It is important to note that the use of certain words may presuppose certain assumptions about the meanings of those words and also, words such as culture, race and ethnicity are often used interchangeably to represent the same meaning (Hays, 2001). It needs to be explicitly stated that in this particular study the use of "cross-culture" or "cross-cultural" does not reference differences in accordance with *race* specifically. Furthermore, what this study does highlight is that the ethnic/racial orientation of individuals is often interwoven with specific cultural orientations resulting in ethno-cultural identities (Dana, 2005).

It has been argued then, that an orientation to a particular way of thinking or theoretical alignment in respect to the relationship or lack thereof between culture and psychopathology is very important (Dana, 2005; Edwards, 2005a; Hays, 2001; Hoshmand, 2010; Spiro, 2001). It may ultimately inform testing and assessment, diagnostics and intervention methods implemented by psychotherapists for pathological disorders such as major depressive disorder and posttraumatic stress disorder across cultures.

According to an cultural-ecological approach, it is these beliefs and values of the clinician and client in relations to their societal positioning that determine the structuring of clinical practice in psychology by acknowledging the complexities of individual cultural identity (Dana, 2005). Dana (2005) goes on to state that some of these individual differences relate to ways of thinking about mind-body dualism, values, spirituality, health-illness beliefs, individualism-collectivism and locus of control and responsibility. According to Corey (2009) "rather than stretching the client to fit the dimensions of a single theory, practitioners need to tailor their theory and practice to fit the unique needs of the client" (p. 426).

A gap in the South African literature exists relative to if/how clinicians practically go about doing so, that is, modifying their theories and practices to suit the needs of clients from different cultural backgrounds – specifically when assessing, diagnosing and treating

disorders such as MDD and PTSD across cultures. This is one particular question that this study aimed to examine.

Etiology and Epidemiology of PTSD and MDD

Apprehensions when discussing cross-cultural assessment and intervention of MDD and PTSD are relative to: the limited comparison of data or epidemiological research across countries and within countries across cultures; and the vast differences in symptomatology and other features of pathology and the nature of links between psychopathology and culture (Draguns & Tanaka-Matsumi, 2003).

Research on both MDD and PTSD has been stunted by the aforementioned concerns as although both disorders are evident in all human societies, they differ in the way they are experienced, the modes in which they are expressed and communicated and the social milieus in which they are structured (Connor & Stein, 2005; Draguns & Tanaka-Motsumi, 2003). In contrast, Petersen and Lund (2011) state that there has been some progress in epidemiological studies within the South African context but that there is a strong need for the facilitation and promotion of services that are culturally congruent.

In their study of the cross-cultural validity of PTSD and the implications of this for DSM-5, Hinton and Lewis-Fernandez (2011), found that there was a need for the implementation of criteria modification and textual clarifications to improve the cultural applicability of PTSD in DSM-5. This, they noted, is particularly relevant to the most observable features of avoidance/numbing, the nature of understanding of trauma caused symptoms and how these might influence symptomatology, and the occurrence of somatic symptoms. As seen above, some of these changes were considered and recently implemented in the DSM-5 including the expansion of the avoidance/numbing cluster into additional categories that may be more relevant to symptom presentation and observation. These changes have thus contributed to the cross-cultural validity of diagnosing PTSD. What is still required is the need for additional texts to expand upon and improve to further increase cross-cultural applicability by highlighting different trauma responses in certain cultures (Hinton & Lewis-Fernandez, 2011) as well as, clinicians‟ perceptions of trauma responses and symptomology. This further highlights the need for this research study in relation to cross-cultural validity of specific disorders such as MDD and PTSD.

It is a widely held conception both nationally and internationally that if the causes of emotional and behavioural problems are identified, this may contribute to preventative strategies relative to the development of pathology or disorders (Barlow, 2002). Universal etiological factors of PTSD can be difficult to determine. Keane and Barlow (2002) highlight factors that may be universal, namely, the level of severity and prolonged nature of the traumatic event. Other than this, they maintain that the interplay between psychological structures and environmental experiences relative to each individual will determine whether that individual will develop PTSD (Barlow, 2002).

In their study of the first estimates of lifetime and current prevalence of MDD from diverse urban areas of Mexico, Slone et al. (2006) found the prevalence to be 12.8% for lifetime, and 6.1% for current 12 months. Some epidemiological factors included that women were more likely to have depression than men, individuals who are divorced, separated or widowed are more susceptible, the experience of childhood trauma and age and education levels were additional relevant factors.

Beevers (2011) highlights the need for more interdisciplinary discussions and integration in highlighting key processes that cause and/or maintain depression. For example, Beevers discusses the relationship between cognitive and biological levels of understanding that are still in early stages and may be controversial in some aspects. Beevers (2011) goes on to state that gene regulating serotonin transmission (5-HTTLPR) is relative to an increased sensitivity to adversarial effects of stress, including vulnerability for major depressive disorder. Also, neurologically, this transmitter may be related to information-processing biases for emotional stimuli. This understanding may have important implications for the treatment and management of MDD (Beevers, 2011).

Many studies on PTSD and MDD tend to focus solely on one disorder, either PTSD or MDD. As research will show, client symptomatology will often include combined symptoms of MDD and PTSD (Ward et al., 2001). This has been highlighted in the changes made to PTSD in DSM-5 where the avoidance/numbing category now includes avoidance and persistent negative alterations in cognitions and mood. This may be relevant in determining the comorbidity of MDD and PTSD. Anxiety, depression and PTSD are often comorbid with each other (Ward et al., 2001) and PTSD is frequently associated with depression (Barlow, 2002). In their study of the relationship between PTSD and pain and

how this is mediated by depression, Poundja, Fikretoglu and Brunet (2006) found that the treatment of PTSD and pain should also consider assessment and treatment of depression.

Thus far, this chapter has highlighted the need for this study in that currently, literature based within a South African context that illustrates the relationship between culture and mental health on a practical level is limited. This is also specifically relevant to the nature of disorders such as MDD and PTSD across cultures and how this may influence treatment outcomes.

Posttraumatic Stress Disorder and Major Depressive Disorder in South Africa

Stein et al. (2008) emphasise the important links between ethnicity and differences in socio-economic prominence, where, in the South African context Whites are more advantaged than other population groups, such as African Coloured and Indian. This is important when looking at the prevalence of psychiatric disorders and poverty, as socio-economic privileges may assist in diminishing psychiatric disorder prevalence. What was significant in this study was that both mood (9.8%) and anxiety disorders (15.8%) were of the most prevalent class of disorders in the country (Stein et al., 2008). In their study on exposure to violence and its relationship to psychopathology in adolescents, Ward, Flisher, Zissis, Muller and Lombard (2001), found that most types of violence are related to the expression of symptoms of PTSD, anxiety and depression. This is supported by a study conducted by Bach and Louw (2010) of the relationship (if any) between depression and exposure to violence among Venda and Northern Sotho adolescents in South Africa. Bach and Louw (2010) found a high prevalence of depression in the study sample that had been exposed to violence and thus concluded that there is a clear correlation between exposure to violence and mental health concerns for adolescents.

An important factor not specified in the above-mentioned studies but that is particularly relevant within the South African context is the high comorbidity HIV/AIDS and psychiatric disorders. According to Sharp, Skinner, Serekoane, and Ross, (2010) there are significant influences on the development of emotional behavioural problems in children who are orphaned by parental deaths due to HIV and other related illnesses. This is supported by Cluver, Orkin, Gardner and Boyes (2012), who state that "AIDS-orphaned children showed higher depression, anxiety and post-traumatic stress disorder (PTSD) scores in both 2005 and

2009 when compared with other orphans and non-orphans" (p. 363). In their study on anxiety and depression amongst patients enrolled in a public sector antiretroviral treatment program in South Africa, Pappin, Wouters and Booysen (2012) found a high prevalence for anxiety (30.6%) and depression (25.4%) within their sample group.

A number of factors such as high and consistent levels of exposure to violence and trauma (such as rape, sexual abuse and hijacking), high levels of poverty, differing socio-economic privilege across ethnic groups and effects of epidemics such as HIV/AIDS are contributing significantly to the high prevalence rates of depression and disorders such as post-traumatic stress disorder within the South African context (Edwards, 2005b).

Furthermore, Edwards (2005b) highlights questions related to the spectrum of posttraumatic stress disorders relative to the South African context in terms of complexity of signs and symptoms presented. Here, he emphasises the significance of single episodes of trauma and cumulative trauma. Cumulative trauma is also referred to by additional theorists such as Judith Herman as „complicated posttraumatic stress disorder‟ and/or „complex post-traumatic stress disorder‟ (CPTSD) (Edwards, 2005b). According to Resick et al. (2012), complex trauma is prolonged in nature and relative to early onset in an individuals‟ life. It is most commonly referred to as the "prolonged trauma of an interpersonal nature, particularly childhood sexual abuse" (p. 242). The phenomenon of complex trauma, although highly significant within the South African context (Edwards, 2005b) is not currently recognised as a distinct psychiatric diagnosis within the current DSM-5 (Resick et al., 2012). Rather, symptoms presented that do not fit the criteria for any of the current trauma and stressor-related disorders is recorded as "other specified trauma- and stressor-related disorder", which then also requires a specific reason or description that is justification for this varying diagnosis or clinical presentation (DSM-5, p. 289)

Literature on CPSTD within the South African context is limited (Edwards, 2005b) and broadly related to merely highlighting the existence and extensive range and complexity of psychological consequences of such trauma. Therefore, further research is needed to widen the application of the PTSD diagnosis and/or presentation, increase clinical understanding of such presentations and develop and improve treatment modes within contexts such as South Africa (Edwards, 2005b). This need is beyond the scope or aims of the current study.

As aforementioned, posttraumatic stress disorder and major depressive disorder can be disabling conditions that can cause considerable distress for individuals and have a

profound impairment on interpersonal relationships in multiple contexts such as home, work and socially (Blatt, 2004; Edwards, 2005b). High prevalence rates of MDD and PTSD and the disabling and maintaining nature of both conditions within the South African context has been highlighted.

Thus, there is a need for further investigation of both disorders and how they are assessed, diagnosed and treated within a multi-cultural context such as South Africa.

Cross-Cultural Assessment and Diagnosis of Posttraumatic Stress Disorder and Major Depressive Disorder

The majority of studies and literature both national and international, regarding the validity or reliability of cross-cultural psychological practices, looks at cultural sensitivity and the linguistic and cultural applicability and translatability of assessment tools, that is, tool adaption and the different normative criteria that need to be applied to different milieu groups (Draguns & Tanaka-Matsumi, 2008; Durieux-Paillard, et al, 2006; Edwards & Steele, 2008; Kohrt et al., 2011; Sharp, et al, 2010).

While cultural orientation of the client and clinician is essential and relative to the entire discipline of psychology and mental health, it is particularly important within the area of client assessment as this forms the first step in therapeutic care. Psychological assessment is a combination of both quantitative and qualitative processes. The quantitative aspect relates to specific tests that have been developed and are used to evaluate and measure human behaviour (Foxcroft & Roodt, 2001). When examining the influences of culture on assessment, although test adaption and translation is imperative, it is important to note that testing forms only one part of the assessment process. Other more qualitatively aligned processes such as family history and interviewing processes are of equal importance during psychological assessment. Thus, there is a need for qualitative approaches to be examined and given as much attention within a South African perspective as assessment tools when examining cross-cultural practices (Foxcroft & Roodt, 2001).

In his book on multicultural assessment Dana (2005) identifies and examines what he calls standard and multicultural assessment. According to Dana (2005) standard assessment encompasses assessment measures, both objective and projective which are commonly used

to measure human behaviour that originated and is predominantly normed and standardised on a Euro-American population. Dana (2005) highlights that standard assessment may include cultural sensitivity, which entails being aware of the applicability of test results. In contrast to this, multicultural assessment transcends cultural sensitivity towards cultural competence. In other words, it refers to the amalgamation of standard assessment applications of all standard instruments with the inclusion of *interview processes* and other test/method sources that will provide additional information necessary to determine sound assessment and diagnoses (Dana, 2005). According to Dana (2005) then, cultural competence refers to the use of cultural knowledge and experience, the awareness of the level of competency of the assessor or clinician, as well as a large emphasis on the skills required by the practitioner to establish rapport and interpret the client"s responses within their individual cultural, linguistic and social context (Dana, 2005).

These perspectives and the theoretical orientation of this study are aligned with the cultural-ecological approach mentioned above. Dana (2005) also highlights the importance of cultural competency as opposed to cultural sensitivity where both quantitative and qualitative aspects of psychological assessment and diagnosis are imperative. Aklin and Turner (2006) support Dana (2005) in emphasising cultural competency and the use of multicultural assessment processes such as pairing quantitative and qualitative methods, the use of collateral sources of information, professional discussions with colleagues or supervision, self-education and continued self-training or attending workshops.

It is the opinion of this current study that *all* investigations into human behaviour should be multicultural in nature due to possible affiliations between an individual"s ethno-culture and psychopathology. In other words, in order to assist valid assessment, diagnosis, and treatment and to avoid over-diagnosis and/or missing the diagnosis completely. Similarly, in his article on ethno-cultural aspects of PTSD Marsella (2010) concludes that although some biological and neurological processes are similar regarding responses to trauma exposure, Marsella (2010) further emphasises that the perceived causes, symptom development and use and/or success of treatment outcomes are highly dependent on ethno-cultural variables.

Psychometric Assessment Processes.

The majority of literature on cross-cultural assessment within the South African context has focused on standard assessment and the translatability of Western assessment tools. Although this is important and necessary, this research highlights the need for the transition from standard assessment and cultural sensitivity to multicultural assessment and cultural competency as mentioned by Dana (2005) above.

In their South African study on the development and validation of the Xhosa versions of the Beck Depression Inventory-II (XBDI-II), the Beck Hopelessness Scale (XBHS) and the Beck Anxiety Inventory (XBAI), Edwards and Steele (2008) found that the clinical function of all three depression scales is much the same as the English scales. That is, the scales provide valid measures of depression, anxiety, hopelessness and risk of suicide. Edwards and Steele (2008) highlight that many health care professionals have a limited understanding of the association with violence and mental health and thus fail to identify psychological problems such as PTSD and MDD in patients. Although the inventories are not used to establish a firm diagnosis but should rather be used as a tool that highlights mental health problems and thus the possible need for additional referrals and treatments (Edwards & Steele, 2008), and may assist with cultural competency.

Sharp et al. (2010) conducted a qualitative study of the cultural appropriateness of the Diagnostic Interview Schedule for Children-Fourth Edition (DISC-IV) in South Africa. Their focus was on adapting the DISC-IV to enhance test fairness, reduce costs, enhance epidemiology, and to improve early detection of emotional-behavioural problems in children in South Africa. Several themes emerged in the results of their study relative to problems with the assessment measure itself, the assessor's way of interpreting the results and specific factors relative to the socio-cultural positioning of the individuals. For example, factors such as the expression of emotion, gender, experience of time and family structure (Sharp et al., 2010). These results point to multicultural assessment and cultural competency.

Boyes, Cluver and Gardner (2012) conducted a study that assessed the psychometric properties of the Child PTSD Checklist for South African Children and Adolescents. They found that the validity and reliability of the checklist was acceptable to good for a large sample of South African youth. They do however highlight the need for further evaluations of additional samples. Boyes et al. (2012) did not however investigate any qualitative factors

that may contribute to the validity and reliability of the assessment tool, that is, they do not refer to multicultural assessment or cultural competency of the assessors.

In their study of the evaluation of the performance of the Kessler scales (K10 and K6) that screen for depression and anxiety disorder, Andersen, Grimsrud, Williams, Stein and Seedat (2011) found that both scales had significantly lower discriminating ability with respect to depression and anxiety among the Black group as opposed to other ethno-cultural groups of White, Coloured, Indian and Asian. Therefore, the scales were found to not be as useful in the general South African population as in international countries. Again no reference was given to the qualitative factors relevant to cultural competency and multicultural assessment put forward by Dana (2005).

Murray et al. (2011) assessed the validity of an adapted version of the UCLA Child Post Traumatic Stress Disorder Index (PTSD-RI) in Zambia. This measure was adapted using items and responses to these items that were seen to be locally relevant to the Zambian context. They found that the assessment measure had good reliability and concurrent validity. This meant that the Zambian version of the PTSD-RI was accurate in detecting traumatic stress among youth in Zambia. According to Murray et al. (2011) then, the validation of tools for the assessment of mental health is possible in low-resourced countries by adapting the measure to the specific local context.

The aforementioned articles from within South Africa and Africa show the importance of the translatability and validation of assessment tools within this context in relation to the accurate assessment of mental health problems. It has also been noted that there is an additional need for studies to focus on the cultural competency not only of assessment measures but relative to those individuals administering the tests. This will further increase the validity and reliability of cross-cultural practices needed in these contexts.

International literature has transcended the notions of multicultural assessment and cultural competency. In their adaption of the Mini International Neuropsychiatric Interview (MINI) sub-sections for major depression and posttraumatic stress disorder in Geneva, Durieux et al. (2006) found that certain sections of the diagnostic instrument were ill adapted for the particular context and either had to be discarded or "reworked". This was done in accordance with the life context of the population as opposed to the cultural specifications

due to changing migration patterns of asylum users. This is significant as the idea of multicultural assessment and competency on a pragmatic level was taken into consideration with specific focus on additional information necessary to determine the validity and reliability of the assessment measure.

In their study on the adaption of the Depression Self-Rating Scale and Child PTSD Symptom Scale in Nepal, Kohrt et al. (2011) assessed the cultural adaptability and validity of the assessment measure. They found that cross-cultural validity and transcultural translation of assessment measures can be performed with the inclusion of the use of structured interviews by trained mental health professionals (Kohrt et al., 2011) This highlights the multicultural assessment notion identified by Dana (2005).

The national literature that has been reviewed here highlights that the validity of translated tools and their applicability within the South African context varies. A gap is identified in the literature where most South African literature focuses on the translatability of assessment tools rather than examining both quantitative and qualitative methods of assessment concurrently. This study aimed to bridge the gap in the national literature by examining the nature of clinicians" practical experiences and highlighting where on the continuum these practices may be. That is, are psychological practices transitioning from standard assessment and cultural sensitivity to multicultural assessment and cultural competency (Dana, 2005) with the inclusion of both quantitative and qualitative assessment procedures to achieve this?

The Interviewing Process

The interviewing process is a critical part of assessment procedures of clients as it provides imperative information relative to the presenting complaints or problems of the client. In clinical interviewing many factors may influence the content and process of the interview (Sadock & Sadock, 2007). Clinical interviewing is one of the most important tools that clinicians have. Clinicians conducting clinical interviews need to be skilled in various aspects such as knowledge of psychopathology, interpersonal communication skills, understanding how clinical signs and symptoms affect the person being interviewed and how in turn these signs and symptoms influence the interviewing process itself (Aklin & Turner, 2006).

Aklin and Turner (2006) state that there is a need for more attention to be given to understanding ethnic and cultural factors in relation to the interviewing process. In addition, they maintain that the use of Semi-Structured Interview methods are more suited for multicultural assessment. This is in contrast to Structured Interview methods that may restrict the type and amount of information provided. Also, Open Interview Methods, which may leave too much room for clinician‟s bias, and the influence of the clinician s theoretical punctuation which may distort information that is obtained during the interviewing process (Aklin & Turner, 2006).

Aklin and Turner (2006) mention three specific problems that may be associated with Open Clinical Interviewing, namely information variance, criterion variance and patient variance. Information variance refers to how information obtained from a client can vary from clinician to clinician. In other words, this refers to the way in which clinicians ask questions, that is, the specific affect or tone used by the clinician can influence the content responses given by clients. In cross-cultural assessment, it is hypothesised that the risk of information variance may be high (Aklin & Turner, 2006).

Criterion variance refers to the clinician‟s specific scoring or interpretation levels that indicate pathology. This is relative to unstructured interviewing where if clinicians fail to consider systematic diagnostic criteria, this can result in high levels of misdiagnosis. Patient variance refers to the variation of signs and symptoms relative to different clients and different stages of disorders that are being experienced by clients. Patient variance according to Aklin and Turner (2006), can lead to poor reliability and disagreement between clinicians and multi-disciplinary teams. Overall, both criterion and patient variance can contribute to misdiagnoses and the development of intervention programs that are not suited to the client‟s needs (Aklin & Turner, 2006).

An important part of the assessment process of clients is the use of The Mental Status Examination (MSE). This relates specifically to the clinicians observations and impressions of the client at the time of the interview (Sadock & Sadock, 2007). The use of the MSE may assist clinicians in highlighting possible information, criterion and patient variance referred to above.

The Cultural Formulation Interview (CFI) is another Semi-Structured Interview schedule that may assist clinicians in gaining information during a mental health assessment relative to how the individual‟s culture may influence certain aspects of a client‟s presentation during the interview. It consists of four domains of assessment namely, "Cultural definition of the problem (questions 1-3); Cultural Perceptions of Cause, Context, and Support (questions 4-10); Cultural Factors Affecting Self-Coping and Past Help Seeking (questions 11-13); and Cultural Factors Affecting Current Help-Seeking (questions 14-16)" (APA, 2013). The CFI is based on a person-centered process and is used in conjunction with additional available clinical material (APA, 2013). There is also an additional informant version of the Cultural Formulation Interview (CFI-IV) that enhances collateral interviews. The CFI and CFI-IV are in line with multicultural assessment processes (Dana, 2005) and is intended to enhance the validity of diagnostic assessment and ultimately improve case formulation and intervention planning (APA, 2013).

Treating Posttraumatic Stress Disorder and Major Depressive Disorder

In their study on the disability and treatment of psychiatric disorders and physical disorders in South Africa, Suliman, Stein, Myer, Williams and Seedat (2010) found that mental disorders, specifically depression, were reported to be consistently more disabling in comparison to physical disorders. Although this was the case, physical disorders are more likely to be treated than mental disorders. Suliman et al. (2010) also noted that the degree of disability increased with comorbidity. This is significant and highlights the need for South African research and practice to focus on the treatment of mental health problems.

As mentioned previously in this chapter, PTSD and MDD are two disorders that are often comorbid (Barlow, 2002; Poundja, Fikretoglu & Brunet, 2006; Ward et al., 2001). Grant and Townend (as cited in Grant, Townend, Mills & Cockx, 2008) highlight the need for a "transdiagnostic" approach to conceptualising co-morbid problems. This is based within a cognitive-behavioural approach to mental illness. In other words, they suggest that clinicians highlight common processes from initial development through to current maintaining factors. This includes focusing on genetic vulnerability or biological components; temperament and personality, early adversity, family structure, interpersonal style, socio-cultural factors and cognitive-behavioral factors. It is hypothesized that these

factors are relevant in the holistic conceptualization, promotion and/or prevention of relapse and remission in individuals (Grant & Townend, 2008; Riso, du Toit, Stein & Young, 2007).

Case Conceptualization

Case conceptualization or formulation is an important task in the work of mental health care professionals such as psychologists. Not only does it explicitly assist making judgements about clients and deciding goals or focus for treatment, it also assists psychologists in determining where best to implement change for a client, that is, the focus of a particular intervention (Schwitzer & Rubin, 2012). Case conceptualization involves using clinical skills to define and refine a diagnosis and from this, determine a treatment plan suited to the specific needs of a client. According to Schwitzer and Rubin (2012) case conceptualization or formulation involves three steps: first the psychologist thoroughly evaluates and assesses the client. Second, the psychologist consolidates the observations, assessments and interpretations made (diagnosis). Third, the psychologist uses a particular theoretical approach or paradigm from which to punctuate from. In other words, the theoretical paradigm is used to make clinical judgements about the client‟s presenting complaints or experiences (Schwitzer & Rubin, 2012). Once the case formulation is complete, the psychologist should have a clearer picture of the client and their needs and thus be able to make informed decisions relative to treatment planning.

According to Schwitzer and Rubin (2012), basic treatment planning consists of four steps. First, the clinician defines and highlights the main problems that require attention. Second, specific goals that are achievable are carefully chosen. Third, the specific methods and modes of treatment are selected in conjunction with the theoretical paradigm used. Fourth, the clinician may determine how changes may be measured and outcomes determined. It is important to note that the specific intervention chosen is often determined in-line with the theoretical paradigm used (Schwitzer & Rubin, 2012).

Following from above, individuals with problems synonymous to PTSD and MDD then, can be understood from a multitude of different psychological paradigms such as Psychoanalytic, Psychodynamic, Person-Centered, Gestalt, Behaviour, Cognitive and Cognitive-Behavioural as well as Systems, African and Interactional perspectives (Corey, 2009). In addition, each paradigm can be viewed from a multicultural perspective for

adaptability, to bridge the gap of diversity between Western and Non-western cultures (Corey, 2009). The scope of literature, specifically international literature, on these paradigms and their multi-cultural application is vast and beyond the scope of this study. In light of this, the current study will highlight and focus more on the most effective and evidenced-based modes of understanding and treatment relative to PTSD and MDD specifically.

Evidenced-Based Modes of Treating PTSD and MDD

According to Edwards (2009) there are a number of different treatments for PTSD. Ranging from "psychodynamic therapy, narrative therapy, cognitive-behavioural therapy (CBT) and cognitive therapy (CT)" (p. 189) to name but a few. These modes of treatment are also noted in the literature as effective for MDD (Kirmayer, 2001; Sadock & Sadock, 2007). Furthermore, within each therapy there are multiple techniques, and treatment procedures with treatment manuals and guides (Edwards, 2009). Cognitive therapy specifically, whether therapist or self-assisted is noted in both national and international literature as a particularly effective mode of treatment for PTSD and depression (Clark & Ehlers, 2005; Edwards & Payne, 2009; Ehlers & Wild, 2010; Ehlers, Clark, Hackmann, McManus & Fennel, 2005). Ehlers et al. 2005 propose a cognitive therapy model in working with PTSD and MDD that is effective in creating greater changes in dysfunctional cognitions relative to post-trauma.

It is also important to note that not only psychotherapy is effective in treating PTSD and MDD but pharmacotherapy as well. In their article on an open trial of citalopram in adolescents with PTSD, Seedat, Lockhat, Kaminer, Zungu-Dirwayi and Stein (2001) found that specific PTSD symptoms such as re-experiencing, avoidance and hyper arousal showed statistical improvements after being treated with citalopram for a 12-week period. Similarly, in their article on clinical considerations at each stage of evaluation and treatment of trauma survivors and PTSD, Conner and Stein (2005) found that administering first-line anti-depressants resulted in decreases in both PTSD and comorbid depression symptoms.

According to Edwards (2009) although these modes of therapy can be effective in working with PTSD, there is a need to use more integrated, evidence-based practices within the South African context. Drawing on Ehler"s et al. 2005 cognitive therapy, as well as specific case studies relevant to the South African context, Edwards (2009) proposes a model

specific to the South African context that focuses on seven particular areas for clinical focus in working with PTSD. In his article Edwards (2009) highlights the need for the inclusion of clinician competencies, metacompetencies, therapist responsiveness, and stages of therapy and case formulation consideration in using this model.

The role of Multicultural Competency in South Africa

The role that cultural diversity plays in psychological services rendered is acknowledged by the Health Professions Council of South Africa (HPCSA) in the rules of conduct pertaining specifically to psychology. The word culture is used in multiple areas within these rules, specifically in relation to the unfair discrimination of clients and culture-appropriate services that need to be made available to clients. This is particularly relevant to assessment, diagnostic and treatment processes (HPSCA, 2004). Although the acknowledgement of cultural factors that may influence services rendered is made by the HPCSA, there are no clear guidelines stipulated in the rules pertaining specifically to the South African context as to what culture-appropriate services entail, and how psychologists are meant to ensure them in practice. Moreover, there are no guidelines as to how/or if these services may differ in multiple contexts such as Private and Government settings or alternatively rural and urban areas.

Therefore, this study highlights the need for more detailed guidelines or strategies in developing and maintaining multicultural competency in order to ensure that cultural-appropriate services are rendered to the South African population. Furthermore, this study also draws attention to the need to examine if and how these services may differ in different contexts or areas of the country.

Strategies for Building Multicultural Competence

International literature maintains that when working with cultural diversity, there is not always a need for psychologists to develop a new set of psychological skills. Rather attention should be given to the additional challenges and issues that may arise when working with clients from different ethno-cultural orientations. As well as the skills required to build and maintain multicultural competency (Constantine & Sue, 2005; Dana, 2005; Draguns & Tanaka-Matsumi, 2003; Hays, 2001).

According to Hays (2001) critical thinking, seeking new and diverse sources of information and direct experience with individuals who have a different ethno-cultural orientations are important components of becoming a culturally responsive therapist. Critical thinking allows a therapist to identify as well as challenge assumptions made, highlight and examine contextually influential factors and imagine and explore alternatives relative to a client‟s needs. In seeking new and diverse sources of information, the therapist is able to educate him/herself in particular groups. Also, the more a therapist has personally experiences individuals from multiple ethno-cultural groups, the more understanding and culturally sensitive they become (Hays, 2001; Vasquez, 2005). Hays (2001) goes on to state that the more culturally responsive a therapist becomes, the more equip they are in forming the therapeutic alliance and establishing respect and understanding with their clients.

Vasquez (2005) emphasises multicultural guidelines specifically for Independent practice settings. This includes knowledge of self and others, reduction of bias and the development of skills such as flexibility and adaptability in conceptualizing intervention plans. Vasquez (2005) goes on to highlight a specific problem encountered in independent practice when working with different cultures. This is relative to the client‟s awareness and expectations of the the clinician‟s ethno-cultural orientation. In other words, some clients may prefer to see psychologist of the same ethno-cultural orientation to theirs or alternatively, they may not due to possible judgement and bias.

Dana (2005) also specifically refers to the notion of clinician and client bias. He highlights the need for clinicians to self-examine their own cultural identities in order to increase awareness and understanding that both the client and the clinician are cultural constructs. This is supported by Corey (2009) who states that "effective counsellors understand their own cultural conditioning, the conditioning of their clients, and the socio-political system which they are a part of" (p. 25). Similarly, Hays (2001) identifies the need for a clinician to conduct a cultural self-assessment in order to better understand their own cultural heritage and how this may influence clinician bias and understanding.

Conclusion

In this chapter, current literature, both national and international, was examined in relation to understanding cross-cultural practices and specific reference was made to the

disorders of MDD and PTSD. The etiology and epidemiology of PTSD and MDD was mentioned and more importantly, **t**he relationship between culture and psychopathology was examined. A cultural-ecological approach to understanding the relationship between culture and mental disorders was found to be a suitable theoretical orientation for this study. In that it allows for a better understanding of the relationship between culture, MDD and PTSD. PTSD and MDD were then examined from within a South African context and specific mention was made to the assessment and treatment thereof from a national and international perspective. The need for psychologists to develop, build and maintain multicultural competencies was found to be applicable within the South African context. Specific strategies from an international perspective were examined in this regard, as a gap in the national literature was highlighted in this chapter, where strategies and guidelines specific to the South African context are limited, indicating the need for this study.

Chapter 3: Methodology

Introduction

In this chapter, the research design theoretical paradigm, and sampling methods for the current study are presented and discussed. The participants of the study are highlighted and the specific data collection and data analysis methods are conferred. Specific mention is given to the validity and reliability of the study as well as all ethical issues considered (see Ethical Clearance Letter, Appendix, 1).

Research Design and Theoretical Orientation

This study is qualitatively aligned within an interpretivist paradigm. According to Krauss (2005) the uniquely directed goal of qualitative research is facilitating and allowing the process of meaning making to unfold. That is, interpretive research focuses on producing or reifying knowledge of a phenomenon or a person‟s world view by looking at webs of meanings attached to the actual lived experience of participants (Krauss, 2005; Maykut & Morehouse, 1994). Interpretive research is associated with methods embedded in the understanding that humans comprehend and operate contextually with the use of language (Dickerson, 2002). According to Smith (2003), the interpretive approach to understanding human experience emphasises the importance of language "as a fundamental property of human communication, interpretation and understanding" (p. 2), where language is seen as productive in the construction of meaning and the individual‟s world.

Thus, the qualitative research design and interpretive theoretical orientation was suitable for this study as it allowed for the in-depth observation and reporting of psychotherapists‟ experiences of cross-cultural approaches through language (spoken text). This was achieved by looking at the reported subjective experiences and meaning production of psychotherapists through talk of their approaches to working with different ethno-cultural groups experiencing MDD and/or PTSD. Within the interpretivist paradigm participants are seen as agents of their own social worlds and as having their own perceptions as a result of their subjectivity (Mattila & Aaltio, 2006). Also the subjective lens of both the participants and the researcher were recognised in this study (Morrow, 2007).

Sampling

According to the Health Professions Council of South Africa, the term „psychologist‟ is defined as "a person registered under the Act as a psychologist, registered counsellor, psychometrist, psycho-technician, intern in psychology or student in professional psychology" (HPCSA, 2006, p. 1). The term „psychotherapist‟ is defined as "an individual, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker who practices psychotherapy" (American Heritage Dictionary of the English Language). Regarding the above definitions, the former definition is more specific in terms of reference to individuals that are registered under a specific Act within the domain of professional psychology within South Africa. The latter definition is one that refers to broader categories of mental health care professionals that implement treatment or the therapeutic component of psychotherapy from within an American context. As both national and international literature was reviewed in this dissertation, the use of the term psychologist and psychotherapist was used interchangeably to encompass both aspects, that is, an individual registered under an Act and within the category of professional psychology within South Africa, as well as an individual that focuses not only on assessment and diagnoses but psychotherapeutic treatment as well.

The sample criteria consisted of psychologists who are practicing psychotherapy with individuals who are suffering from MDD and/or PTSD; who have been in private practice for at least three years post-registration with the Health Professions Council of South Africa; and who work and reside in the province of KwaZulu-Natal (see Participant Invitation Letter in Appendix 2). Although an age (all participants were assumed to be over the age of 18) and/or gender specific criterion was not set for participants, an additional but not necessary criterion was that the participant sample be ethno-culturally diverse. That is, to select participants from multiple cultures.

The location for this study was KwaZulu-Natal. This is significantly linked to the study‟s intended sample and the availability of registered psychologists. As aforementioned, a particular criterion in this study was that the sample itself may be ethno-culturally diverse. Due to the limited availability of African, Coloured and Indian psychologists working in South Africa (Aston, 2006; Sharp et al. 2010) who fit the sample criteria, the location of the study included the broader province as opposed to a particular area within the province.

A sample of six psychotherapists was selected for this study. This was achieved with the use of purposive and snowball sampling techniques. According to Durrheim and Painter (2006) the three main components of purposive sampling are to take into consideration the availability and willingness of individuals to participate and that "cases that are typical of the population are selected" (p. 139). An initial sample that was seen as the most productive sample to answer the studies questions and achieve the studies aims was recruited with purposive sampling. Here, participants were identified from internet sources indicating currently registered psychologists in private practice in the general KwaZulu-Natal area that match the stipulated criteria for the study. An example of an internet source was www.medpages.co.za.

Following the identification of two psychotherapists who suitably fit the purposive criteria, the remaining four participants were recruited with a second method of snowball sampling. According to Kelly (2006 as cited in Terre Blanche & Durrheim, 2006) the process of snowballing is undertaken by allowing certain participants to lead the researcher to additional appropriate participants. In accordance with the two methods of sampling that were used in this study, once the initial two psychologists were recruited, they were then asked to suggest any possible colleague/s or psychotherapists known to them that fit the criteria. This was done until all six participants were recruited.

Data Collection Procedure

In staying aligned with the interpretivisit approach of this study where language is seen as important in meaning production and understanding, an appropriate data collection method for this study was face-to-face semi-structured, in-depth individual interviews. Each interview was approximately 45-60 minutes in length (see Interview Schedule in Appendix 4). According to Kelly (2006) interviewing is suited to interpretive approaches to research due to their naturalistic and conversational qualities. Semi-structured interviewing allowed the researcher to guide the interview in order to acquire the type of information needed to address the aims and questions of this study whilst still allowing participants to communicate spontaneously in order to capture the essence of their experiences.

If deemed necessary by the researcher and participants, a second interview ensued as a telephonic follow-up interview. This helped to clarify misunderstandings or broaden

understanding with the use of additional questioning informed by the initial interviews. This method of data clarification is viewed as productive in qualitative research (Sturges & Hanrahan, 2004) as it allows for a deeper exploration of participants experiences and the researchers understanding of those experiences. These follow-up interviews were dependent on the time-constraints of both the study and the participants. The second follow-up interviews were conducted either face-to-face or telephonically. Moreover, interviewing as a material collection method was suited to the time-constraints of this study and its participants.

Analysis of Data

The analysis approach used within this study is thematic networks analysis. Thematic networks analysis comprises of a three-stage, six-step process similar to common qualitative thematic analysis. The distinguishing feature of thematic networks analysis is the inclusion of the thematic networks as tools used during the analysis process (Attride-Sterling, 2001). Where thematic content analysis involves identifying recurring themes in literature or data (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005), thematic networks analysis is also an ideal method for identifying, analysing and reporting themes found in individual interviews as well as across interviews (Attride-Stirling, 2001). In addition, thematic networks assist the researcher in systematically determining specific themes and patterns by breaking-down the text material. Also, once the text is more manageable, thematic networks assist in exploring the relationships between themes and communicating this in a consice manner that is clear to the reader (Hanington & Martib, 2012).

The first stage of analysis termed stage A is the "reduction or breakdown of text" (Attride-Sterling, 2001, p.391). Within this stage there are three steps: Step 1 is the development of a framework for coding that is used to divide the relevant segments of text; step 2 involves the identification of themes from within the relevant segments of text and developing them and step 3 involves the construction of the thematic networks and the development of the relevant basic, organizational and global themes which are then illustrated and refined (Attride-Sterling, 2001).

According to Hanington and Martib (2012), basic themes can be defined as text segments that come directly from the data collected. They are simple and need to be understood within the context of other basic themes. Once basic themes are gathered and

clustered together in terms of similar themes, they begin to form Organising themes. The grouping of organising themes allows for a specific assertion to be made or position to be taken. When organising themes are grouped, the global theme is determined by an overarching point of the text or global representation of the text material underneath the global theme (Hanington & Martib, 2012),

The second stage of analysis is termed stage B and involves an in-depth exploration of the text. The second stage has two particular steps following from above: Step 4 is to describe and explore the previously developed thematic networks and step 5 involves summarising those networks (Attride-Sterling, 2001). The third stage is the final stage of integration and exploration and has one final step of interpreting the patterns that emerge from the developed thematic networks (Attride-Sterling, 2001).

The included thematic network approach allowed for the concise structuring and depiction of themes identified. Furthermore, this method of analysis was suited to this study in that not only did this method result in a rich body of data but it also allowed for detailed interpretations to be made by the researcher (Attride-Stirling, 2001).

Methodological Considerations

Legitimisation.

According to Bergman and Coxon (2005) in qualitative research no clear rules exist regarding the appropriateness of the purpose and function of a study directly comparable with quantitative research. Rather within the interpretive paradigm, rigour is focused more on design coherence, the appropriateness, implementation and dependability of sampling, material collection and analysis methods and the depth, detail and comprehensiveness and coherence of the analysis that is produced (Bergman & Coxon, 2005).

Credibility.

In qualitative research, the strive is not to measure and ensure validity as this is a positivist concept. Instead, a qualitative researcher ensures and maintains the credibility and coherence of their study. Credibility refers to the task of continually working with evidence or hypotheses whilst conducting the research study that may better explain the results of the

study. In other words, credibility is obtained when the results of the study are rich and sound (Van der Riet & Durrheim, 2006).

According to Durrheim and Wassenaar (2002), "coherence is based on the degree to which the various elements of the design fit together within the framework provided by the research paradigm" (p. 60). Within this study, there is coherence in the use of cultural relativism as an underpinning theory of the study and the qualitative, interpretive paradigm and thematic networks analysis as the methodological paradigms of the study. In that philosophically and empirically, both theories deny the existence of universal judgements (Draguns & Tanaka-Matsumi, 2003) and rather emphasise the use and importance of context (language, culture etc.) in understanding human behaviour and meaning production (Krauss, 2005; Smith, 2003). This means that the theoretical basis of the dissertation is aligned with the methods used to interpret and understand the findings produced within this study.

Where, the use of the theory of cultural relativism, the particular methods of data collection (interviewing) and material analysis (thematic networks analysis) "fit" within the interpretive paradigm of the research, as both the theory and methods allowed for the collection of rich material and the in-depth understanding that were needed to address the particular aims and questions of the study. In other words, the interviewing method allowed for the production of rich data and the analysis method of thematic networks allows for a detailed examination of that data within each interview and across interviews. Secondly, the face-to-face interviewing method and the inclusion of follow-up interviews (telephonic, if requested by participants) ensured a certain level of trustworthiness of the data as it allowed for the data''s accuracy and relevance to be reviewed (Sturges & Hanrahan, 2004).

To guarantee the credibility of this study, the researcher ensured that all the research questions and methods formed an integrated unit in which the methods for obtaining answers to the questions, and the means for assuring the credibility of the potential answers, were clearly conceptualized and linked to the research questions (Maxwell, 2004).

Dependability.

According to Van der Riet and Durrheim (2006) reliability of a study''s findings is determined by the degree to which results can be repeated, and this can be measured in

quantitative research. As mentioned, this study is aligned with an interpretive paradigm that assumes that individuals exist in changing contexts and thus will behave differently and change expressed opinions over time (Van der Riet & Durrheim, 2006). This means that the focus here was more on dependability than reliability. Dependability refers to the degree to which findings are convincible (Van der Riet & Durrheim, 2006). In other words, to what degree do the findings represent what was actually said and/or done during the research study? This was achieved in this study by providing clear and detailed descriptions of contextual interaction, data collection and data analysis methods (Van der Riet & Durrheim, 2006) and highlighting any changes made and how these changes may have influenced the outcome of the study.

Transferability.

Another important element of authentication with qualitative research is that of transferability. This involves the extent to which the findings of the study can be compared to the broader populations and settings (Durrheim & Wassenaar, 2002). In this particular study, due to the small sample size of the study, the findings cannot be generalizable to the broader population. Rather, the findings may be relevant and transferable to other individuals who meet the same criteria as the participants of this study and the same context within which the study took place, namely, psychotherapists in private practice in KwaZulu-Natal.

In qualitative research, the usefulness of small sample sizes is encouraged as generalizability of findings is not emphasized as a main objective in the same way as it is in quantitative research (Van der Riet & Durrheim, 2006). Thus, a sample size of six was sufficient for this qualitative study in order to reach data saturation (Lewis & Richie, 2003).

Ethical Considerations

Independent and competent ethical review.

Prior to the onset of data collection, the research proposal was subjected to an independent and competent ethical review. Ethical approval was obtained from the University of KwaZulu-Natal Higher Degrees Committee and Research Ethics Committee (see Ethical Clearance Letter in Appendix 1). Once approval was obtained, the research was commenced. According to Kuper, Lingard and Levinson (2008), "ethics in qualitative research should

extend beyond prescriptive guidelines and research ethics boards into a thorough exploration of the ethical consequences of collecting personal experiences and opening these experiences to public scrutiny" (p. 689). This was achieved in this sturdy as additional ethical concerns were highlighted and addressed relative to gaining informed consent from participants, ensuring confidentiality and anonymity, examining the benefits and drawbacks of the study for the participants themselves and the greater community, as well as highlighting the limitations of the study.

Informed consent.

According to Ritchie and Lewis (2003), informed consent is an imperative step before data collection can commence in any research study. In this study, a letter of invitation regarding individual involvement and the overall nature of the study was e-mailed and/or posted to the psychologists identified. In addition to this letter of invitation, once the relevant psychologists agreed to participate in the study and in order to ensure that each participant provided informed consent, they were then asked to read and sign a typed consent form. This consent form stipulated the nature of the study, their involvement and potential withdrawal from the study as well as other ethical concerns such as information concerning what the collected data may be used for (Ritchie & Lewis, 2003) (see Participant Consent Form in Appendix 3). Psychologists participating in this study did not incur monetary costs for participating but the professional time-limitations of psychologists working in private practice was acknowledged throughout the study.

On-going respect for participants.

In this study confidentiality of participants was ensured where all personal information of participants and the details of their practices were only known to the researcher, the researcher"s supervisor and the transcriber. To ensure anonymity no personal names of any nature was revealed in the study as each participant were assigned a pseudonym, e.g., psychologist 1 to 6. Furthermore, if any personal names of clients were revealed during the interviews these were only known to the researcher, transcriber and supervisor and were also given pseudonyms to protect their identity. Furthermore, the transcriber was asked to sign a confidentiality form ensuring ethical practice. All recorded data was stored in a locked cabinet during the research process and will be discarded within five years of the completion of the study as use of referral for possible future publications.

This was made explicit to the participants. Furthermore, the tapes and transcripts were labeled accurately with the use of pseudonyms to ensure accurate storage of data (Ritchie & Lewis, 2003).

Social value.

The beneficiaries of this research are two-fold. Firstly, the clinicians who participate in the study were able to reflect on their own approaches to cross-cultural clinical work in order to improve or reify knowledge and future experiences. Clinicians will also be able to compare their methods to those used by other clinicians through reading the final product of this study, thus drawing on the knowledge and experience of other psychologists. Secondly, and most importantly, the data collected has the potential to improve cross-cultural approaches and ultimately clients" experiences of assessment, diagnosis and treatment of mental health problems. Hence, the study demonstrated social value.

Favourable risk/benefit ratio.

According to Kuper, Lingard and Levinson (2008), minimising harm in research studies is essential and doing so involves not only safeguarding the participants from public scrutiny but also acknowledging any personal distress that participants may be potentially vulnerable to. In this study, no incentives were offered to participants and minimal factors increasing vulnerability or potential risks or harms were foreseen for participants who were involved in this study. Furthermore, on final completion of the study, participants will be e-mailed a summarized version of the study focusing on the findings and discussion of the results. Participants may thus benefit both directly from the interview process which may encourage refection on current individual practices as well as indirectly through comparisons with others professional practices when reading the final findings and discussion of the study.

Conclusion

In this chapter, the qualitative research design, interpretivist theoretical paradigm, and purposive and snowball sampling methods for the current study were presented and discussed. The study used semi-structured interviewing as the main method of data collection and thematic networks analysis was used as the main method of data analysis. The degrees to which the study"s findings are credible, coherent, dependable and transferable were noted.

Specific ethical themes of the study were discussed namely, the submission and clearance of the study with ethical reviews, the process and attainment of informed consent from participants, the researchers on-going respect for participants throughout the study, the social value of the study and the favourable risk/benefit ratio of the study was highlighted. The findings of the study are presented in the following chapter.

Chapter 4: Results

Introduction

High rates of trauma, anxiety and depression are a large concern worldwide and particularly within the South Africa context. Cross-cultural practices are needed in order to ensure that all individuals are receiving a high level of valid assessment, diagnosis and adequate treatment for PTSD and MDD specifically. Therefore, there is a need to examine what sort of cross-cultural or multicultural approaches if any, do psychotherapists use in practice to ensure this. In particular there is a need for this study to look specifically at private practice, that is, after predominant training and practical orientation has been completed.

In the first section of this chapter, an overall examination of the contextual setting of this study is provided to allow the thematic networks identified in this study to emerge as situated within a particular context. This includes highlighting the context of private practice as opposed to the public domain that the psychologists work in; the culturally variant representation of the clients that the psychologists work with; the nature of problems that the clients experience as well as the particular theoretical paradigms the psychologists work from in understanding their clients.

The second section of this chapter focuses on the findings obtained from the interpretation of the text material. For the purpose of this chapter each emergent thematic network is represented in tabular form. This serves as an illustration without hierarchy of the global, organising and basic themes identified as well as the issues discussed and codes that were used. The different themes identified are supported with the use of text segments from the interview conducted with six psychologists. These themes are then described and discussed briefly. It is important to highlight that although the two thematic networks are displayed and discussed in a clear and concise manner in this chapter, the reader essentially must remember that the networks are understood within a particular context and that in reality, the themes are interrelated with one another and the particular contexts within which they occur.

The Context

Six psychologists were interviewed in this study. All six psychologists are female and have worked in private practice within the area of KwaZulu-Natal for more than three years

post registration with the Health Professions Council of South Africa. The six participants are registered in categories of Counselling and Clinical Psychology. The participants" ages ranged between 25 and 65 respectively. Other relevant descriptions of each participant: such as race, gender, religion, type of practice area, clientele description and theoretical orientation/training contexts are highlighted in table 1 below.

Table 1

Participant Sample Descriptors

Participant	Race	Gender	Religion	Type of Practice area	Clientele Description	Theoretical Orientation/Training Contexts
P 1	White	Female	Christian	Urban and Rural	Assessment, Diagnoses, Short-term Therapy	Neuropsychological/ University of Pretoria
P 2	White	Female	Christian	Urban	Assessment, Diagnoses, Therapy	Psychodynamic/ Cognitive Behavioural/ University of KwaZulu-Natal
P 3	Coloured	Female	Agnostic	Urban	Assessment, Diagnoses, Therapy	Psychodynamic/ University of KwaZulu-Natal
P 4	Indian	Female	Tamil	Urban	Assessment, Diagnoses, Therapy	Psychodynamic/ Cognitive Behavioural/ University of the Witwatersrand
P 5	Indian	Female	Muslim	Semi-rural	Assessment, Diagnoses, Therapy	Trauma and Cognitive Behavioural/ University of KwaZulu-Natal

P 6	African	Female	Christian	Rural	Assessment, Diagnoses, Therapy	Narrative/ Cognitive Behavioural University of Zululand

The transcription conventions implemented in terms of the material text are: R which represents the researcher and P1, P2, P3, P4, P5 and P6 which represent each psychologist respectfully. In order to ensure anonymity of the areas of practice, any mention or reference made to the practice settings or its location is represented by the use of location A, B and C respectfully. It is highlighted that the punctuation within the transcribed text material is to some degree the researchers semantic imposition on what was said during the interviews, although the use of punctuation such as commas and full stops, are important for clarity. In addition, sections highlighted bold in the material text represents the researcher"s added emphasis to highlight or stress important sections of the text.

Private vs. Public Division

Some of the participants spoke of the contextual differences and systemic problems relative to assessment, diagnosis and treatment within the public sector as opposed to the domain of private practice.

P1: so for example if you wanted to get a job now in any kind of government sector or hospital or a clinic you probably wouldn't get one based on the fact that you probably don't speak an African language…so that is the biggest challenge so everything you do now is limited for the most part to private practice so that in itself is a problem.

Above, P1 highlights that she feels limited to private practice as there are certain factors such as the language a psychologist may speak, that will determine the availability of employment within the government sector. P1 reports that factors such as not being able to speak an African language may hinder her from being employed in the government sector and ultimately result in a focus on private practice.

P2: in the government you gotta speak Zulu or an African language and that's the end of the story and there aren't that many jobs available in the private sector for

psychologists so what are your alternatives then its private practice that's what you've got.

Similarly, P2 above states that there are specific language requirements needed of psychologists regarding when applying for posts in the public sector. P2 continues to highlight that one of the options then for psychologists who do not speak an African language is private practice.

Clientele as Representative of Cultural Diversity

The participants were asked directly about the ethnic diversity of their clientele. Interestingly, they reported on their clients according to racial categories. This is significant as it highlights how discourses are used interchangeably, namely words such as culture, race, ethnicity and language etc.

P1: they are highly diverse, all races, Asian, European and African race groups but predominantly, I would say African.

P2: I think based in location A it's mainly Indian and White, not many African, I have had a few though, couples.

P4: shoo, very very much so, I can't even tell you a race that I see that is the majority that I see in my practice I really see, in terms of South African races I see a lot of Indian, Black and White. I see a lot less Coloured people because the population is so low in location B.

P5: I feel that it is a fair representation according to the demographics because I have the White clients that come in and they prefer to see me. Maybe it is because of the other companies that I represent that I am the closest call and when they start with me the rapport is built up and they prefer to continue with me even when those sessions are exhausted and they have to continue with private and then in corporate also because all the companies I work for are demographically represented. So it is not just Indian clients coming in to see me. And with the local schools as well I am getting a mixed representation.

It was reported that the psychotherapist‟s clients are representative of the cultural diversity of the particular area in which their private practice is situated. The area in which P5‟s private practice is situated seemed to be more representative of the countries cultural diversity as a whole. Whereas, the clients for P1, P2, and P4 were specific to particular cultures/races of White, Indian and African.

Rates and Comorbidity of Trauma, Anxiety and Depression

All six participants reported high rates of trauma, anxiety and depression in relation to the problems and difficulties their clientele experience.

> *P2: The major major issues are always anxiety and depression…amongst the Indians there's a lot of domestic violence and then with White couples I guess everybody just escalating fights or arguments that they don't know or how to stop or bring down.*

> *P3: Surprisingly even though I see some children I would say maybe 60 percent of my cases are made up of depression and a lot of trauma cases as well and between both practices I get a lot of trauma cases in Location C, from rape, to hi-jacking and break-ins, witnessing parents being abusive.*

> *P6: Um, I would definitely say depression I think most people are pretty depressed and with that comes anxiety I've never really seen just anxiety on its own most of them come with depression.*

> *P5: Um, low self-esteem. And the low-self-esteem shows itself in relationships, in performance at school. It shows itself in suicidal behaviour, it shows itself in the workplace…so poor general functioning, poor self-image, not having the tools to, very passive behaviour, or aggressive behaviour.*

> *P1: also psychological adjustment, I work in the medico-legal field so it's mostly people that have been in accidents and have sustained either brain injury or orthopaedic injury and they might have brain damage or psychological problems and*

> *then, also people who have been harassed by the police or might have post-traumatic stress.*

Each participant reflected on the nature of problems that people experience within a South African context. High rates of depression and anxiety were reported as well as high rates of trauma that may be precipitating or maintaining factors relative to depression and anxiety.

> *P3: you know depression is something that from the youngest to the oldest people are experiencing. Sadly in our country PTSD is such a common thing as well because people are exposed to traumas on a daily basis.*

As indicated above, P3 reports that PTSD is also common due to people experiencing trauma on a "**daily basis".** This highlights the potential that people within South Africa are at a high risk for experiencing multiple traumas or on-going trauma. For example, the high rates of ***domestic abuse, children witnessing parents being abusive, rape, hi-jacking and break-ins,*** noted by P2 and P3 above.

Co-Morbidity of Depression and PTSD

P6 and P4 below reported on the relationship between depression and PTSD that they have noted whilst assessing, diagnosing and treating clients. P6 states that PTSD is often missed as a diagnosis and focus for treatment if clinicians focus purely on signs and symptoms of depression and anxiety. This is significant as it highlights the similarities that may exist concerning signs and symptoms of depression, anxiety and PTSD.

> *P6: yes depression and anxiety definitely play hand in hand as well and I think that's why often people can miss PTSD symptoms because they focus on the depression and anxiety.*

> *P4: I think people who have PTSD that's long term, or they've had it for a very long time, I think they developed I notice that they develop depression because they can't understand what's going on there's a sense of them losing themselves they can't understand why they responding this way and there seems to be the depression that*

develops because they feel like they've lost control of themselves and they've lost who they used to be.

P4 above states that PTSD can often be a precipitating factor for the additional development of depression in clients. P4 highlights that this may be due to clients experiencing feelings of losing control or a sense of dissociation **"they've lost who they used to be"** that leads to depressive symptoms.

Psychotherapists' Theoretical Paradigms

The participants were asked directly about their theoretical paradigms and modes of intervention. They reported using integrated modes and punctuating from Neuropsychological, Psychodynamic, Narrative, and Cognitive and Cognitive-Behavioural paradigms.

P2: I tend to formulate a case in a psychodynamic way but work with a client in a narrative and CBT way… so I tend to work more narratively which is a lot more directive and CBT with depression and trauma I find works wonders. So for both I would use CBT.

P3: So those are three main, um, narrative, CBT and then play therapy.

P4: I certainly think psychodynamically. I interpret my patients psychodynamically but I wouldn't say that I practice psychodynamically. You know the techniques I use are a big mixture.

P6: Cognitive behavioural restructuring I predominately work with that because I believe that there is no point in waiting for others to change around you to make your life better. I believe firmly that you take on the ship, you take on the control. And when you do take on the control here (points to head) you take on control of your emotional. Then you changing your feelings, you changing your behaviour.

The importance of knowing and understanding the paradigm that each clinician punctuates from is highlighted by this study. This has important implications for the ways in which the clinician understands their client‟s problems.

Interpretation Process and Findings

Two global themes emerged during the interpretation of the text material from the individual interviews conducted. The first global theme was informed by the content and process that occurs when assessing, diagnosing and treating problems or disorders in practice across cultures. The second global theme focuses on the different aspects of multicultural practices looking specifically at the similarities and differences, if any, between culturally sensitive practices and cultural competency. In addition to this, also how this may affect the content and process mentioned in global theme one above.

Global theme 1: Assessment, diagnosis and clinical judgement.

Table 2 below displays the sub-themes that emerged under assessment, diagnosis and clinical judgement.

Table 2

Global Theme 1: Assessment, Diagnosis and Clinical Judgement

Codes	Issues Discussed	Basic Themes	Organising Themes	Global Themes
- Qualitative process - Rapport - DSM - Case formulation - Clinician bias	• Transparency • Signs and symptoms • Patterns and themes • Collateral information • Clinician‟s self-awareness	1. Intake interview and DSM 2. Cultural amalgamation 3.Innate knowledge vs. acquired knowledge	1. Interviewing processes	1. Assessment, diagnosis and clinical judgement
-Quantitative Process Norms and	• Psychometric tests as guides • Language Barriers	4. Adaption vs.	2. Psychometric	

Standardisation -Language and Translation -Context specific	• Embracing Difference • Socio-economic Factors	Translation and Development	Processes	

This thematic network was informed by the ways in which psychotherapists understand, interpret and practically assess, diagnose and treat their client‟s problems across cultures within the context of private practice. This included the particular everyday practical approaches that these clinicians use relative to PTSD and MDD. This thematic network constitutes two organising themes and five basic themes. Discussions concerning everyday practices highlighted similar ways in which the clinicians assess, diagnose and intervene, as well as some differences in this regard.

Organising theme 1: Interviewing processes.

Basic theme 1: Intake interview.

In the first basic theme, the importance of the interviewing process was highlighted in identifying specific cultural factors that may influence a clinician‟s understanding of their clients, their context and problems relative to that context.

Below, P2 reports that that through the clinical interview and history-taking she is already able to determine *themes and patterns* relative to her client‟s presentation.

> *P2: For example I will do a huge history taking and I might even do a life line with them, to understand themes and patterns that arise and that would be my understanding of the influences that are at play in terms of what they are experiencing now.*

Similarly, P3 below states that the intake is the most *important aspect.*

> *P3: I think the most important aspect is the intake that you do, cause I do a very very very detailed intake with the client and the parents. I spend 2 to 2 and half hours just with the parents. The initial intake and get a full history about the presenting problem and I just let them talk it all out cause often they end up answering most of my*

questions just by doing that. Then after that I'll go into the more finer details that I need like everything, from pregnancy and their developmental milestones, cultural orientation, academic history and medical history.

Basic theme 2: Cultural amalgamation.

In basic theme two, the existence of specific, clear and concise divisions between cultural orientations and sub-cultures within those orientations of their clients was denied by all the psychologists. Two perceptions were reported and highlighted.

One, cultural orientations are no longer divided and clear-cut, but rather are integrated within the South African context. P2 reports on her understanding of the different discourses of ethnicity, race, language and culture. P2 states that as a clinician, one cannot assume that a client's racial orientation will determine their cultural orientation and vice versa.

P2: I suppose for me ethnicity is the umbrella term and within that there are differences so you've got different races, languages and cultures. But you might find that within one race there are different cultures, do you understand? You can't just say all Black people have Zulu culture because they don't. Not all White people are English some are Afrikaans, some are French some come from Australia and all different cultures. Similarly with the Indian culture you got your Tamil, you got your Hindi you got your Muslim, those are all very different as well.

P5: When you talk about the cross-culturally, more and more there is that merging and you cannot now look distinctly at an African culture and say this is what they need and the Indian culture and the White culture, I am doing the same with all of them.

P5 reports above that she uses the same methods of assessment and treatment with each client regardless of their cultural orientation "**I am doing the same with all of them".**

Two, within each broad cultural orientation there are sub-cultures and each client can believe or hold different levels of orthodoxy in relation to these cultural beliefs, reported by P3 below

P3: Definitely because I think that's also what complicates things, is that we think that race and culture is like so well divided but it's actually not, because really they all run into each other. There's varies of degrees some are much more orthodox than others.

Similarly, P4 below reports on the differences in the same cultures that exist according to geographical positioning of where the client lives, namely whether it is in an urban area or alternatively more rural areas. P4 states that because client‟s cultural orientation may vary in relation to this, it is important to determine where their level of commitment to a particular cultural orientation lies.

P4: So in my practice I typically you know I do say to people you know what culture would you say you invest in? If I see Zulu people I say how invested are you because I think a lot of people invest in the traditional and then some investment in the more modern urban side so in fact I think I do that with all my patients.

Basic theme 3: Acquired cultural knowledge and experience of the clinician.
Variations were noted in the participants‟ perceptions of how clinicians are able to identify, understand and use the information relative to what is reported by the client and the cultural content that they obtain through the interviewing process.

Three of the participants, namely, P1, P2 and P4 reported that training is important when using the DSM criteria and/or theoretical understandings relative to psychiatric signs and symptom presentation of PTSD and MDD.

P1: well I'm acting on academic knowledge so I can't quite define it for you but um I would say that I would basically define it terms of these things post-traumatic stress or symptoms that you might expect according to the DSM and the same with depression and all the symptoms that you might express found there.

P2: I would use the DSM. I would look at depression in terms of the vegetative symptoms primarily disturbance, appetite disturbance and then the kind of mood

disturbance those are the 3 main ones but then I'd also look in terms of their relationships with people around them and their coping skills you know a lot of people tend to just drop out of their lives the more severe the depression gets.

P4: Like I said in the beginning I wouldn't say that I'm not too invested in diagnosing and you know how it's been categorised in terms of the DSM. I do think more psychodynamically so I tend to think more in terms of personality and where they fit on the continuum you know between neurosis, psychosis and then in the middle borderline.

The other three participants, namely, P3, P5 and P6 reported that they do refer to the DSM criteria and other theoretical alignments but that they also hold a broader orientation to this manual and the theories in that the individual context (culture and religion) may at times override theoretical underpinnings.

P6: You know what I think with our training, we're so kind of boxed into thinking that way that we can't do anything without referring back to the DSM like all the time and yes I think it becomes a natural instinct. I have to swear when I was an Intern and Comm Serve my DSM was my bible…But I think as you practice and as you go along, it just becomes like second nature. But there's a lot of things you may pick up that you might not have, if you're only focused on those kind of symptoms you know and you didn't look at whole picture because you know what I found is every situation is different, every family is different how they cope with it is different based on their cultural background whether is traditional beliefs or religious beliefs or whatever it is…you have to be more a bit flexible in your thinking than just working within that box.

In the extract below, not only does P5 highlight a broader orientation to the application of theoretical paradigms but that a clinician's perception of this has implications for the therapeutic relationship that is formed

P5: Yes, that is where your rapport is established and if someone has spent years and years believing in something and you come across as this know it all, you've cut it, you've lost it. They don't trust you, so you've got to be sensitive you've got to get into

their shoes and see it from their perspective and not make less of whatever they
believe in and what they are saying.

All six participants reported that psycho-education is an important part of the interventions they do with their clients regardless of the client‟s cultural orientation. Furthermore, all six participants maintained that they are able to adapt and use the theoretical paradigms they punctuate from with all their clients. This is reported by P4 and represented in the extract below.

P4: You know it's, I've at least found it very easy to transfer psychodynamics to most
cultures.

Organising theme 2: Psychometric processes.

Basic theme 4: Adaption vs. translation and development.
There were varying perceptions reported concerning the use of psychometric assessments within the South African context. Some clinicians reported that they do not use psychometric assessments at all and that there is a need for psychometric assessments to be translated or indigenous tests to be developed due to language barriers and standardisation being the predominant problem. Others reported that they may administer psychometric assessments but that these are then adapted to the context of the individual and that cultural factors are highlighted during the interpretation of the tests.

As reflected in the extract below, P1 reports that in her experience of assessing within the medico-legal field, many psychologists in South Africa do not know how to adjust test norms in order to ensure validity.

P1: basically because the Universities don't give adequate guidelines to the students
on how to use the American based tests on our less privileged population thus most
psychologists in South Africa don't know how to use it adequately and that's a huge
huge problem. In the medico-legal field because what happens is people get
diagnosed with brain damage and other disorders simply because unadjusted norms
have been used… I think it's absolutely unnecessary to devise new tests.

P2 reports that in her experience language barriers are the predominant problem when using psychometric assessments.

P2: yah I think the main issue that it really comes down to is the language barrier often I mean I think if you are looking at assessments if there is a language issue which there often is then that would be the predominant problem more so than I think necessarily the culture.

P3 shared her experiences of using the Draw-A-Person Test (DAP) across cultures. She states that in one experience the validity of the assessment may have been potentially compromised if the DAP was interpreted without acknowledging the cultural context of the child that was being assessed.

P3: I was doing an assessment with him and you know we do like the DAP and KFD and all of that and he asked me can I draw the eyes, am I allowed to draw the eyes. And I never thought about that because in Muslim homes you not supposed to have pictures of like full faces with eyes and things like that. And I thought how many kids have been assessed wrong from an emotional perspective because they didn't draw eyes…

Global theme 2: Multicultural practices and interventions.

Table 3 below displays the sub-themes that emerged under multicultural practices and interventions.

Table 3

Global Theme 2: Multicultural Practices and Interventions

Codes	Issues Discussed	Basic Themes	Organising Themes	Global Themes

			3. Cultural Sensitivity vs. Cultural Competency	2. Multicultural Practices and Interventions
- Awareness - Thinking - Difference - Similarities - Test procedures - Test administration - Test interpretation - Language - Culture	• Identifying cultural factors • Appropriate selection of psychometric assessments • Understanding your client"s context • Adequate selection of assessments • Adequate administration • Adequate Interpretation	5. Awareness of cultural factors during the interviewing process 6. Awareness of applicability and limitations of assessment procedures and results		
- Cultural awareness: clinician - Cultural awareness: client - Supervision/ teamwork - Theory/ academic - Training	• Clinician"s paradigms and cultural background • Multi-disciplinary team work • Awareness of personal level of competency • Rapport • Training • Self-education • Self-training	7. The Innate Cultural Knowledge and Experience of the Clinician 8. The cultural orientation and expectations of the client 9.Information Integration and Application		

This thematic network was informed by the ways in which psychotherapists view assessment, diagnosis and treatment with multiple cultures. This included their understanding of these practices, the theoretical underpinning of these practices if any and what is required of them during their own clinical practice. This thematic network consists of two organising themes and four basic themes. Discussions concerning each clinician"s perception of cross-cultural assessment, diagnosis and treatment highlighted similar ideas as well as some differences in this regard.

Organising theme 3: Cultural sensitivity vs. cultural competency.

Basic theme 5: Awareness of cultural factors during the interviewing process.

Two clinicians, namely, P1 and P6 reported that in order to have a better understanding of clients they mainly need to identify cultural factors. This is represented by the extracts below:

P1:…if people come with more Africanised approaches just from the Sangomas just say from something like a person is bewitched or he has been poisoned or he has bad spirits that's harassing him, because I don't know much about that I would simply acknowledge it… I think what does happen is that similar symptoms might be interpreted differently in the different groups.

P6: So you'll find that extended family and extended family of extended family is important to Indians and they all kind of get together for massive functions and you'll find that kids don't leave home until 25-30 even then they still very meshed with their parents and it's so different to the White culture. So in terms of understanding or formulating those cases, you do need to take into account that that's normal for them, you know where as if I was working with a White couple, somebody who was still living with their parents at the age of 30 we would think "oh well maybe you need to move out" and "this is a problem" but you can't work that way with Indian people.

Basic theme 6: Awareness of applicability and limitations of assessment procedures and results.

Similarly, P6 reported that in order to have a better understanding of clients she mainly needs to identify cultural factors during administration of psychometric assessment and interpret or ***adjust*** them according to these factors.

P6: and there's a lot of research that's been done in South Africa on the effect of what I would call the global term that I use is mores that would include education, cultures, socio economic, status, language everything and there is definitely a great need to adjust assessments appropriately to that.

Basic theme 7: The innate cultural knowledge and experience of the clinician.

In contrast to P1 and P6 in basic above, P2 and P4 reported that in their experiences, not only is it important to be culturally sensitive theme 5 and 6, that is, to be aware of, and identify cultural factors. There are other factors that are essential to consider when practicing psychology in a multi-cultural settings. These include: the specific cultural orientation and awareness thereof of the clinicians themselves, as well as the experiences and knowledge that clinicians gain from assessing, diagnosing and treating clients from different cultural orientations.

In the extract presented below, P4 reports that in her experiences, assumptions and judgments were made about her, in relation to her racial and cultural category of Coloured. This experience, she reports, influenced her perception in that practically, she cannot "**generalise**" interpretations made relative to the culture of her clients as each individual is "**unique**".

> *P4: I don't think I would use the words culturally sensitive I suppose you know **I try to view everybody as just purely unique.** I'm Coloured but I grew up I was one of the first to go to the white schools after Apartheid so I grew up technically in a White school but in a Coloured home and it became very difficult you know people would say to me "oh you're Coloured" and I'll say "I'm not typically Coloured" I don't know a lot of Coloured people I don't know the slang you know so I think from that background I started to **appreciate you know you just can't generalise any kind of culture based on anything.***

In the following extract, P2 reports that in her experience, the more she is able to assess, diagnose and apply interventions with a particular cultural group, the more knowledgeable she becomes and the more she can understand some practices that may be relative to that cultural group. Similarly, P2 reports that when assessing, diagnosing and treating cultural groups that she has not had much experience with, she does not feel "**adequate enough**".

> *P2: I would find that the more I work with a certain cultural group the more equipped I become. So I learn through my clients just like everybody does and because I don't have that many African clients I find that when I am working with them I don't feel*

adequate enough. Whereas through the years working extensively with Indian clients I've started to understand, you know what they're prayers are and temple and family dynamics. So I have a better grasp of that.

Basic theme 8: The cultural orientation and expectations of the client.

Some of the participants highlighted that the expectations that clients have of the clinician and therapy itself are very important and do influence the outcomes of sessions. This is highlighted by P6 in the extract below.

*P6: So similarly with Black people you do have to take into account their culture and what's important to them. So for example a lot of the traditional healing stuff, Sangomas, Muthi and the witchcraft side of things, I've often found they plays a big role in terms of **what they bring to therapy**.*

P3 expressed that in her experience; sharing the same cultural orientation with clients may actually hinder clients from seeking help from that clinician or may have a negative impact on the therapeutic relationship itself.

P3: There are other Muslim clients who wouldn't want to see me because of the like stigma attached to whatever their issue is. For example, if it was an affair or something like that and they may think that me being a Muslim female and that culture thinks that I'm going to be judgemental.

P5 below reports that including cultural practices within the intervention methods used may influence the length of time and number of sessions. P5 reports that regardless of this, she will always **"encourage"** her clients to attend therapy and to conduct traditional practices.

P5: Even there, it might take me a longer time where we are still having completion with the ancestral beliefs, but I never ignore that I always encourage them to do both. Even with the Indian when we talk about rural and cultural. Even lots of my Indian clients want to go to their priests and so on.

Basic theme 9: Information integration and application.

P2, P3, P4, P5, and P6 reported that when assessing, diagnosing and intervening within a multicultural setting, it is important to have a holistic view of your client. Some of the clinicians highlight how they are able to achieve this, namely: by integrating information obtained from the interviewing process, psychometric assessments and collateral interviews conducted. This is illustrated by reports from P5 in the following extracts.

> *P5: um a lot of the tools I use I use as a guide I don't use it as a be all and end all. So for example with the Becks, I don't use only the assessment. I take each one and I marry them, the clinical interviews and then the assessments.*

> *P5: You know in terms of the challenges in South Africa because we are so varied in our backgrounds and our experiences, you know, it's very interesting every day I don't know what case I am going to get so I can't use the same methods with my next one because every case is just so different.*

In addition to integrating information obtained, P3 highlights the importance of sharing information intra-disciplinarily that may be useful or that clinicians may be cautious of relative to cultural factors. This is reported in the extract below.

> *P3: I've mentioned we run a peer supervision group for about 6 or 7 psychologists in Location A and I'm the only Muslim in the group so I made sure I fill them all in on cultural things, you know **I mean I'm Muslim and I never thought of some of these things. So you know, why would anyone else think of it?***

Conclusion

This chapter illustrated the themes and patterns that emerged as the main findings of this research study. Firstly, the chapter highlighted the specific context of the study in order to assist the reader in understanding the setting from which the findings emerged. Secondly, the two global themes that emerged as the main overarching representations of the text material were described and illustrated. This included examining psychotherapists understanding, interpretation and practical processes with their client"s problems across cultures and within private practice. As well as, examining the ways in which

psychotherapists view assessment, diagnosis and treatment with multiple cultures. Overall, this chapter presented an idea of how psychotherapists work with clients from different cultural backgrounds in private practice, looking specifically at MDD and PTSD as disorders that are commonly experienced by clients. A more detailed discussion on these findings is presented in Chapter 5.

Chapter 5: Discussion

Introduction

In chapter 5, the second and third stages of the thematic networks data analysis are combined to produce an analytic discussion of the study material. This chapter then, provides a discussion of the research setting and of the two global themes identified and illustrated in Chapter 4. Following the discussion of the studies objectives and consolidation of the research questions in relation to current literature, this chapter also includes some limitations of the current study and recommendations for future research studies.

In the current study, the main objectives taken on by the researcher were to explore and determine whether psychotherapists" – working in private practice – approaches to assessment, diagnosis and treatment of MDD and PTSD differ according to their clients" ethno-cultural orientation. The psychotherapists" perceptions of assessing, diagnosing and treating clients from different ethno-cultural groups are examined, their definitions of MDD and PTSD are highlighted and the client"s responses to assessment, diagnostic, and intervention approaches are discussed in this chapter.

The context of Private Practices

The systemic problematic nature and differences in private practice versus the public sector in the South African context was reported by two psychotherapists. This was particularly relevant to language barriers that exist between psychotherapists and their clients when applying for positions within the public domain. This means that these psychotherapists" experiences may, for the most part, be limited to being employed in private practice. Stein et al. (2008) emphasise the important links between ethnicity and differences in socio-economic prominence, where, in the South African context whites are more advantaged than other population groups such as African, Coloured and Indian. In relation to Stein et al. (2008) then, this may mean that psychotherapists are limited to the number of different clients that they are exposed to in private practice, as a limited group of clients are able to make use of private practice services.

Interestingly, the majority of participants reported experiencing and assessing, diagnosing and treating a multitude of ethno-culturally diverse individuals in their private practices. They also reported that the specific ethno-cultural orientations of the clients they

assess, diagnose and treat are representative of the specific cultural orientations of the area in which each psychotherapist works. This is significant as it demonstrates that various ethno-cultural groups are in need of and make use of private psychological services in multiple areas in KwaZulu-Natal. It also highlights that not only do psychotherapists assess, diagnose and intervene with multiple ethno-cultural oriented clients within the public domain but also within private practice as well. This means that there was a discrepancy in the psychotherapist"s perceptions and experiences and perhaps warrants more investigation. It will be discussed later in this chapter that the development of cultural competency in psychotherapists is also determined by the broader cultural context within which they assess, diagnose and intervene as well as the experiences they have.

The words culture, ethnicity and race were noted to be used interchangeably by all participants. This is synonymous to the literature reviewed in this study which highlights that the term culture is often used interchangeably to include both the broader dimensions of society, but it can also be representative of the differing compositions of each individual client (Draguns & Tanaka-Matsumi, 2003). Furthermore, the ethnic/racial orientation of individuals is often interwoven with specific cultural orientations resulting in ethno-cultural identities (Dana, 2005). Therefore, the psychotherapists" perceptions were noted as aligned with the theory highlighted in this study.

High rates of trauma, anxiety and depressive disorders are well documented in the South African literature (Bach & Louw, 2010; Edwards, 2005b; Stein et al., 2008; Ward et al., 2001). This was found to be the case in this particular research study. All six participants reported high rates of trauma, anxiety and depression in relation to the problems that their clients experience and problems that are predominantly dealt with in psychotherapeutic practices. They also noted high rates of MDD and PTSD specifically. Also, precipitating, and maintaining factors highlighted by the psychotherapists included high rates of trauma exposure such as abuse, rape, hi-jacking and break-ins.

This is synonymous with the literature where high prevalence rates of MDD and PTSD and the disabling and maintain nature of both conditions within the South African context is well highlighted in Chapter 2. For example, Bach and Louw (2010) state that there is a clear correlation between exposure to violence and mental health concerns in adolescents. Furthermore, a number of factors such as high levels of exposure to violence and trauma,

high levels of poverty, differing socio-economic privilege across ethnic groups and effects of epidemics such as HIV/AIDS are contributing significantly to the high prevalence rates of depression and disorders such as post-traumatic stress disorder within the South African context (Edwards, 2005b).

In addition to emphasizing the extensive occurrence of MDD and PTSD in their practices, the participants also reported on the relationship between MDD and PTSD. Where, in their experiences, there is a close relationship between the two disorders. In that, similarities may exist relative to the signs and symptom presentation of both. Furthermore, the participants highlight that one disorder may precipitate the development of the other.

The psychotherapists" perceptions of the relationship between MDD and PTSD is aligned with national and international literature where research shows, PTSD and depression are two disorders that are often comorbid (Barlow, 2002; Poundja, Fikretoglu & Brunet, 2006; Ward et al., 2001). Furthermore, salient symptomatology will often include combined symptoms of MDD and PTSD (Barlow, 2002; Ward et al., 2001)

Participants reported punctuating from multiple integrated theoretical paradigms and intervention modes. This they noted was relative to treating co-morbid problems as well. These included Neuropsychological, Psychodynamic, Narrative, and Cognitive and Cognitive-Behavioural paradigms. This is synonymous to current literature on the necessity for integrated methods of understanding client"s problems and the modes of interventions used. The literature highlights that problems need to be conceptualised in terms of co-morbidity and that this can be achieved using integrated methods of a number of different therapies such as psychodynamic therapy, narrative therapy, cognitive-behavioural therapy (CBT) and cognitive therapy (CT) (Edwards, 2009; Grant & Townend, as cited in Grant, Townend, Mills & Cockx, 2008). These modes of treatment are also noted in the literature as effective for MDD (Kirmayer, 2001; Sadock & Sadock, 2007). Furthermore, within each therapy there are multiple techniques, and treatment procedures with treatment manuals and guides (Edwards, 2009).

Assessment, Diagnosis and Clinical Judgement

The specific ways in which psychotherapists understand, perceive and practically assess, diagnose and treat their clients" problems of MDD and PTSD across cultures was central in the conceptualisation of the global theme of Assessment, Diagnosis and Clinical Judgement. This is relative to both the content and process of addressing disorders such as MDD and PTSD. Throughout this study, the importance of the interviewing processes relative to identifying cultural factors has been emphasised. In particular that it provides imperative information relative to the presenting complaints or problems of the client (Aklin & Turner, 2006; Sadock & Sadock, 2007).

In their understanding of qualitative assessment methods, the psychotherapists emphasised the need for an in-depth intake interview and history-taking in order to not only highlight content, that is, the reported signs and symptoms of both disorders, but the process as well. That is, to highlight *themes and patterns* in understanding the client"s presentation within this interview.

It emerged that these themes and patterns are very important for the identification of an individual client"s perception of their own cultural orientation. In the participants" perceptions, the existence of specific, clear and concise divisions between cultural orientations and sub-cultures was denied by all the psychotherapists. In other words, all six psychotherapists maintain that in the South African context, cultures are now amalgamated. Also, within this amalgamation, individuals maintain different levels of orthodoxy. This means that not only is it problematic to generalise cultural perceptions to specific individuals as a result of their reported ethno-cultural orientation, but that this has significant implications for interventions. As generalisations cannot be made concerning how one ethno-cultural group will respond the same to particular intervention methods.

Rather, in this study the participants highlight a need for specific attention to be given to each client as an individual rather than to make generalisations based on ones ethno-cultural orientation. This is aligned with cultural-ecological approach maintained within this study where the beliefs and values of the clinician and client in relation to their societal positioning determine the structuring of clinical practice in psychology by acknowledging the complexities of individual cultural identity (Dana, 2005). Dana (2005) goes on to state that some of these individual differences relate to ways of thinking about mind-body dualism,

values, spirituality, health-illness beliefs, individualism-collectivism and locus of control and responsibility. This is supported by Corey (2009), who highlights that clinicians need to adapt their modes of theory and practice to fit their client‟s needs as opposed to fitting clients into a particular theory or mode of intervention.

Therefore, cultural beliefs and meaning are important and necessary to consider with each individual and generalisations cannot be made by purely determining a client‟s ethno-cultural orientation. In other words, this does not provide sufficient information for how an individual‟s problems should be understood, assessed, diagnosed and treated. This is synonymous with the opinion of this research study in that *all* investigations into human behaviour should be multicultural in nature due to possible affiliations between an individual‟s ethno-culture and psychopathology. Furthermore, this study emphasises that the perceived causes, symptom development and use and/or success of treatment outcomes are highly dependent on individual ethno-cultural variables (Aklin & Turner, 2006; Dana, 2005; Marsella, 2010).

The results of this study emphasised not only the importance of considering a client‟s ethno-cultural orientation but also the level of acquired cultural knowledge and experience of the psychotherapist required to produce sound assessment and diagnosis. This refers specifically to the training and clinical judgement of psychotherapists. Here, the psychotherapists seemed to be divided.

Some of the psychotherapists reported that in their perception and experience there is a need for clinicians to work closely with the DSM criteria and theoretical understanding emphasised during their training and throughout their practical experiences. For others, although they do believe in using the DSM and other theoretical underpinnings, they also highlight that these techniques are based in Western ideals that may not be practically applicable within the South African context. The literature in this study has highlighted that although the DSM-5 acknowledges that a relationship between culture and pathology exists and that it is imperative to be aware of and acknowledge this relationship when assessing and diagnosing MDD and PTSD, it does not provide contextual factors specific to the South African context (APA, 2013; Stetka & Corell, 2013).

Participants were also divided in their perceptions of whether psychometric assessment tools are applicable and helpful within the South African context. Central in this division was discussions of test adaption versus the translation and new development of indigenous tests specific to the South African context. Some of the psychotherapists reported that they never use psychometric assessment tools unless they have been translated into the language of their client or if they have been standardised to the population from which their client stems from as they are not valid or useful in their practices. Others reported that they may use the psychometric tools as a guide in highlighting factors relevant to PTSD and MDD but not as a diagnostic tool in itself and that interpretations are made with caution in relation to cultural factors that may influence the findings of the assessment measures.

This is interesting as the disconnected findings from this study represent specific debates that exist in the literature on this topic within the South African context. In other words, some of the literature on cross-cultural assessment within African contexts highlights the need for test adaption and standardisation of assessment tools (Boyes, Cluver & Gardener, 2012; Edwards & Steele, 2008; Murray et al. 2011; Sharp et al. 2010). Other literature focuses on the translatability of western assessment tools and development of new indigenous assessment measures specific to African contexts (Andersen et al., 2011). Some psychometric assessments used, as reported by the participants in diagnosing PTSD and MDD include the Draw-A-Person Test, the Beck Depression and Beck Anxiety Inventories.

Furthermore, the debate that emerged in the findings of this study can be related to the distinctions between standard and multicultural assessment highlighted by Dana (2005) in his book on multicultural assessment. According to Dana (2005) standard assessment encompasses assessment measures, both objective and projective which are commonly used to measure human behaviour that originated and is predominantly normed and standardised on a Euro-American population. Dana (2005) highlights that standard assessment may include cultural sensitivity, which entails being aware of the applicability of test results. This is comparative to the participants that may use the psychometric tools as a guide in highlighting factors relevant to PTSD and MDD but not as a diagnostic tool in itself and that interpretations are made with caution in relation to cultural factors that may influence the findings of the assessment measures

In contrast to this, multicultural assessment transcends cultural sensitivity towards cultural competence. In other words, it refers to the amalgamation of standard assessment applications of all standard instruments with the inclusion of *interview processes* and other *test/method sources* that will provide additional information necessary to determine sound assessment and diagnoses (Dana, 2005). This is comparative to the participants that never use psychometric assessment tools unless they have been translated into the language of their client or if they have been standardised to the population from which their client stems from as they are not valid or useful in their practices.

According to Dana (2005) then, cultural competence refers to the use of cultural knowledge and experience, the awareness of the level of competency of the assessor or clinician, as well as a large emphasis on the skills required by the practitioner to establish rapport and interpret the client"s responses within their individual cultural; linguistic and social context (Dana, 2005). This is highlighted as imperative in relation to the findings of cultural amalgamation. Where, universal truths cannot be made concerning an individual"s cultural orientation and thus the use of multiple assessment methods (both qualitative and quantitative) is imperative. As well as the use of additional sources of information, such as collateral interviews, professional discussions with colleagues or supervision, and training (Aklin & Turner, 2006; Dana, 2005).

In relation to the overall findings of the global theme of assessment, diagnosis and clinical judgement and the literature mentioned the majority of the psychotherapist"s perceptions and experience of assessment and diagnostic practices seem to be more aligned with multicultural assessment and cultural competency (Dana, 2005). Two other participants reported on practices that are more aligned with standard assessment with the inclusion of cultural sensitivity (Dana, 2005).

These findings are closely linked to the second global theme of multicultural practices.

Multicultural Practices and Interventions

An overview of the ways in which psychotherapists broadly view their assessment, diagnosis and treatment methods with multiple cultures informed the global theme of Multicultural Practices and Interventions. This included their understanding of these

practices, the theoretical underpinning of these practices if any and what is required of them during their own clinical processes and how this is relative to the interventions used.

Two of the clinicians reported using cultural sensitivity practices where clinicians are required to be aware of cultural factors during the interviewing process and be aware of the applicability and limitations of assessment procedures and results. In contrast to this, other participants reported that there is more to multicultural assessment, diagnosis and treatment than purely being aware of cultural factors. Specific to these practices, they highlight three particular processes that assist in developing multicultural competencies in practice.

Firstly, they report on the need for psychotherapists to be mindful of their own innate cultural knowledge and experiences of assessing, diagnosing and treating individuals with specific cultures. One participant reports that the more she works with (experiences) a particular cultural group the more knowledgeable she becomes and the more she can understand **some** practices relative to that cultural group. This is one particular component of cultural competency highlighted by Dana (2005) who refers to the use of cultural knowledge and experiences of the clinician. This is synonymous with other literature in that the more a therapist has personal experiences with individuals from multiple ethno-cultural groups, the more understanding and culturally competent they become (Hays, 2001, Vasquez, 2005).

Secondly, the participants reported that in their experiences, examining the individual client‟s cultural orientation and how this creates expectations relative to the clinician and psychological practices is important. Again this is highlighted as a second component or strategy for building multicultural competence. Dana (2005) states that a large emphasis should be put on the skills required by the practitioner to establish rapport and interpret the client‟s responses within their individual cultural, linguistic and social context (Dana, 2005). Hays (2001) also states that the more culturally responsive a therapist becomes, the more equip they are in forming the therapeutic alliance and establishing respect and understanding with their clients.

One participant highlighted that certain client‟s may **bring** things to therapy. Another participant reported that, in her experience, sharing the same cultural orientation with her clients does not necessarily assist with rapport development and understanding. Rather it may hinder this process or pre-empt a client to decide not to attend therapy with that

psychotherapist. This is supported and highlighted by the literature. Vasquez (2005) highlights a specific problem encountered in independent practice when assessing, diagnosing and treating people with different cultures. This is relative to the client‟s awareness and expectations of the clinician‟s ethno-cultural orientation. In other words, some clients may prefer to see psychologist of the same ethno-cultural orientation to theirs or alternatively, they may not due to possible judgement and bias.

Another participant highlights that a client‟s cultural orientation and the specific practices that they believe in can influence the interventions used and their length. This participant goes on to report that she will include these practices within her interventions. According to Hays (2001) critical thinking, seeking new and diverse sources of information and direct experience with individuals who have a different ethno-cultural orientations are important components of becoming a culturally responsive therapist. Critical thinking allows a therapist to identify as well as challenge assumptions made, highlight and examine contextually influential factors and imagine and explore alternative interventions relative to a client‟s needs (Hays, 2001). Therefore, the aforementioned participant‟s strategies for interventions are aligned with the literature on strategies for building multicultural competency.

Third, five of the six participants highlighted that when assessing, diagnosing and treating in multicultural settings, it is important to view your client holistically. This is achieved through information integration. In other words, the participants report that they will use information obtained from the interviewing processes (both with the client and with collateral sources); any information obtained from psychometric assessment measure/s; as well as multi-disciplinary discussions with colleagues to gain a better understanding of their client‟s and their problems. This is synonymous with the literature where Dana (2005) highlights the importance of cultural competency as opposed to cultural sensitivity where both quantitative and qualitative aspects of psychological assessment and diagnosis are imperative. Aklin and Turner (2006) support Dana (2005) in emphasising cultural competency and the use of multicultural assessment processes such as pairing quantitative and qualitative methods, the use of collateral sources of information, professional discussions with colleagues or supervision, self-education and continued self-training or attending workshops.

A particular important strategy for building multicultural competency was not directly referred to by any of the participants but is consistently highlighted by the literature. This is the notion of clinician bias (Dana, 2005). Dana, (2005) highlights the need for clinicians to self-examine their own cultural identities in order to increase awareness and understanding that both the client and the clinician are cultural constructs. This is supported by Corey (2009) who states that "effective counsellors understand their own cultural conditioning, the conditioning of their clients, and the socio-political system which they are a part of" (p. 25). Similarly, Hays (2001) identifies the need for a clinician to conduct a cultural self-assessment in order to better understand their own cultural heritage and how this may influence clinician bias and understanding. Explanations as to why the participants of the study did not directly refer to clinician bias could be relative to the importance and emphasis made in theory, training and practice on the need to understand clients. In other words, there is a constant focus on determining knowledge and understanding relative to individual clients" ethno-cultural orientations. This means that self-knowledge, cultural self-assessment and self-reflexivity relative to the clinician themselves may be overlooked as important components in the development of this understanding as well.

It is also possible that the notion of social desirability may have had a role to play in participants wanting to be perceived by the researcher as void of bias or unethical practices. The concept of social desirability is commonly referred to in research and the need to present oneself in a positive manner is acknowledged as basic human nature (Neeley & Cronley, 2004).

Conclusion

This chapter focused on a discussion of the main findings of the current study. The discussions are relative to how psychotherapists perceive the relationship between culture and mental health and how this may influence their psychological practices. The main findings of the study are that culturally diverse psychotherapists do believe there is a need for diverse cross-cultural approaches to the assessment, diagnosis and treatment of PTSD and MDD. In relation to this, they do not however believe that purely identifying a client's cultural orientation will determine the assessments used, diagnoses made and treatment mode used. Thus, they believe that making assumptions and generalisations relative to assessment, diagnosis and treatment of PTSD and MDD based on an individual's cultural orientation

alone is not helpful in practice. Rather, each client needs to be assessed and diagnosed holistically and an intervention program developed specific to each individual rather than each cultural/ethnic group.

Chapter 6: Conclusion

Introduction

This thesis has presented the context and the background to the research problem. It has discussed currently available literature from studies that explored psychotherapists" approaches to cross-cultural assessment, diagnosis and treatment of PTSD and MDD. The findings of the study are presented and discussed above. In this chapter, conclusions drawn from the study are discussed. Limitations are also discussed, and recommendations are suggested.

Conclusions Drawn in Relation to the Research Questions

The first fundamental question or research problem highlighted by this study is whether a given sample of psychotherapist thinks there is a need for diverse cross-cultural assessment approaches in their practices? It is apparent that there is a need, but it was also highlighted that the ‚diverse approaches" used may differ between psychotherapists. Where, the applicability of certain assessment procedures is relative to the language a client speaks and the comparison between the standardisation of the assessment measure and the client"s context. There is a belief that assessment procedures used within the South African context should be used broadly, with caution, and merely as a guideline in conjunction with other information sources rather than diagnostic tools.

In relation to the second question of *how does a given sample of psychotherapists define MDD and PTSD*, the findings were similar to the question addressed above. Perceptions are divided in accordance with different beliefs about diversity and mental illness such as PTSD and MDD. It is evident that some psychotherapists believe that the use of the DSM-5 and other theoretical orientations is applicable in the South African context and others maintain that the context within which these manuals and theories was developed does not lend itself to clear applicability in the South African context. Thus contextual factors require attention when using manuals and theories not developed within South Africa.

Do the specific approaches for assessment, diagnosis, and treatment used by a given sample of psychotherapists for MDD and PTSD differ between the client"s ethnic groups? Overall, there is an emphasis regarding the necessity and importance of understanding a client"s ethno-cultural orientation. It should be noted that methods for doing so may differ in

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accordance with the perceptions highlighted above. One belief is that acknowledging ethno-cultural beliefs and practices is sufficient. Another belief takes this a step further by integrating this information into practice by either including it in the interventions used or integrating information – both qualitative and quantitative – to form a holistic view of their client.

It is also acknowledged that although necessary, a client‟s ethno-cultural orientation is not sufficient in determining the approaches used by psychotherapists for MDD and PTSD. So, although cultural orientation is an important element to consider when assessing, diagnosing and treating a client it does not presume what methods may suit the needs of that client.

Similarly, in relation to the final question posed, of *whether client's responses to assessment, diagnosis and interventions for MDD and PTSD differ according to their ethnic group* – again, ethno-cultural orientation is important - but it does not determine how a client will respond. It also does not determine that there are particular responses in relation to particular ethno-cultural groups.

Rather, it can also be concluded that it is ultimately a combination of the perception held by the psychotherapist relative to the relationship between culture and pathology; and the client‟s perception of the therapist and therapy. This will ultimately influence the level of understanding the psychotherapist forms of their client; the rapport or therapeutic alliance formed between the client and psychotherapist; as well as what information is used in what ways. Overall, these factors will determine the modes of intervention used as well as how clients respond to these interventions.

Implications for Theory and Practice

Based on the findings and conclusions drawn in this study the following implications are highlighted for theory and practice in relation to the assessment, diagnosis and treatment of PTSD and MDD. In identifying what culturally ethical practices in private practice may entail, from the findings of this study, it is highlighted that psychotherapists need to be aware of their own perceptions of what they believe the relationship between culture and pathology to be. In other words, to what extent do they believe that an individual‟s ethno-cultural orientation is influential in understanding pathology or disorders such as PTSD and MDD.

This awareness is also linked to notion of clinician bias that was not directly referred to by participants but highlighted in the literature. The current study emphasises the importance of self-knowledge, cultural self-assessment and self-reflexivity relative to the clinician themselves, as an important component of developing and maintaining cultural competency in practice.

Second, a psychotherapist's perception and awareness of this perception may ultimately inform practical decisions made either during assessment processes, diagnoses made and the intervention programs developed for MDD and PTSD. This will also determine the level of understanding between the client and psychotherapist. In other words, if a psychotherapist maintains that the level of cultural applicability is low, this may inform the use of standard assessment with the inclusion of culturally sensitive practices. On the other hand, the perception that the level of cultural influence is high could inform practices that are more aligned with multicultural assessment and cultural competency. It has also been highlighted that other contextual factors also do contribute to the development of cultural competency, such as the cultural diversity of the clientele that make use of independent psychological services.

Findings of this study are highly valuable in contributing to the enhancement of knowledge pertaining to cross-cultural theory and practice. It has also contributed to the beginning stages of the identification of broad guidelines relative to culturally-appropriate services rendered by psychotherapists in private practice within KwaZulu-Natal in South Africa.

Limitations

One anticipated limitation of this study related to the sampling of participants. As literature reflects, the number of non-White psychologists (African, Coloured and Indian) does not compare with the number of White psychologists practicing in South Africa (Sharp et al., 2010). This is also applicable to KwaZulu-Natal which is the provincial focus of this study. In accordance with these statistical ratios it was expected that the intended sample of two African, one Coloured, one Indian and two White participants would not be achieved. This was the case in this research study. As mentioned above, this was noted as an additional but not necessary criterion and therefore did not hinder the results of the study.

Recommendations for Further Research

As highlighted in the current study, the relationship between culture and pathology is an intricate one and research on the topic is limited in the South African context. Thus, future research studies could be conducted using larger participant samples that are more diverse in nature. That is, using larger samples of participants, from multiple ethno-cultural orientations, from multiple provinces within the South African context. Comparison studies – either broadly oriented to cross-cultural practices or to specifically nominated disorders – could also be conducted within different provinces and between provinces within South Africa to determine if psychological services may differ in different contexts or areas of the country.

Conclusion

This study aimed to investigate the practical processes that are used by psychotherapists in the province of KwaZulu-Natal (KZN) when assessing, diagnosing and treating client‟s that are from multiple ethno-cultural orientations. This was investigated within an interpretive paradigm, examining the psychotherapists‟ perceptions of the relationship between culture and psychopathology –with specific reference to disorders of MDD and PTSD - on a micro-level. That is, between interacting cultures within the same province.

The significant findings of the current study indicates that when assessing, diagnosing and treating PTSD and MDD, it is ultimately a combination of the perception held by psychotherapists relative to the relationship between culture and pathology; and the client‟s perception of the therapist and therapy. This ultimately influences the level of understanding the psychotherapist forms of their client; the rapport or therapeutic alliance formed between the client and psychotherapist; as well as what information is used in what ways. Overall, these factors will determine the modes of intervention used as well as how clients respond to these interventions in private practice within the province of KwaZulu-Natal.

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Appendix 1 Ethical Clearance Letter

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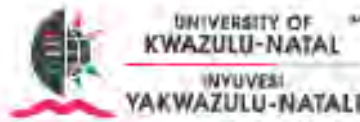
37 Mar 2013

Ms Meggan Slabbert 206322174
School of Applied Human Humae Sciences
Pietermaritzburg Campus

Dear Ms Slabbert

Protocol reference number: HSS/0364/013M
Project title: A qualitative study of Psychotherapists' Approaches to Cross-Cultural assessment, diagnosis and treatment of Posttraumatic Stress Disorder and Major Depression Disorder in KwaZulu-Natal

EXPEDITED APPROVAL

I wish to inform you that your application has been granted Full Approval through an expedited review process.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shenuka Singh (Deputy Chair)
Humanities & Social Science Research Ethics Committee

/pm

cc Supervisor: Ms Phindile Mayaba
cc Academic Leader: Prof DP McCracken
cc School Admin : Mr Shonelo Duma

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INSPIRING GREATNESS

Appendix 2 Participant Invitation Letter

Are you a clinical or counselling psychologist practicing psychotherapy in private practice with individuals who are suffering from either Depression and/or Posttraumatic Stress Disorder?

Have you been in private practice for at least 3 years – post-registration with the Health Professions Council of South Africa?

Do you work and reside in the province of KwaZulu-Natal?

If you answered „yes‟ to the above questions, this letter serves as a formal invitation to participate in a study being conducted for a thesis in fulfillment of the requirements of the degree of Master of Social Science in Clinical Psychology. This study is being conducted by Meggan Slabbert (Student Number - 206522974) and is being supervised by Ms Phindile Mayaba at the University of KwaZulu-Natal, Pietermaritzburg Campus.

The study aims to explore psychotherapists‟ approaches to assessment, diagnoses and treatment of Major Depression (MD) and Posttraumatic Stress Disorder (PTSD) within private practice for different ethno-cultural population groups.

If you are willing to participate in the study please contact me via e-mail or telephonically.

Fondest Regards,

Ms Meggan Slabbert   Ms Phindile Mayaba

Clinical Psychology Masters Student   Educational Psychologist (Research

                                           Project Supervisor)

E-mail: meggan.slabbert@gmail.com   Email: Mayabap@ukzn.ac.za

Telephone: 072 245 74 88   Telephone: (033) 260 5364

Appendix 3 Participant Consent Form

I _____ hereby agree to take part in this study for a thesis in fulfillment of the requirements of the degree of Master of Social Science in Clinical Psychology, conducted by Meggan Slabbert.

This study aims to explore psychotherapists" approaches to assessment, diagnoses and treatment of Major Depression and Posttraumatic Stress Disorder (PTSD) within private practice for different ethno-cultural population groups.

As a participant in this study, I understand that:

1. This research has obtained clearance from the Higher Degrees Committee and Ethical Committee of the University of KwaZulu-Natal Pietermaritzburg Campus.

2. My participation involves having one or more interviews audio-recorded (or conducted telephonically if requested for the second interview) and observed by the researcher at an agreed upon date and time.

3. The audio-recordings will be transcribed by one or more nominated third parties.

4. The researcher will use the information gathered throughout the research to compile a thesis and possibly for publications at a later stage.

5. All personal information will remain anonymous and confidentiality will be of importance for all parties who have access to research material. All identifying information will be removed or changed with the use of pseudonyms in the final thesis e.g. Psychologist1.

6. All material obtained for the study will be destroyed within 2 years of completion of the study to allow for potential publication.

7. This research is being supervised by Ms Phindile Mayaba who is a lecturer in the Psychology department at the University of KwaZulu-Natal, Pietermaritzburg Campus.

8. All parties (researcher, supervisor and transcriber) who will have access to the material obtained will be required to declare in writing that they will maintain anonymity as well as confidentiality.

9. I have the right to withdraw from the process if I believe it is no longer in my interests. I also undertake that I have committed myself to participating in the research

at some level and will only withdraw under extreme circumstances and after discussing it fully with the researcher. I understand that my withdrawal will disrupt the researcher˒s progress in an important component of the study.

10. I have the right to voice any concerns about my participation in the study and the use of the material obtained at a later date and have these concerns addressed to my satisfaction.

11. I will have a summarized version of the final project made available to me should I wish to read it once the study is complete.

12. The researcher has discussed the study and permission form with me and, I understand and am aware of the above information concerning the nature of the study.

……………………………   ………………………………
SIGNED BY PARTICIPANT   Date

……………………………….   …………………………………...
SIGNED BY RESEARCHER Ms. M. Slabbert   Date
Clinical Psychology Masters Student
Meggan.slabbert@gmail.com

………………………………….   ……………………………….
SIGNED BY SUPERVISOR Ms P. Mayaba   Date
Educational Psychologist (Research Project Supervisor)
Email address: Mayabap@ukzn.ac.za

Appendix 4 Interview Schedule

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Introduction

- Can you please begin by telling me a bit about yourself

-age, race, ethnicity, religion?

- and your practice:

-what is your registration or scope of practice?

-how many years have you been in private practice for?

-what do you specialise in?

- How racially diverse are your clientele?
- What are the most predominant problems your clientele experience?

Assessment and diagnosis

Overview

- What model/therapeutic frame do you most frequently use in your practice?
- How would you define the disorders of PTSD and MDD? / In relation to this model/frame?
- In your experience and to your knowledge, how, if at all, are MDD and PTSD comorbid
- What, to your knowledge and in your experience does culturally sensitive practices entail?
- Do you think there is a need for cross-culturally aligned practices in your everyday work when dealing with PTSD and MDD?

Approach or model used

- Is there an overall theoretical approach linked to your therapeutic frame that specifies or informs culturally sensitive assessment of PTSD and/or MDD?
- What/if any assessment tests (both quantitative and qualitative) do you most commonly use in practice to diagnose PTSD and/or MDD?

Applicability to SA and different ethno-cultures

- How applicable are these psychometric tests in South Africa according to the standardization?
- How culturally sensitive are these psychometric tests?
- What are the special considerations around the tools for diagnosis of PTSD and/or MDD? In other words, would the use of these tools differ according to different ethno-cultural groups?

Interventions

- In relation to what was discussed above, how would you tailor your interventions for individuals from different ethno-cultural groups for PTSD and MDD?
- Do the client‟s responses differ to these interventions for PTSD and MDD depending on their ethno-cultural group?

Psychotherapist/Continuing Professional Development and Culture

- Do you think that culturally sensitive practices form part of your continued professional development as a psychologist in practice?
- What might this entail in a South African context?
- In what ways do you think your ethno-cultural orientation influences the way in which you practice and treat individuals with PTSD and/or MDD?

Conclusion

- In what ways is this challenging for you as a professional working within South Africa?
- In what ways may this be a positive experience – working as a professional within South Africa?
- What recommendations would you give to someone who is about to start their own practice in relation to cross-cultural assessment, diagnosis and intervention for PTSD and MDD?
- Is there anything else you would like to add or comment on?
- Thank you for your participation it has been greatly appreciated.