A QUALITATIVE EXPLORATION ON HOW BLACK AFRICAN PSYCHOLOGISTS PRACTISE CULTURALLY COMPETENT CARE WHEN HELPING BLACK AFRICAN CLIENTS WHO HOLD TRADITIONAL EXPLANATORY MODELS OF ILLNESS

By

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DECLARATION

I, **Olwethu Mncono**, declare that this research thesis - entitled *A qualitative exploration on how Black African psychologists practise culturally competent care when helping Black African clients who hold traditional explanatory models of illness* - is my original work except where otherwise stated. I declare that this thesis has not previously been submitted for any qualification at any other university. I have acknowledged all sources in the reference list.

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Olwethu Mncono

March 2018

DEDICATION

To my mother

Fundiswa Mncono

Widowed at 32, raising 3 kids on your own, you are a powerhouse. Thank you for all you have sacrificed for me during this journey. You lost your parents at a young age and never had the opportunity to be educated but you always placed value on the importance of education.

Thank you for the motivation which pushed me to carry on even when I wanted to give up. I never thought this day would come but you always believed in my abilities that I would make it happen. You are my rock and my ALL. I thank God for you!

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"To God be the Glory great things he has done…"

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ABSTRACT

To date, existing literature on psychological theories and the practice of psychology are deeply entrenched in Western experiences. This is so, despite psychology and psychotherapy being implemented in academic institutions and practised by Africans facing challenges that are specific to Africa's existential issues. Psychology and psychotherapy are viewed as irreplaceable and indisputable sciences. This view is inaccurate and does not accommodate the African context.

A pivotal role in the delivery of health care in Africa is the client's culture in the treatment process. 'Cultural competency', a term used in anthropology, defines how medical professionals exercise respect and integrate the clients' cultural beliefs and habits into curative practise, in an attempt to minimise cross-cultural health inequalities and increase general client fulfilment.

The study highlights the importance of cultural competent care within the psychotherapeutic setting. The objective of this study is to understand how Black African psychologists practise culturally competent care. Face-to-face, semi-structured interviews were conducted with nine Black African psychologists to understand how they practise culturally competent care in South African psychological spaces. The data from the interviews was transcribed, coded and thematically analysed according to the objectives of the study.

From this study it was revealed that the willingness to implement culturally competent care enhances trust and confidence in clients. Furthermore, it was indicated - in the study - that knowledge of cultural competence can be acquired through community engagements and consultations with the elderly in the society. While substantial literature exists on the implementation of cultural competency, there has been limited effort in understanding how it must be applied in practise.

The study further highlights the need for extensive training in the practise of cultural competence at the level of first-year Masters psychological studies.

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KEY TERMS AND CONCEPTS

Culture: "A collective pattern of learned beliefs and behaviours that can be shared among groups". (Purnell, 2011, p. 30)

Explanatory models: A source of reference that guides the process of psychotherapy. It facilitates the construction and understanding of mental illness.

Cultural Competent Care: The ability to work effectively across diverse cultures and populations. (Cavillo, Ballantrye, Pacquiao, Purnell, Villaruel, 2009).

Culture Congruent Care: Customised care aimed to fit the patients' own values, beliefs, traditions, practice and lifestyle.

Multiculturalism: A concept that aims to "encourage inclusion and enhances our ability to recognize ourselves in others" (Comas-Díaz, 2011, p. 243).

CHAPTER 1: INTRODUCTION TO THE STUDY

1.1 Introduction

The focus of this research study is to explore how Black African psychologists practise culturally competent care with individuals who hold traditional African beliefs. The interest of the author lies in understanding the perceptions held by the sample group towards clients who use traditional explanatory models of illness. Their experience in working with such clients is useful as it will facilitate an in-depth understanding of how experienced Black psychologists incorporate their clients' explanatory model of illness in the assessment and intervention process. The study is guided by the research question: *How do Black African psychologists practise culturally competent care when dealing with Black African clients who hold traditional explanatory models of illness?*

Smith (2009) states that mental health is a state of well-being which allows one to realise their ability to deal with normal stressors of life, work productively and contribute to their communities. The DSM-IV-TR (2004) considers a mental disorder as "a clinically significant behavioural or a psychological syndrome or pattern that occurs in an individual and that is associated with present distress, disability or significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (p. xxxi). Elaborating on this, the Commonwealth Department of Health and Aged Care (2000, p. 3) states that "mental disorders normally interfere with an individual's cognitive, emotional or social abilities". Furthermore Long & *Zietkiewicz* (2002) asserts that "the constructions of madness set up power relations between individuals that are regarded as 'sane' and those that are labelled as 'insane' and this divide serves to justify the unjust treatment of those individuals identified as insane in their communities and in essence the 'other' is created" (p. 153).

According to Truscott (2010), psychotherapy can be understood as a distinctive craft that requires specialised skills to achieve curative capabilities. Prochask and Norcoss (2002) define 'psychotherapy' as the "learnt and intended application of clinical approaches and

collaborating stances resulting from psychological principles" (p. 17). Its sole purpose is to assist individuals to alter their behaviours, cognitions, emotions, and/or other personal characteristics. Over 40 years of research, involving numerous studies and several clients, delivers reliable sustenance for the conclusion that psychotherapy, in its various distinct forms, is highly effective.

Greenberg and Paivio (1997) wrote that often in psychotherapy, if not all the time, emotions surface and these need to be dealt with. A culture-centred perspective can be beneficial in that it serves as means of ensuring accurate assessment and meaningful understanding of the cultural constructs. It expresses awareness and knowledge of one's culture. According to Pedersen (1999) this can provide the opportunity to strengthen modern theories of psychological intervention through incorporating the client's cultural context into the therapeutic process. Pedersen further highlights the importance of a culture-centred approach in psychotherapy as it can enhance the quality of the therapeutic relationship. He further stresses that the integration involves tasks of differentiating, symbolising, owning and articulating our bodily-felt emotional experience, surrendering and accepting our emotions as indications, and being able to synthesise different emotions in response to the same person or circumstances.

Human beings are inherently social creatures. Often defined through social feedback from interactions with others, the on-going interactions shape the very essence of who we are. One relationship, which is perhaps the most complex and potentially most healing, is that which exists between therapist and client (Clarkson, 2003). Although conceptualised in different ways, the importance of this relationship is a common theme permeating the myriad of therapeutic approaches existing today (Clarkson, 2003; Gelso and Carter, 1994; McWilliams, 2004). Regardless of the therapist's discipline, the goal in all therapeutic encounters is to help, heal and restore. How this is done depends on the therapist and client. Just as both individuals are unique and multifaceted so too is each interaction between them. Guy and Brady (2001) use the metaphor of music to explain this encounter. The authors refer to "the melody played in clinical work, not as a solo or even a duet", but rather as "a rich symphony played by a full-sized orchestra" (p. 993). The client's own life's story, the therapist's past experience, their conscious and unconscious responses to both, as well as the real relationship

which develops are interwoven together to form a relationship of countless exchanges and connections (Brady, 2001).

Empathy is a fundamental element of therapy. It can be understood as one of the core principles of psychotherapy (Gladstein, 1983). Empathy is the glue that facilitates understanding and the prediction of one's behaviour so creating an environment to be one with the client (Baron-Cohen & Wheelwright, 2004, p. 1). Rogers cites his work published in 1957 when giving his initial definition of 'empathy':

> "The state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy and with the emotional components and meaning which pertain thereto as if one were the person, but without ever losing the 'as if' condition. Thus, it means to sense the hurt or pleasure of another as he senses it and to perceive the causes as he perceives them, but without ever losing the recognition that it is as if I were hurt or pleased and so forth. If this 'as if' quality is lost, then the state is one of identification" (1980, p 140).

Rogers had discovered that listening very attentively to the client was a pivotal component in being helpful. However, listening to the client's feelings and reflecting these feelings back to the client proved to be the most efficient approach. The definition of empathy evolved as time went on. Rogers used analogies such as "living in another's life", experiencing it in the most sensitive way, avoiding judging them, sensing the meaning clients often are unable to articulate. The author points out that therapists who are empathic tend to direct the clients' meaning sensitively (Rogers, 1980).

Psychologists as health-care providers, increasingly work with multicultural patients internationally (Birnbaum, 2012). They render psychological services to patients irrespective of race, age, ethnicity or gender. As such they need to be knowledgeable about various cultures. Psychologists who are more informed about cultural dynamics tend to work with great ease and comfort with all patients (Alshehri, 2015). Being informed about various cultural norms creates the opportunity for psychologists to be better suited in approaching

situations relating to culturally diverse patients. Without self-confidence, psychologists may be at a disadvantage in providing adequate health care. Consequently, a culturally self-confident psychologist increases the patient's confidence and belief that they will be offered quality health care. This often results in overcoming any limitations related to racial and ethnic discrepancies (National Research Council, 2004).

Strengthened relations in psychotherapy through cultural competence may result in a better outcome of the psychotherapeutic process, which is centred on communication, rapport, accurate diagnosis and treatment (Hagman, 2006; Renfrew *et al*., 2013). Psychologists need to become informed about the cultural factors that influence patients' ability to perceive life and symptom presentation. Furthermore, the psychotherapist becomes conscious of the cultural impediments that may hinder the treatment process (Birnbaum, 2012).

1.2 Background and context of the study

'Cultural competency' is a term used in anthropology. It defines how a healthcare professional uses the knowledge they have about a client's culture to diagnose and treat illness. Medicine has always been classified as a science as it employs scientific methods in its diagnostic and treatment techniques.

Previously, it was understood that the foundation of medical knowledge was scientific in nature. This meant that patients were treated using empirical methods (Nordqvist, 2012). The general assumption this operated under used the heart as an analogy. All humans have a heart that has the same structure regardless of the human being. The human body's physiological components can be analysed in the same way unless one is suffering from a medical disorder that is interrupting a normal process. The pertinent question to ask is: Are we really the same?

Human beings are a direct outcome of their social and cultural experiences. These experiences often have a direct function in influencing the responsiveness and effectiveness of health-care interventions.

In order to define the concept of 'cultural competency' successfully it is necessary to unpack the meaning of "culture." In this study 'culture' is defined as "the totality of socially transmitted behavioural patterns, values, customs, lifeway's, arts, and all other products of human work and thought characteristics of a population of people that guide their world view and decision making" (Purnell, 2011, p. 30). The ability for medical professionals to exhibit respect and integrate patients' cultural beliefs and practises in the treatment plan, thus eliminating cross-cultural health inequalities to improve overall satisfaction, is known as cultural competency.

Calvillo *et al*. (2009) define 'cultural competency' as the "attitudes, knowledge and skills essential for working with individuals from a diverse population" like South Africa (p. 137). The authors further explain the term as a continuous progression that encompasses accepting and respecting individual differences without exerting one's influence. Ton *et al*. (2005) view cultural competency as a set of "culturally congruent strategies, behaviours, attitudes and policies used in cross-cultural situations" (p 491). It is understood as a process where the clinician constantly attempts to achieve the ability to operate effectively within the client's cultural framework by maintaining an open attitude and using culturally appropriate skills and interventions. Cultural competence is rooted in cultural awareness, cultural knowledge and the use of skills that are central for a culturally competent service (Wilson, 2010).

Cultural competence creates the opportunity to explore the client's beliefs and assumptions, thus allowing the opportunity to negotiate a treatment plan which is stereotype-free (Bhui *et al*, 2008). Being culturally competent as a clinician is important and demands that one understands traditional explanatory models of illness to create the opportunity to observe how culture influences the individual (Calvillo *et al*, 2009). The necessity to expand culturally competent curative practices is expressed by various disciplines. Nonetheless putting this into action is not visible within the medical field (Cavillo et al, 2009).

Conducting research of culturally competent practises in South Africa will benefit in understanding how the concept is implemented in practise, which will be helpful for training programmes that formally instruct health professionals on how to provide culturally competent care in the South African context.

South Africa is commonly referred to as a 'rainbow nation' as it is composed of different ethnic or cultural groups from different socio-economic and political stratums. As such it is essential for health-care services to implement culturally competent practises to deliver effective health care in a proficient way.

In the early years of the 20th century, economic and health policies benefited white people owing to the structure of the apartheid policies (Benator, 2013). However, there has been substantial progress in rectifying practices that only benefited the minority. Although much has been done to ensure that all can access health care, ensuring culturally competent care remains a challenge (Betancourt *et al*., 2002).

1.2 Research problem

As psychological therapies originate from Europe and North America, their application to non-Western populations has been questioned with many approaches being individually orientated. Collectivist cultures are thought to be of less benefit in Western approaches as their ability to attain a psychological sense of well-being is closely related to the community as a whole (Bracken *et al*., 1995). Taking the diversity of the barriers listed above into account, it is therefore imperative that deeper investigation and research be conducted to ensure that clients' cultural patterns, beliefs and values are compatible with the treatment plan (cited in Smith-Rodrigues and Bernal, 2011).

When psychologists devise culturally congruent treatment plans, it is important to understand how clients conceptualise illness using their traditional explanatory models of illness. These models will reveal in-depth information based on the client's experience (Swartz, 1998). This study will assist in gaining an understanding of how Black African psychologists practise culturally competent care when treating Black African clients who hold traditional explanatory models of illness. The amount of research that has been conducted in the discipline of cultural competence and psychology is insufficient. The relevant contribution of cultural competency in psychotherapy in Africa is under-researched. Thus, the researcher has identified the study as beneficial as it will facilitate the identification of the intervention strategies used by Black African psychologists when working with Black African clients.

The intervention strategies identified will help contribute towards increasing our understanding of the provision of culturally competent psychological care within the African context with a view to making recommendations for professional training programmes in the African context. The study will facilitate the identification of the intervention strategies used by Black African psychologists when working with Black African clients.

1.3.1 Aim

To understand how Black African psychologists practise culturally competent care when helping Black African clients who hold traditional explanatory models of illness.

1.3.2 Objectives

(a) To understand the perceptions of culturally competent care held by Black African psychologists.
(b) To understand how Black African psychologists incorporate clients' traditional explanatory models of illness into the therapeutic relationship and intervention process.
(c) To understand the role played by training institutions in enabling Black African psychologists to provide culturally competent care.

1.4 Research questions

1.4.1 Primary research question

How do Black African psychologists practise culturally competent care when helping Black African clients who hold traditional explanatory models of illness?

1.4.2 Secondary research questions

(a) What are the perceptions held by Black African psychologists about culturally competent care?
(b) Do Black African psychologists incorporate clients' traditional explanatory models of illness into the therapeutic relationship and intervention process?
(c) What is the role played by the training of Black African psychologists in facilitating culturally competent care?

1.5 Chapter outline

The chapter and content analysis applicable to this research report are elaborated on below:

Chapter 1: Introduction and general orientation

This serves as the introduction to the research study. The background and context to the study is looked at and the structure of the research is discussed. This section of the proposed study introduces the research topic and gives the background to the study. The largest segment of this chapter consists of the research proposal. It is here that the research problem is explained, key research questions are formulated and key research objectives are stated.

Chapter 2: Literature review

This chapter reviews available literature about challenges affecting health-care professionals in providing cultural competent care. The content of this chapter is sourced from different databases worldwide. It is the intention of the researcher to give preference to most recent literature on the topic. However, any literature relevant to the proposed study will be considered. The perspectives of various researchers on the same topic will also be considered in the discussion. In conclusion, the researcher will state her position clearly regarding the views of other researchers or authors.

Chapter 3: Research design and methodology

This chapter outlines and discusses the study's research design and methodology. The design and methodology chosen for the study is qualified in detail. Topics such as data-collection, data analysis, research sample and population, data validity and reliability, ethical considerations and research constraints including the importance of conducting this study are discussed.

Chapter 4: Analysis and interpretation of results

Data obtained will be analysed by means of thematic analysis.

Chapter 5: Discussions, conclusions and recommendations

In this chapter, interview outcomes are weighed against those of the literature study to determine similarities and differences. Conclusions and recommendations regarding the literature study and interviews conducted will be drawn and made. It is expected that this section of the study will also reveal the shortcomings and strengths of the study with respect to responding to the research questions and achieving the objectives stated at the beginning of the study.

1. 6 Chapter summary

This chapter outlines the dynamics and challenges experienced by psychologists when working with clients who use traditional explanatory models of illness. It gives the reader a better understanding of the study undertaken and a background to the study. Specific attention is given to the problem statement and a summary of the research.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

An analysis of literature on culture and mental health highlights that the delivery of health care, particularly to those who require mental health-care treatment has always presented a challenge, especially in a culturally diverse context like South Africa. To understand the complexity of the country's diverse context completely, it is essential firstly to define what mental health is. Smith (2009) defines 'mental health' as a state of well-being, which allows one to realise their ability to deal with common pressures of life, work efficiently and to add value to their communities. Individuals who suffer from mental illness do not possess the above-mentioned characteristics of a mentally capable individual.

According to Vogel (2009) the accomplishment of a state of psychological and emotional well-being is "challenging and requires psychologists with knowledge and skills in Western counselling practises as well as indigenous African knowledge systems" (p. 176). The DSM-IV-TR (2004) considers a 'mental disorder' as "a clinically significant behavioural or a psychological syndrome or pattern that occurs in an individual and is associated with present distress, disability or significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (p. xxxi). Furthermore Long *et al*. (2002) asserts that "the constructions of madness set up power relations between individuals that are regarded as 'sane' and those that are labeled as 'insane' and this divide serves to justify the unjust treatment of those individuals identified as insane in their communities" and in essence, the 'other' is created (p.153). The need to understand how culture shapes distress and disorders could, in turn, inform culturally appropriate and accepted manifestations of mental illness (Lopez and Guarnaccia, 2000).

The African culture views an individual as belonging to the greater community. This therefore implies that social context is reflected in the individual's behaviour, beliefs and values (Motsi & Masango, 2012). On the other hand, Western philosophy views an individual as body and soul which means that Western philosophy employs an individualistic perspective. Sidima, (cited in Magesa 1997) and Mugambi (1976) share similar traditional African world views as Mbiti (1969) who is a recognised expert in traditional and customary values. Mbiti argues that "I am because we are, and since we are, therefore I am" (Motsi & Masango, 2012). The above argument from various scholars confirms that social contextualisation is an imperative part of the treatment process that psychologists should take cognisance of when working with clients for appropriate and effective treatment. According to Yang & Pearson (2002) the challenge for psychologists is to incorporate cultural competent care to the existing psychotherapeutic principles that guide treatment plans and ensure its effectiveness. It is against this assumption that Motsi & Masango (2012) argue that psychological interventions should be redefined and considered using an African viewpoint.

In the following section, the researcher attempts to explore other literature and arguments by various scholars on the practise of cultural competent care. The researcher probes into the different traditional explanatory models of illness and concludes by investigating the level at which cultural competent care is incorporated in training programmes.

2.2 The concept of culture

Swartz (1998) views culture as "a set of guidelines (both implicit and explicit) which individuals inherit as members of a certain society, which they internalise in relation to others, to supernatural forces or gods, and to the natural environment" (p. 6). The author further highlights that the social environment always changes, therefore social rules change as well. This means that culture cannot be stagnant. Culture is not static but dynamic. Corin (1995) states that culture informs our worldview, the very view with which we engage in assigning meaning to personal and collective experiences. Semaj (1996) further echoes this: "We are products of our culture, but at the same time, have the ability to consciously reconstruct our culture" (p. 198).

We are not simply passive individuals who act with no reaction. Rather, culture engages with us and we engage with it and - in that way - it is reproduced.

A culture-centred perspective can be beneficial in that it serves as a means of ensuring accurate assessment and meaningful understanding of the cultural constructs. It expresses awareness and knowledge of one's culture. It can provide the opportunity to strengthen modern theories of psychological intervention, through incorporating the client's cultural context into the therapeutic process (Pedersen, 1999). Pedersen further highlights the importance of a culture-centred approach in psychotherapy as it can enhance the quality of the therapeutic relationship. A significant factor in dealing with mental health-care is the understanding between health-care providers and their patients. It is therefore imperative to identify and distinguish how health-care providers understand disease and how patients comprehend disease. Pedersen puts emphasis on how healthcare providers look at illness as an abnormality of the body, whereas the patient's understanding is often based on his or her cultural context. According to Tung & Zhizhong (2015) culture often has an influence on how individuals experience pain. Chinese patients, for example, may be reluctant to complain about feeling any pain because in their culture it is considered a weakness to express any form of strong emotion.

Pedersen and Swartz both echo the same sentiments, that any clinical attempts to gain a holistic picture of meaning-making, beliefs and so forth of a community, which disregards the cultural context, runs the risk of subtly maintaining cultural stereotypes (Pedersen, 1999; Swartz, 1998). However, cultural contexts do not constitute a homogeneous people. As a result, not all individuals of a given culture adhere to its practises (Lopez *et al*., 2000; Ida, 2007). For example, some individuals may prefer Western-trained health practitioners over traditional healers or vice versa. Others favour both. At times they may be content with Western explanatory models of illness though they may understand and attribute mental illness to traditional African beliefs (Moloi, 2002; Sandlana and Mtetwa, 2008). Therefore, understanding the cultural dimensions underlying a client's belief system can be useful for a successful therapeutic intervention (Mosotho *et al*., 2008).

Murray *et al*. (2004) view individuals as "embedded in small systems which are nested within larger systems" (p. 328). This community health psychology (CHP) approach attempts to gain a holistic picture of the community and believes in the capabilities of communities which need to be supported for full expression. It is important to note that CHP is aimed at promoting "social justice, empowerment and respect for diversity" (Murray *et al*., 2004, p. 329). In a post-apartheid South Africa, which is rooted in diversity and where the previously disadvantaged have increased contact with mental health facilities, it has turned out to be more necessary to utilise a culture-inclusive approach and practise to mental health.

As stated earlier, it is a misguided practise to attempt an understanding of a community independent of its culture. The idea of mental health is culturally bound (Pedersen, 1999; Swart, 1998; Azibo, 1996). The different cultures that we are born into, and raised within, inform our conceptual understanding of mental illness and affect the type of mental health service we employ (Taylor, Welch, Kim & Sherman, 2007; Long *et al*., 2002). Helman (cited in Campbell-Hall *et al.,* 2010, p. 612) further argues that the individual's explanatory model of his/her experience of mental illness will be informed by cultural conceptualisations of "causation, precipitating events, initial symptoms, expected course of illness as well as treatment".

2.3 Dominant epistemological views and their implication for mental health care

There are several approaches that scholars have often relied on when seeking to explain and understand the nature of mental health issues and illness. Therefore, for the purpose of this study, only three epistemological views will be considered: biomedical, psychological and traditional explanatory models. These provide the scholarly lens and theoretical framework for this study.

2.3.1 Biomedical Model

The biomedical approach, as the name suggests, concentrates on the body, including the brain and its physiology. It understands mental illness without taking environmental factors into account (Petersen & Waddell, 1998). This model perceives mental disorders to be caused by malfunction and abnormalities in the brain, thus resulting in maladaptive behavioural formations in an individual. The model assumes that mental illness or disorders have their own prognosis and respond to pharmacological treatments and cures (Nevid *et al*., 2000). As such, the method employed by the approach in treating mental illness has contributed to a wide array of medicinal developments that have caused a decline in the predominance of severe mental illness symptoms. Notably, such a decline should not be understood as curative but merely a reduction of the severity of symptoms. The approach has also employed brain imaging techniques to understand the nature of brain malfunctioning during mental illness (Nevid *et al*., 2000).

The biological model also argues that mental illness is caused by genetic factors and illnesses like bipolar disorder, schizophrenia, alcoholism, autism, anxiety disorders, among others are mainly genetically induced (Elder *et al*., 2009; Konneker *et al*., 2008; Kronenfeld, 2001). However, despite its influential role in explaining and treating the symptoms of mental disorders, the biomedical approach was criticised on many grounds. It was argued that the model excludes the role of the environment (culture) and psychological influences on the development, prognosis and treatment of mental disorders (Szasz, 1974).

2.3.2 Psychological Model of mental illness

The psychological approach to mental health problems focuses on corrective measures towards maladaptive and irrational patterns of cognitive processes. It incorporates the biological model explanations to mental disorders and puts more emphasis on remedying the thinking and behavioural patterns of people suffering from mental illness or disorders (Nevid *et al*., 2000; Bentall *et al*., 2009). Holmes & Nevid state that mental illness arises from distorted configuration of the self and denial of ideas and emotions.

This then contributes to increased frustrations which are the preliminary cause of abnormal behaviour orientations in individuals.

Two psychological approaches to mental illness that stand out are the psychoanalysis/psychodynamic approach and the behavioural/cognitive behavioural approach. According to Nevid *et al*. (2000) the psychoanalytical perspective considers the intrinsic and unconscious drives and motives that influence human behaviours. It mainly follows the Freudian understanding of human behaviour and personality, thus, interprets mental illness by looking at the conflicts that exist among the id, ego and superego (Nevid *et al*., 2000; Holmes, 2006). The behavioural approach with its empiricist viewpoint rejects psychoanalytical explanations of unconscious behaviour as not observable and measurable. To them, learning plays a major role in explaining both normal and abnormal behaviours. Behaviourists' are of the view that behaviours can be learned through operant conditioning and reinforcement, in the same way our current behaviours can be learned and unlearned (Nevid *et al*., 2000). These psychological approaches focus on corrective measures and fail to incorporate societal or traditional explanatory models of illness.

2.3.3 Traditional African explanatory model of mental illness

Several cultural dynamics have an imperative role in constructing and understanding mental illness (Helman, 1994). According to Edwards (n. d), "animistic theories ascribe the disorder to the behaviour of some personalized supernatural agent such as a spirit or God" (p. 5). For example, when an individual falls ill, one of many explanations given is that of ancestors withdrawing their protection because the individual has wronged the ancestors (Edwards *et al*., 2009; Berg, 2003). In addition to ancestors withdrawing their protection, which often results in the absence of health and well-being, illness is often seen as a result of witchcraft or sorcery owing to interpersonal conflicts or supernatural forces (Helman, 1994). Edwards (n.d) refers to this understanding as a magical theory. He also maintains that these theories can be used as the source of "understanding traditional African cosmological, religious, social and moral world view" of the individual (p. 6). Sodi (2009) suggests that an understanding of these traditional African explanatory models as elements of psychology would be helpful in incorporating and creating more appropriate psychotherapeutic approaches.

The field of psychology is moving towards understanding illness in a more culture sensitive way. It seeks to integrate more of how the client understands their own illness. This is supported by the growing trend in research aimed at exploring individual's interpretation of illness. This includes studies by Sorsdahl *et al*. (2010), Lynch and Medin (2010) & Buus *et al*. (2012). Explanatory models fall into two categories: those that ascribe illness to physical causes and those that ascribe it to psycho-social issues. The classification of explanatory models (physical/psycho-social) is based on the works of Murdock (1980) and Evans-Princhard (1937). These two researchers performed an ethnographic study that includes 139 countries which were non-industrial. The findings of that study were related to psycho-social factors. Similar studies conducted in Central Africa and America yielded comparable results. The main outstanding themes were related to common traditional explanatory causes of illness.

Kleinman (1991) defines 'explanatory models' as a source of reference that guides the process of psychotherapy. These explanatory models are used to acquire in-depth understanding of how illness manifests, how it is understood and how treatment is carried out. Explanatory models allow for holistic understanding in the clinical setting. The models enable the process of uncovering the causes of illness all the way to devising an effective treatment plan for appropriate practice. "Meaning" attributed to particular illnesses is at the centre of this model. How one experiences their illness and gives meaning to it purely defines what this model is about (Buss *et al*., 2012). Kleinman *et al*. (1978) emphasise the significance of using the distinction between "disease and illness". "Disease in the Western medical paradigm is a malfunctioning or maladaption of the biological and psychophysiological process in the individual, whereas illness represents personal, interpersonal and cultural reactions to diseases or discomfort" (p. 252). The authors further state that illness in its entirety is moulded by culture, how people talk about their illness to others, the way in which they converse, how their symptoms present, how they seek help and treatment adherence are all deeply influenced by culture. The study undertaken is compatible with the perspective of the traditional explanatory model as it seeks to explore how Black African psychologists incorporate the concept of cultural competence into psychotherapy. Kleinman (1980) further explains that all engaged in the psychotherapeutic process hold their own explanatory models to understanding the meaning of illness.

As such, clients' explanatory models are often overlooked to accommodate the biomedical model. This poses a risk as it excludes the clients' belief systems.

Kleinman identified that "universalist psychiatry" imposed Western models on non-Western cultures. He further discovered that the models discarded one's experience of illness and highlighted the importance of these experiences as they were fully-laced with imperative and beneficial information that would inform the treatment plan (Swartz, 1998). Explanatory models are deeply rooted in culture and are thus a cultural construct. One's social positions and systems of meaning are influenced by their ability to comprehend experience and manage illness. In addition, culture not only influences clients but also practitioners' ability to understand symptom presentation, treatment plans and the suitability of the designed treatment plan. Cultural rules guide how individuals behave when ill. This highlights the disparities in defining disorders and how individuals manage these (Kleinman *et al*., 1978).

The way in which clients explain the process of psychotherapy and understand their treatment plan differs from the understanding of the practitioner. Research shows that clients are most content when psychologists try to use their explanatory model to understand their illness. This creates an opportunity to share information thus moving away from the model where practitioner knows best (Bhui & Bhugra, 2002). According to Kleinman (1991), an explanatory model of illness should be centred around answering certain concerns, such as: "Why me? Why now? What is wrong? How long will it last? How serious is it? Who can intervene or treat the condition?" (Bhui & Bhugra, 2002, p.6).
Based on the latter, Kleinman developed a set of questions to guide the thorough evaluation of one's explanatory model of illness (Hark & DeLisser, 2011, p. 217):

- "What do you think has caused your problem?"
- "Why do you think it started when it did?"
- "What do you think your sickness does to you? How does it work?"
- "How severe is your sickness? Will it have a short or long course?"
- "What kind of treatment do you think you should receive?"
- "What are the most important results you hope to receive from this treatment?"
- "What are the chief problems your sickness has caused for you?"
- "What do you fear most about your sickness?"

The most imperative bases of an explanatory model are to understand one's personal experiences of emotional distress, thereby putting that understanding into effective psychotherapeutic practice (Bhui & Bhugra, 2004). According to Swartz (1998) clinicians have the responsibility of going even further into understanding explanatory models, by negotiating existing explanatory models between the clinician and client. This will assist in devising a treatment plan that will be suitable to all engaged in the process of psychotherapy.

In 2006, Bhui *et al* conducted a study that investigated "common mental disorders", mainly mood or anxiety disorders (p. 967). The study established that the participants ascribed spiritual and or physical causes of their emotional distresses to traditional explanatory models, thus preferring an intervention that was spiritual and medical in nature. In indigenous practices, individuals often use animistic theories to explain illness. Specific rituals are then performed to appease the ancestors. In their belief, this assists in overcoming whatever spiritual imbalances that exist and ensures protection from any harm (Eagle, 2004).

2.4 Cultural competence

A large part of one's identity is shaped by culture and the ability to communicate one's opinions is also prompted by cultural principles (Morris, 2014). As a result, when individuals from different cultural backgrounds engage with one another, "cultural codes" are used. These codes regulate what one believes is "right or wrong, good or bad, sacred or profane, important or unimportant" (Uhlmann *et al*., 2011). The interaction between the two may be understood differently, which may result in unsuccessful interaction. To mitigate these communication obstacles, cultural competence must be acquired (Morris, 2014). Cultural competence can be described as "the ability to successfully work across diverse cultures, not restricted to age, race, class, gender, or sexual orientation… an evolving process in which an organization incorporates practices, policies, and training opportunities into the daily life of the organization" **(**NSGC Membership Committee, 2013**).** The purpose of cultural competency in counselling is to create the opportunity for healthcare professionals and clients to discuss health concerns without cultural differences hindering the conversation (Warren & Wilson, 2013, p. 6). Commonly, cultural competence encompasses improving three fundamental elements: "knowledge, skills and attitudes" (Morris, 2014, p. 18). An

additional element to consider is desire. Psychologists need to sincerely desire to acquire information regarding diversity thus ensuring growth within the therapeutic setting (GCCCT).

According to the author (Morris, 2014), cultural competency is "an essential skill for healthcare providers in all divisions of patient care, ranging from psychiatrists and psychologists, to nurses and social workers" (p. 15). Effective cultural competency in counselling compels a psychologist to utilise a set of "skills and attitudes" (Morris, 2014, p. 16). A thorough discussion of one of the skills took place in the paragraphs above. This skill speaks to the therapists ability to find out as much as possible about the client's "values and perceptions, particularly illness, emotion, and family relationships" (Morris, 2014, p. 16). Secondly, a culturally competent counsellor must at all times be humble and appreciate diverse cultures. Counsellors need to be cognisant that no 'right' or 'wrong' culture exists and should at all times appreciate the opportunity to acquire new knowledge from individuals who are from diverse cultures. Thirdly, it is necessary for the counsellor to possess the ability to employ the client's "cultural codes" to ensure a more operative counselling setting (p. 16). The client's values and beliefs should at all times be considered as imperative resources, instead of being regarded as counselling challenges (Uhlmann *et al*., 2011). The last skill articulates the counsellors "awareness about their own cultural values and their impact on how one reasons, acts, communicates and perceives reality, including biases" (Morris, 2014, p. 16).

A culture-centred perspective can be beneficial in that it serves as a means of ensuring accurate assessment and meaningful understanding of the cultural constructs. It expresses awareness and knowledge of one's culture. It can provide the opportunity to strengthen modern theories of psychological intervention through interpreting the client's cultural context (Pedersen, 1999). Pedersen further highlights the importance of a culture-centred approach in psychotherapy as it can enhance the quality of the therapeutic relationship.

2.5 Conceptual framework

In 1998, a model of health care was developed for the first time to facilitate the practise of cultural competence. The model regarded cultural competence as a range of essential strategies that contributed towards a successful intervention in the therapeutic process. These strategies ensure that suitable treatment plans meet the needs of the clients which are devised and efficiently used within a client's cultural context (Campinha-Bacote, 2002). The model was based on the following:

"Cultural competence is a process, and consists of given constructs (awareness, knowledge, skills, encounters, and desire). It is an essential component in rendering effective and culturally responsive services to culturally and ethnically diverse patients." (p. 181)

Below are the five notions the model is based on (Campinha-Bacote, 2002):

(1) "Awareness is understood as the self-examination and in-depth exploration of one's own cultural and professional background" (p. 182). The ability for health-care providers to recognise their stereotypical views may benefit the therapeutic process.

(2) "Knowledge is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups" (p. 182). Points of focus during intervention include: "health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy" (p. 182). Health-care providers are continuously encouraged to be mindful of the uniqueness of each client's life story and experiences.

(3) "Skills refer to the ability to collect relevant cultural data regarding the patient's presenting problem and accurately perform a culturally based assessment" (p. 182).

(4) "Encounters refer to the process that encourages the healthcare provider to directly engage in cross-cultural interactions with clients from culturally diverse backgrounds" (p. 182).

(5) "Desire is the motivational construct that is the process of healthcare providers becoming culturally aware, culturally knowledgeable, culturally skilful, and have experience with cultural encounters, not because they have to, rather, because they are willing to improve"

(p. 182). For effective practise of cultural competence health-care providers need to remember that the above mentioned constructs are co-dependent. “Cultural encounters” were identified in a revised model by Campinha-Bacote (2002) to be a distinctive feature of cultural competence. “Cultural encounters” are at the core of practising cultural competence as they authenticate, enhance subsequently altering “existing values, beliefs and practices about a particular cultural group” (p. 183). The desire to acquire more knowledge about different cultures is a direct result of cultural encounters and the willingness to learn. Allowing oneself to be open and emotionally available creates the opportunity for more learning, thus resulting in a successful therapeutic engagement. (Campinha-Bacote, 2011).

The Culturally Congruence Care Model was developed by Schim et al. (2007). This model is centred on enhancing the perception and experience of the client in therapy. The most essential objective in culturally congruent care is ensuring successful and efficient engagements takes place in the therapeutic process. The model is based on numerous notions and ideologies; for example: (1) “the desired outcome of culturally congruent care must be evaluated from the perspective of the recipients and the providers of care” (p. 108), (2) “specific competencies (cognitive, affective, and psychomotor behaviours) can be defined, learned, and identified in practise” (p. 108), (3) “the scope of competence is related to the number and variety of diverse groups and people encountered in community, social, and/or service contexts” (p. 108), and lastly (4), “the depth of competence is related to the amount of exposure and type of interaction with which particular groups and people encountered in community, social, and/or service contexts” (p. 108).

The model also has these additional propositions:

(1) “culturally congruent care, with diverse people and groups representing a community of service at a given place and time, is necessary for health service quality” (p. 108),

(2) “culturally competent behaviours on the part of providers are necessary but not sufficient to produce culturally congruent care” (p. 108).

As documented in writings, it is acknowledged that cultural competence within the health-care environment is represented by various aspects that make it whole. Psychoanalysis for instance remains a progressively developing field. It would be beneficial to evaluate the suitability of psychoanalysis in settings where cultural competence is a dominant feature. This would serve as a fundamental advantage to the field of psychology as more knowledge could be acquired, thus assisting clients in the long run (Campinha-Bacote, 2011). Adjustments could further be developed in line with the principles of psychology to ensure that there is a fit between psychoanalysis and the diverse population of South Africa.

A "fourth force" identified in psychology is *Multiculturalism* (Pedersen, 1991). *Multiculturalism* seeks to "encourage inclusion and enhance our ability to recognize ourselves in others" (Comas-Díaz, 2011, p. 276). In 1950-1960 a Civil rights movement developed a mental health movement in the United States; at the core was multiculturalism (Arredondo & Perez, 2003; Hurley & Gerstein, 2013). The movement which was driven by psychologists challenged the universal relevance of psychotherapeutic approaches that used "Euro American cultural values and norms" as a benchmark (p. 284). Various multicultural movements in the field of psychology have questioned traditional approaches. These movements assert that psychotherapy hardly addresses issues related to power, privilege and social context in its entirety.

In 1994 the American Psychiatric Association issued a cultural formulation, which could account for culture-bound syndromes. This was a direct outcome of recognising culture and the part it plays when one is being diagnosed. It further established procedures aimed at health-care workers who interact with individuals who come from culturally diverse populations. However, this was only approved in 2003 (American Psychiatric Association, 2003). The guiding principles set allowed for "Multicultural Education, Training, Research, Practice and Organisational Change" (American Psychological Association, 2003, p. 382). These principles of practise attribute great importance by contextualising the individual's life and facilitate culturally competent practise. It ensures that health-care providers use culturally suitable evaluation measures and psychological assessments, encompasses a comprehensive variety of "psychological interventions and includes the use of various culture-specific healing interventions" (Comas-Díaz, 2011, p. 398).

Cultural competence was established around the period of 1970s to the 80s, it was to be utilised as a structure in mental health. It was to assist therapists to include the sociocultural context of a "client's life" and the influence it has on the practise of psychotherapy (Kirmayer, 2012, p. 154). *Cultural competence* is a form of practise or positioning that is not related to a specific psychotherapeutic modality however, it is associated with "a way of construing the therapeutic encounter" (Sue, 2003, p. 968). As stated by Sue in 1998, cultural competence ought to incorporate "scientific" learning, this will inspire health-care providers to avoid making impulsive assumptions about clients who come from different sociocultural backgrounds. The therapeutic encounter will also motivate the therapist to be mindful of their own cultural experiences and cultural background. Furthermore, Sue (2001) describes the importance of recognising how individuals identify themselves in relation to the world, to their culture, and how they identify themselves independently. Health-care providers often disregard the direct link individuals have with "groups", the connexion is often related to their mental well-being. This then suggests that cultural competence is directly connected to social integrity, providing contact to suitable psychological services (Sue, 2001).

Culturally competent psychologists aspire to utilise numerous practises: "(a) improve therapist's self-awareness, (b) develop overall awareness about multicultural concerns and the influence of belonging in a cultural group on clients, (c) acquire a sense of multicultural self-efficacy or the therapist's sense of confidence in providing culturally competent care, (d) understand distinctive cultural factors, (e) develop an effective counselling working coalition in which empathy and collaboration are emphasised and (f) develop intervention skills in working with culturally diverse clients" (Constantine & Ladany, 2001, p. 486; Sue, 2001, p. 806).

Numerous challenges in providing cultural competent care have been identified by various sources. To name a few: the struggle in attending to one's own biases; the preference to elude issues that cause discomfort, for instance racial discrimination; homophobia and emotions associated with it and the difficulty of accepting responsibility for behaviours that have direct or indirect influence on social injustice (Sue, 2001).

As argued by Sorsdahl *et al* (2010) there is a need to promote the incorporation of cultural beliefs systems within the South African health-care system. This is largely driven by understanding that the successful provision of mental health care to clients requires the involvement of both service users and providers. In this way, engaging both the clients and health practitioners will reveal the different values and cultural beliefs that shape the prognosis and treatment of mental illnesses. Such discussions will thus foster the selection of the most appropriate treatment plan that is aligned to "values and beliefs" of the patient.

Sorsdahl *et al*. (2010) noted that in South Africa most scholarly work has concentrated on public perceptions of the causes of mental disorders or strange illnesses with few focusing on general perceptions of common mental disorders (CMD) like depression.
A study conducted in Mpumalanga on traditional healers' explanatory models revealed that CMDs, like depression, were perceived to be the result of stress and that such would not need to be treated by medical practitioners. Disorders such as schizophrenia were associated with witchcraft or ancestral calling, which led to them being perceived as curable through the help of traditional healers (Sorsdahl *et al*, 2010). In this way, the findings do augment the necessity to collaborate mental health care with Western and traditional systems so that the shared knowledge can be utilised to the betterment of mental patients.

2.6 Conclusion

The current discussion has elaborated on the need for cultural competence to promote more responsive as well as effective mental health-care. In this chapter, the discussion has concisely shown the need for cultural competence in mental health-care. It has also highlighted that the treatment of mental health-care users has been largely dominated by varying interpretations and epistemological viewpoints. Importantly, the chapter has indicated the various factors that characterise the construction as well as the understanding of mental illness by focusing on the explanatory models for mental illnesses. It has also been argued in this chapter that there is a need to ensure the integration of both traditional healing systems' and the Western approaches to health-care in order to enhance cultural competence in the treatment of mental illnesses.

CHAPTER 3: RESEARCH METHOD AND DESIGN

3.1 Introduction

The primary objective of this study is to determine what factors influence culturally competent health-care practise among Black African psychologists dealing with Black African clients who hold traditional explanatory models of illness in South Africa. The following chapter defines the methodology applied in this research; it further examines how the research objectives are met and identifies suitable responses to the research questions. An overall account of the methodology used in this research study will be discussed in the sections that follow. This chapter clarifies the research design and provides an in depth account of the data-collection, analysis and the interpretation methods utilised. The reliability and validity methods which are at the core for any research are reflected on (De Vos, Strydom, Fouche & Delport, 2005).

3.2 Research methodology

3.2.1 Qualitative approach

In qualitative research, the researcher hopes to explore and describe the importance of traditional explanatory models of illness in therapy. De Vos *et al* reports that a qualitative research approach is the appropriate paradigm to use when wanting to explain phenomena related to life's experiences and the meaning given to these experiences. This qualitative research approach is said to be "systematic and interactive" (p. 124). It is further reported that the significance of qualitative research is to be able to comprehend a specific social situation and the interaction that takes place within that environment (De Vos *et al*., 2005). The aim of choosing a methodology should also be guided by the attempt to answer the research question (Greener, 2008).

Qualitative methods enable the researcher to receive relevant information as open-ended questions are used to guide the process of research (Saunders *et al*. 2011). The researcher utilised semi-structured interview questions to acquire better knowledge into the participant's experiences in relation to providing counselling to African clients who hold traditional explanatory models of illness.

3.2.2 The interpretive research paradigm

The researcher felt that an interpretive research paradigm is the most appropriate because it would create an opportunity for the subjective meaning of the participants to be better understood. The term 'Verstehen' is given great emphasis in literature as it refers to "empathetic reliving" where importance is ascribed to understanding text within a context (Blanche *et al*., 2006, p.275). To comprehend how participants conceptualize meaning, the researcher is required to have knowledge of how the participants' values, judgments and beliefs inform their meaning (Johnson, 1998). The researcher is then viewed as a tool that gathers and examines information systematically (Blanche *et al*., 2006).

3.2.3 Research location

In an attempt to meet one of the various research aims, it is imperative for the researcher to justify why a particular location was selected and further have clear reasons as to why it is the most suitable (Berg, 2007). The preferred location of choice is Durban, a coastal city in eastern South Africa's KwaZulu-Natal province, which is known for its African, Indian and colonial influences (Google, nd). This decision was highly influenced by the inadequate availability of research on understanding how Black African psychologists in South Africa treat Black African clients who have traditional explanatory models of illness. The researcher was a trainee psychologist at the University of KwaZulu-Natal and a member of the psychology clinic when data-collection took place in 2011. This made it easier for her to get access to relevant material related to the subject under investigation.

3.2.4 Participants

The participants are nine Black African psychologists practising in and around the KwaZulu-Natal area. Blanche *et al* (2006) conclude that the population selected for the research should be those to whom the research question applies. For the current study, the inclusion criteria was that the participants must be Black African psychologists as they were likely in a better position to comprehend explanatory models of illness held by individuals with a similar cultural background. In addition, participants had to have had experience working with indigenous African clients who hold traditional explanatory models of illness. Finally, participants had to have had three or more years' experience as the assumption is that they would have had sufficient exposure to employing cultural competent care.

3.2.5 Recruitment

Since the researcher had identified a specific group of individuals, the sample was drawn through non-probability purposeful snowball sampling. "Purposive sampling is a form of non-probability sampling". It represents an intentional practise of choosing individuals that may indicate specific features the researcher hopes to explore, which in this case refers to Black psychologists in the Durban area in South Africa (Babbie, 2005, p. 86). Snowballing basically refers to a research method used by the researcher to find relevant participants. One or more participants are selected, those individuals then direct the researcher towards relevant participants who will meet the criteria of the study (Bryman, 20008). In total, nine psychologists with over three years of experience in health-care practise were approached by the researcher using the snowballing method (Bryman & Bell, 2003).

3.2.6 Data collection

The researcher devised a semi-structured interview schedule where questions were based on predetermined notions including cultural background and socialisation of the participants (see Appendix 2). The assumption was that they (psychologists) would have some sort of exposure to cultural dynamics owing to the nature of their cultural predisposition. The work experience of the participants would also facilitate the researcher attaining valuable

information. Themes such as the participants views towards traditional explanatory models of illness, the experience they had in working with clients who use these models and how they would intervene during therapy were the driving notions in creating an interview schedule (see Appendix 2).

According to Fisher *et al*. (2007) in semi-structured interviews, researchers are guided by a set of questions that are devised in line with the themes the researcher hopes to explore. The research participants are at liberty to respond to the questions to the best of their ability, with no limitations. Furthermore, the researcher probes to acquire additional significant answers thus determining concealed topics. In this research, the questions attempted to explore features that motivate or impede the practice of culturally competent health-care. The respondents were requested and subsequently agreed to respond in English though Xhosa and Zulu was used in some instances.

3.2.7 Conducting the interviews

Face-to-face interviews were conducted using an interview guide to establish factors influencing the practise of culturally competent care amongst the selected practitioners. The researcher's tone of voice attempted to be unbiased and interviewees were urged to respond as openly as they felt comfortable to. Open-ended questions proved to be an effective tool as it encouraged more dialogue. Eliminating total bias is impractical however the researcher attempted to be neutral and open minded during the data collection phase. (Strauss & Corbin, 1994; Miles & Huberman, 1994).

3.2.8 Data analysis

Using an interpretive paradigm as a basis, the researcher conducted a basic thematic analysis (Rubin and Rubin 1995, cited in Ward, 2008). Thematic data analysis was further deemed suitable because it is quick and easy to use for novice researchers (Yildiran & Holt, 2014).

The following thematic analysis steps were followed:

1. Familiarisation and immersion:
Obtaining a basic understanding of the meaning of the data is at the core of the first phase of analysis (Blanche *et al*., 2006). Transcripts were read several times and notes were taken to familiarise the researcher with the data. It took the researcher several days to familiarise herself with the transcripts in preparation for deducing themes as the data analysis process unfolded.

2. Deducing themes:
This stage is about "deducing themes" from the data. Themes often recurring are "meanings, activities and feelings" (Aronson, 1994, p1). The researcher identified themes that frequently appeared from the transcriptions.

3. Coding:
At this stage, certain areas of the data are highlighted as being significant to recurring themes. It was at this stage that the researcher became aware of predominant themes and sub-themes and coded the data into the themes identified in the previous stage (Blanche *et al*., 2006).

4. Elaboration:

This stage is concerned with "exploring themes more closely" (Blanche *et al*., 2006, p.324). At this stage, the researcher examined the themes to decipher meanings and align these to the study objectives.

5. Interpretation and checking:

The researcher at this stage reflected on "themes and sub-themes in relation to" literature on cultural competent care (Blanche *et al*., 2006, p.324).

3.3 Reliability and Validity

Social research utilises two constructs to eliminate bias, these are "reliability and validity". There is limited work that shows the use of these two constructs in qualitative research (Cresswell, 2007). One author Stenbacka (2001) insists that the use of these two constructs is irrelevant to qualitative research. It is clear from the above statement that there are opposing

opinions associated to the relevance of reliability and validity in qualitative research. Despite these contrasting views, reliability and validity continue to be significant instruments of assessing in qualitative or quantitative research, as they continue to examine matters related to truth. In practise, reliability may be achieved easily however validity is more challenging to accomplish. The two concepts (reliability & validity) work hand in hand but at times they may contrast (Neuman, 2011).

Maxwell (2008) established a way validity could be achieved. This author believes that at various phases qualitative research may possibly be authenticated by means of "descriptive validity, interpretive validity, theoretical validity, generalisability and evaluative validity" (p. 908). Interpretive validity was used to guarantee that the outcomes of the research were valid. During this stage the researcher ensures that the interviewees experience is reported meticulously, so that the interviewees' perspective is understood (Maxwell, 1992). The researcher attempted to use the participants' words through a process of paraphrasing. This ensured that the viewpoints, thoughts and intentions of the participants were clearly understood. It is essentially making an inference from what was said by the participants. This enables better understanding of the factors that have a direct impact on the practise of culturally competent health-care among Black African psychologists dealing with Black African clients who hold traditional explanatory models of illness (Maxwell, 2014).

To ensure reliability, the researcher documented the procedures undertaken to ensure that the study can be replicated in future (Yin, 2003).

3.4 Ethical considerations

Ethical concerns or dynamics are significant in research studies; they can be defined as virtuous etiquettes and values that govern the behaviour of an individual within a profession. From a study perspective, ethical factors are the integral relationships a researcher has with his/ her research subjects. The most important aspect to take into account when conducting a research study is ensuring that the interviewees are guaranteed confidentiality and safety.

Moreover, possible ethical discord may emerge while the researcher attempts to identify a sample relevant to the study.

The most important concern is how the researcher analyses material and the ability to protect the interviewees during the course of research. Therefore it is imperative that the researcher finds stability between preserving confidentiality and processing relevant data for the research. Researchers must at all times be cognizant of the negative outcome that would arise from poorly safe keeping the information gathered and the confidentiality component of data collected. In an attempt to address concerns related to ethical practise, the researcher employed the institutions ethics procedures. A consent form detailing the aims of the study and how privacy of data would be ensured was given to the research participants. Participants were assured of confidentiality and anonymity by guaranteeing each participant that their names would be concealed in the reporting and the write up of this study (Fisher et al, 2007) (see Appendix 1).

To ensure that this research omitted critical ethical concerns, the researcher made sure that:

(a) Participants took part in the interviews on a voluntary bases;

(b) All audio recordings were allocated a letter of the alphabet to guarantee anonymity.

(c) Due security measures were taken in order to protect the researcher's computer.

3.5 Chapter summary

This section dealt with the methodology used in this research study. It broadly described how the study was conducted using the interpretivist paradigm, which offered a better way of understanding and expressing the interpretations and understandings of the research data. The chapter also indicates the measures that the researcher had to utilise in order to effectively guarantee validity, reliability and ethical justifications of the study.

CHAPTER 4: RESULTS AND INTERPRETATION

4.1 Introduction

The study seeks to understand how black African psychologists practice culturally competent care with their clients who embrace traditional African beliefs. Thus, the researcher interviewed nine psychologists who had engaged with Black African clients who embraced traditionalism and indigenous explanatory discourses of mental health illnesses. The following chapter is to report on the research outcomes using reflective accounts of the participants.

4.2 Black psychologists' perspectives on traditional explanatory models of illness and care

As indicated earlier, the objective of this research study is to obtain thorough insight of how Black psychologists practise culturally competent care when working with clients with mental health challenges. In this respect, the researcher first had to ask interviewees what their perceptions are regarding the usage of explanatory models of mental illness and care in the provision of counselling. Some interviewees stated;

"…based on my experience, it's more of a spiritual nature…" (Interviewee S, 2011)

"My view on traditional explanatory models of illness is that it is part and parcel of our society. It exists - it's there and clients present with it. It is therefore important that when we assist these individuals that present with these conditions that first and foremost whether we have the insight into it or not but we allow ourselves to first understand rather than to just push it away as if it doesn't exist…" (Interviewee SS, 2011).

"Obviously as a black person, most of these things I know, growing up but I didn't practise them personally…I grew to understanding that there is more to just saying I am depressed… I have grown to understand that the people who believe in it actually basically don't see any other view of reasoning as to why they are having those problems" (Interviewee N, 2011).

"I understand it in terms of what people believe in and things that they present with, so it is not things that you have in books or literature. It is people's perspective of what their problems are or their experiences of illness…" (Interviewee NN, 2011).

It was noted that the interviewees believed that culture contributes to one's meaning and understanding of illness. This was affirmed by one psychologist, who suggestively indicated that:

"*The patient's point of view in terms of what is causing the illness…in some cases they present the very same symptoms but their own understanding of the illness is much more based on their cultural beliefs…"* (Interviewee M, 2011).

According to one participant (Interviewee B, 2011) it is important to comprehend clients' understanding of their symptoms before seeking to assist a client, for cultural illnesses have varying meanings. For instance one may say '*kuvel'umkhuhlane*' which may be interpreted as signifying death in the family. Furthermore, a relevant theme that emerged was the importance of understanding the meaning attached to illness and disease fully. This was affirmed by some interviewees who said, *"I try my best to understand the person meaning making system based on their world view"* (Interviewee B, 2011) and *"I think it's important basically that we understand…"* (Interviewee, SS, 2011).

4.3 Experiences and attitudes towards patients who utilise explanatory models

Regardless of the general understanding of explanatory models, one of the psychologists interviewed in this study revealed negativity towards culturally ingrained interpretations of health. This is noted in the following response:

"*…I would hear of some people say that they go there (traditional healers) first and spend a lot of time and a lot of money there and then eventually they come to the Western world where the symptoms are addressed biologically… I can never ever advise my client to go and see a sangoma to treat depression or psychosis because I don't have any experience that would show that it works - you know, that they will eventually be healed. To the contrary, I refer to psychiatrists all the time …"* (Interviewee S, 2011).

The majority of the sample embraces traditional models in therapeutic interventions. This is exemplified by the next quote:

"*Well, I will engage the person in terms of why would they think that it is muthi that the boyfriend has left them. Is it something that they are used to in terms of explaining the causes of whatever illnesses that they might have…I do believe in them and I do encourage them as well…"* (Interviewee T, 2011).

"I am black and I understand so they feel more comfortable and start explaining whatever that they need to. I am mentioning this because there is a lot of that where these problems with culture are intertwined with challenges of people being conformed or changed…" (Interviewee SS, 2011).

Some respondents (n=2) went to the extent of expressing a willingness to learn from clients who embrace traditional explanatory perspectives (Interviewee N, 2011) as they felt that it would promoted freedom of expression, which made them feel more empowered (Interviewee B, 2011), as indicated in the following quotations:

"…*I have learned from them and I find out from them what they want to do about it…"*(Interviewee N, 2011)

"…*I am comfortable with it because I have to go with the persons' understanding… My view is based on the person's history; based on the persons world view; based on the person's background and how this person defines and solves problems culturally…"* (Interview B, 2011).

The interviewees expressed a willingness to engage clients on their beliefs and views of illness. This is also noted in the following response:

"..,*I would engage them because look, I am Zulu so I know that there is cultural beliefs, traditional beliefs so I do engage such people…"* (Interviewee SS, 2011). *"… Each person when they come in I would like to hear what they say… and I have learned from them…"* (Interviewee N, 2011).

It was also noted from the respondents that being culturally sensitive instils a sense of confidence in the clients enabling clients to feel at ease and willing to engage in therapy as captured in the following quotes:

"…*You find that with that belief they tend to feel better so I am open to it…"* (Interviewee B, 2011)

"…*I understand so they feel more comfortable and start explaining whatever that they need to…"* (Interviewee, SS, 2011).

Being open, non-judgemental (Interviewee M, 2011) and empathic towards clients' understandings of their illness was also thought to help not only promote collaborative care but also the empowerment of clients. One respondent commented this to say:

"…*I began to want to understand instead of assuming that I understand that there is no place for this in psychology and all of that…"* (Interviewee SS, 2011)

Another had this to say:

"…*You can add on the belief that she has power; you can add a value, empower them and give the sense that "I can do things*" (Interviewee M, 2011)

Being supportive of clients' wishes to also use services using traditional explanatory methods was identified as being an essential part in engaging in the treatment process. This was further articulated in the response as follows:

"… If that person wishes to go to a traditional healer… my duty is to empower them as long that is going to benefit them and is in line with their belief system…you have to clarify and help the person see that this issue that they are presenting with needs Western doctors or a traditional healer….you have to empower them because she/he will not go to where you are sending them…" (Interviewee B, 2011).

"…*My view is that I think there needs to be a collaboration between these two models, such that it is shared. There is a shared view so that the Western model can … learn something from the traditional model and traditional model can learn something from the Western model…"* (Interviewee S, 2011).

4.4 Cultural competence in the therapeutic relationship and intervention process

All respondents indicated having experience with clients who embrace cultural explanations to illness (Interviewees S, SS, N, T, M, P, NN, B & G, 2011). As indicated earlier, eight of the nine psychologists interviewed indicated their willingness to listen to the client's understanding of their illness and managed to be empathetic and immerse themselves in the different cultures of their clients. This is shown when they responded the following when asked how they make these clients feel at ease when they divulge their issues: *"…I do believe in them and I do encourage them as well…;…you actually get their level…show that you are interested"* (Interviewees T & N, 2011).

One interviewee reported the need to contextualise Western models so that these align with the varying complexities that clients who embrace traditional explanatory models are faced with. This is noted by one of the respondents:

"…The treatment plan is quite interesting in that we were taught that there is C-B-T, there is psychodynamic therapy, there is this and that. Even though you don't throw them away but it is very important to know that you are with this patient, you are here for them and you are applying this to the current situation in which they are finding distress. You would still use them, but make them relevant to this person…." (Interviewee T, 2011).

4.5 Cultural competence training

The following study revealed that most interviewees had previous training on cultural competence though it may have not prepared fully prepared them for the therapeutic process (Interviewees N, S, SS, P, NN, T, B & G, 2011). A further advantage identified was that the interviewees had all acquired their qualifications in the KwaZulu-Natal area. They believed that this worked to their advantage as opposed to those who had been at university in other provinces because clients in this particular province are more open to embracing and practising their traditional and cultural ways. Others indicated that they had acquired such knowledge during their graduate studies:

"…As I have just mentioned that the advantage is that I am from the University of Zululand and there is an extensive emphasis on culture from the professors themselves so I started there…" (Interviewee G, 2011)

This was also highlighted by another respondent who said:

"…To add to that, maybe I was really lucky to be in Natal. You know, Natal, when I got there, one of the things that attracted me to apply to Natal University was this thing of holistic. That's what attracted me to Natal. I was happy when I got in for our first-year case study where we worked as a team - community project…" (Interviewee P, 2011).

It was also noted that much of the knowledge on cultural competence implementation has been gained through the respondents' interactions with different clients who held traditional explanatory models. (Interviews S,N,M, N,SS, NN, P & G, 2011). Others indicated that they acquired such knowledge as a result reading different scholarly writings and through consulting or visiting the elderly in the community. The cultural experts in the community acted as educational support in times where they lacked adequate information regarding a particular phenomenon. About this, one participant said:

"…I can still go home or to my community if I am stuck with something and talk to people that are in the know; like the elderly and see if there is actually something like that but also still consult literature like the DSM and books on culture and mental health…" (Interviewee N, 2011).

4.6 Conclusion

It has been established from this chapter that most psychologists interviewed practise cultural competent care when dealing with different clients who hold traditional explanatory models of illness. It has been indicated that this is because of training and exposure or experience that most of them had with clients. It has been noted from the study that cultural awareness or sensitivity is important as it increases trust and confidence between the health-care provider and client. Most notably, it has been established that for cultural competence to be successful there is a need for a collaborative approach in the client-therapist interaction that is promoted by conducive contexts in which there is willingness to listen and empathise with the meanings or perceptions of clients. The following chapter will give a summary of the research study and focus on recommendations for future studies.

CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1. Introduction

As mentioned previously this study seeks to investigate how Black African psychologists work with clients that hold traditional explanatory models of illness. This was largely driven by the need to encourage cultural competence in health-care practices since various scholars have contended that a patient's choice of treatment is largely influenced by their culture (National Research Council, 2004; Hagman, 2006; Renfrew *et al*., 2013; Morris, 2008; Birnbaum, 2012; Cooper *et al*., 2014; Alshehri, 2015).

A sample of nine psychologists was purposively selected for participation in the study. The study utilises qualitative interviews which probe in an attempt to acquire a comprehensive understanding of the psychologists' perspectives and experience of working with clients who embrace traditional explanatory models of illnesses.

The research study analysed the data using thematic analysis. The results are discussed and compared to some of the literature on culturally competent care. The next section gives a summary of the main outcomes of the study.

5.2 Discussion

5.2.1 Perspectives on traditional explanatory models

According to Kleinman (1980) traditional explanatory models are employed when a person seeks to understand their illness in relation to the causes, symptoms, course and treatment of the problem. The interviewees in the study show a general comprehensive awareness of traditional explanatory models of mental illness.

From statements discussed in chapter 4.2 of this study, it can be deduced that most of the respondents had an understanding that traditional explanatory models of mental illnesses and disorders are rooted in cultural beliefs.

In this, Corin (1995) and Semaj (1996) argue that much of our construction of the social world and daily life challenges are largely a by-product of culture. Semaj (1996, p. 198) comments: "We are products of our culture…". Most of the interviewees thus indicated that culture largely contributes to clients or patients' construction of meanings of illness whether mental or general. In this way, an individual's perception of mental illnesses largely hinges on his or her cultural beliefs. Different cultural experiences and orientations that individuals are socialised into form significant conceptual and cognitive mappings that clients often relate to when explaining - or seeking solutions to - mental illnesses they encounter (Helman, 1994; Sherman, 2007; Long *et al*., 2002; Campbell-Hall *et al*., 2010; Jacob, 2010).

Thus, there is a need to ensure that a psychologist can grasp the differential meanings and explanations attached to illnesses and diseases by clients. Hence, medical practitioners need to understand the cultural dimensions underlying patients' or clients' belief systems as this will help in the choice and method of therapeutic intervention to be employed (Mosotho *et al*., 2008; Sodi, 2009).

5.2.2 Experiences and attitudes

One psychologist portrayed a negative attitude towards traditional healing practises, which he perceived to be non-effective. However, the same respondent indicated that he had grown up in a family where his grandmother was a sangoma and from this experience these traditional approaches to healing were not always successful in addressing symptoms of mental illness. He further points out that though he had little faith in traditional healing practises, he does explore traditional explanations to mental illness when presented by clients during the therapeutic process. The respondent goes on to say that he understands that his responsibility is to move with the client towards healing (Interviewee S, 2011).

The other eight respondents have no reservations towards clients who utilise traditional healing practises. Their responses indicate that they have a positive attitude towards clients who embrace traditional explanations of mental illness. Not only did the respondents accept and welcome clients who have indigenous views of mental illness, they also sought to gain knowledge and appreciation of the clients understanding of the illnesses to get to the root of the problem. This approach supports the cultural competence model of Campinha-Bacote (2002) which argues that "therapists need to have a comprehensive awareness of an individual's cultural background and be more open and engaging of clients' beliefs and views" (p. 182).

Such willingness and openness ensures that patients feel at ease to work with the psychologists. From this we note that most of the psychologists interviewed showed positive attitudes and a readiness to work with clients who hold traditional explanatory models of illness. This could have been because the sample only consisted of black African psychologists. However, as highlighted by the literature on cultural competence, culture consciousness in medical care is not only limited to a certain ethnic group, but should be practised by all practitioners, irrespective of demographical or biographical characteristics (Schim *et al*. 2007, p. 108). Cultural congruence demands a reciprocal interaction "between the health-care providers and the clients" as competencies are deemed to be shared and learned (Schim *et al*. 2007, p. 108).

Along with this positive attitude was a willingness to engage in a collaborative approach to treatment where there was cooperation between the Western and traditional explanatory methods. Shared knowledge between the two approaches can help address most of the challenges that clients face and contribute largely to the skills and expertise of therapists. This resonates with arguments by Constantine and Ladany (2001), Sue (2001) and Sorsdahl *et al*. (2010) that culturally competent therapists should cultivate a successful sharing relationship where empathy and collaborative mental health care - between the two intervention models - is emphasised for the betterment of the clients.

5.2.3 Cultural competence in therapeutic practise

The results of the research study suggest the benefits of cultural competence in therapeutic relationships and the intervention process. As indicated by the findings, most of the psychologists interviewed were culturally sensitive and incorporated traditional explanatory models into their "therapeutic process".

From the results of the research study it was noted that all the respondents have had experience with clients who embrace cultural explanations of illness. They related different experiences and encounters of dealing with patients who use traditional explanatory models. For example, one of them related the experience he had with an old lady who started drinking when she became a *sangoma* and came for therapy as her body was swelling. After narrating her experience the psychologist had to consider different viewpoints from a cultural perspective. The psychologist reports that his client had said that she was bound to drink since the spirit in her had instructed her to do so. However, the biological effect was that the alcohol was causing the swelling. The psychologist could not merely highlight that the swelling was because of alcohol abuse and recommended rehabilitation and in the process of doing so he had to engage all the factors contributing to the presenting problem (Interviewee N, 2011).

Faced with such a dilemma, the psychologist suggested that in therapy, one needs to be open-minded and consider all factors when dealing with clients who embrace traditional explanatory models. In this sense, in being culturally competent there is a need for verstehen and empathy towards clients. This is in harmony with the idea espoused by Morris (2014) that an effective culturally competent therapist or psychologist needs to have both the "knowledge and awareness of cultural values and perceptions" of the client, with regard to illness, as well as be humble and willing to see things through the lens of the client.

It was also established in the study that when implementing culturally competent care one needs to be able to utilise psychological interventions flexibly in different clinical contexts. The respondents highlighted that as psychologists, there is a need to ensure that the Western

models that are adopted are contextualised so that they are suitable for clients who embrace traditional explanations. In addition, the psychologists revealed that one needs to know what motivates clients and thus be able to utilise skills that will enhance comprehensive connection with clients. Calvillo *et al* (2009) echoes the above statement and expands on the notion that this will only be possible through deliberations that are built on mutual respect, acceptance and trust.

5.2.4 Cultural competency training

Cultural competence is rooted in cultural awareness, knowledge and skills which are central for culturally competent service (Wilson, 2010). The interviewees noted that their former institutions of higher learning played a major role in equipping them with some knowledge on how to engage clients who embraced traditional explanatory models of illness. It is also imperative to mention that the sample group consists of graduates from University of Zululand and the University of KwaZulu-Natal (UKZN). The interviewees believed that their clients awarded them the opportunity to learn more about their worldview and how they experience it.

Though majority of the intervention process was learned in practice, the institutions did play a role in knowing the basics of therapeutic intervention. Furthermore one interviewee found the ability to consult cultural experts in the community helped her understand better what clients were faced with. This reverberates with the argument made by Sue (2001) that therapists need to know how to deliver suitable mental health-care services to different groups of clients. The need for training is also highlighted by Lo & Fung (2003) who suggest that psychologists need to be trained before engaging with clients so that they acquire the right skills and aptitudes that are essential for psychotherapeutic purposes.

However, evidence from the current study suggests that irrespective of being exposed to the provision of culturally competent care during training, much of the knowledge and understanding of practising culturally competent care practices results from exposure to, and experience with dealing with clients who hold traditional explanations to illness.

5.3 Summary of Findings

This chapter discusses at length findings from the research study. It was determined that culturally competent care is an integral part of the therapeutic process when dealing with clients who hold traditional explanatory models. Exposure to cultural competent care was reported to be helpful during theoretical and practical training by the respondents. Yet it was also indicated knowledge of cultural competence does not only emanate from training and education, but exposure to clients holding traditional African beliefs helped to hone their skills in how to both accommodate these beliefs and contextualise the implementation of Western therapeutic practices.

The respondents also indicated that since they are African, they were well-acquainted with the need for the search for African causal explanations as many Black African clients use traditional explanatory models in explaining and understanding illnesses. In this way, the study established that psychologists may need to have dialogues and community engagements to be aware of the meanings and interpretations that people attach to mental illnesses.

The findings also indicate that promoting empathy, cultural sensitivity and openness enhances trust and confidence among the clients and therapists. It has been noted that this trust and confidence is centred on cultural identity as clients were reported to feel comfortable talking about their traditional explanatory models of illness to therapists with similar cultural backgrounds. Being ‘African’ or of an African ethnicity was associated with cultural sensitivity as clients perceived that if the psychologist is Black or is of their ethnic group, he or she can understand their illness and the traditional causal forces behind it.

The findings of this study also indicate that most Black African psychologists interviewed implemented cultural competent care. In other words, they were open to clients’ traditional beliefs as well as not obstructing clients to consult their traditional healers while continuing therapy. This has been evident in that respondents indicated that clients could identify and connect with them based on a general perception that since they were Africans they could explain and understand ‘isintu’ cultural/indigenous issues. This openness to traditional beliefs and willingness to engage with them is exemplified by one of the psychologists interviewed

indicating that he had consulted the elderly in his community to have a better understanding of how certain illnesses were understood within the community. This assisted him to better understand the traditional spiritual understanding of mental illness.

The study also highlights that when it comes to dealing with clients who embrace traditional explanatory models of illness; psychologists need to be flexible in their intervention and treatment options. It was also highlighted in the findings that not only was it important to listen, but also to immerse oneself as a therapist in the cultures of the clients so as to be able to comprehend the meaning attached to illness by clients. In this way, the general perception amongst the respondents is that tolerance is not enough. Acceptance of multiculturalism and explanations of causality of mental illness will foster a conducive environment where clients will have the freedom to express their understanding without fear of being judged or reprimanded by therapists.

5.4 Recommendations

This current section offers recommendations and suggestions emanating from the findings. The recommendations are aimed at addressing the challenges or obstacles that therapists are faced with when dealing with clients who embrace African traditional explanations of illnesses. In promoting culturally competent care, psychologists can employ many mechanisms to ensure positive outcomes.

From the study the following were suggested as methods that could be employed to promote cultural competence when dealing with clients who embrace traditional explanatory models of illnesses. These recommendations may be helpful in promoting culturally sensitive care:

- There is a need to ensure that training includes instilling students with the values of culturally competent care. Such training could be enhanced by bringing together trainee psychology students with traditional healers to enhance knowledge-sharing which will be beneficial to psychology students as they will gain a better understanding of traditional cultural perspectives of illnesses which they could then draw on when dealing with patients who hold traditional explanatory models.

- Psychology training institutions should make it mandatory for students to undergo, or engage in, some formal community engagement process which exposes them to communities where traditional explanatory models of illness are still common. This must happen prior to their formal appointment as psychologists. This practical training will ensure that the students grasp the nature of traditional cultural beliefs.
- The psychology curriculum offered should maintain a balance between Western and African models of psychology. The reason why traditional explanatory models have had a lesser effect on therapeutic interventions and treatment is because Western schools of thoughts have dominated the discourses of psychology. Hence, the need to include African explanatory models in the curriculum for both undergraduate and postgraduate studies.
- There should be more formal training in which both the traditional healers and psychology students participate in shared or collaborative learning as this will promote knowledge transfer between the two actors, which will benefit psychology students as they will now be able to comprehend the nature of cultural perspectives towards illnesses, which they can be able to refer to and integrate when dealing with patients who use traditional explanatory models.
- Re-curriculation to ensure a balance between Western and African psychology. This will address the bias towards teaching Western thought, which becomes daunting to apply when it comes to the South African context.

5.5. Limitations of the study

The research study only focuses on Black African service providers and would have been strengthened if the views of service providers from other race groups were considered. The views of clients were also not considered. The views of both clients and health-care providers could have helped in ensuring that the results of the study were not only informed by the opinions of service providers. The small sample drawn solely from KwaZulu-Natal and the qualitative nature of the study is also a key limitation as the study cannot be generalised or applied to other contexts.

5.6. Conclusion

Culturally competent care is important to the modern health-care system as there are always instances in which both the African and Western understanding of mental illness coincide. It is important that psychologists share world views of illness in their therapeutic interventions and treatments with clients who hold African indigenous explanations of illnesses. It has been argued that openness to traditional explanatory models of illness promotes a willingness and confidence on the part of the clients to share their beliefs and perceptions of illness with therapists. This, as indicated in the study, promotes cultural competent care as psychologists can be able to decipher and give proper therapeutic interventions to clients who present with symptoms of mental illness. As such, the study indicates the need for empathetic willingness to listen as well as objectivity and non-judgemental behaviour from the psychologists if they are to practise cultural competence.

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Appendix 1: Informed Consent Form

Dear Participant

I am a Master's student in Clinical Psychology at the University of Kwa-Zulu Natal, Howard College in Durban. As part of my master's degree I am required to conduct a study of any kind therefore I am conducting a study on: "The intervention strategies employed by Black African psychologists when helping Black African clients who adhere to traditional African belief systems to explain their psychological distress". I request that you please allow me to interview you for approximately an hour, using an audio-recorder.

All of the information shared in the interview will be kept confidential and your identity will be anonymous. You are not requested to write your name on any of the documents nor will your name be associated with you in anyway. The research data will be kept for a period of five years in a secure and safe environment as coordinated with my supervisor, after the five years have lapsed the transcripts, process notes or any written notes which might have been used will be shredded and audio-tapes will be destroyed.

The researcher would appreciate your participation in the above-mentioned study, participation in this study is voluntary and you may choose to discontinue from the research at any time; however it is advised that you please notify the researcher at least two weeks (14 working days) in advance. If you would like to take part in this study please return the informed consent form back to the researcher within a week (7 working days); the researcher will then make contact to establish when you will be available to participate in the interview.

To take part in this study you must be: a registered Clinical or counselling psychologist who has been in practice for a period of three years or more; a Black African psychologist who has consulted with clients who adhere to traditional African belief systems to explain their psychological distress.

If you require to be notified of the outcome of the study please let the researcher know. For more information feel free to contact the researcher and the supervisor at the address provided below.

Thank you for taking time out to participate in the study.

Yours faithfully

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If you wish to obtain information on your rights as a participant, please contact Ms Phumelele Ximba, Research Office, UKZN, on 031 360 3587.

EXAMPLE OF DECLARATION

I…… (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT DATE

…….. ……

Appendix 2: Interview Guide

Semi-structured interview questions

1. What are your views of traditional explanatory models of illness?
    a. **Probe for knowledge and attitudes as well as attitudes towards clients who hold traditional explanatory models of illness**
2. What experience do you have in working with Black African clients who explain their psychological distress using traditional African belief systems?
3. How do you work with these clients?
    a. Probe for how they would make a client feel at ease to divulge their explanatory model of illness
    b. **Probe for how the participant incorporates the clients traditional explanatory models into the assessment of the presenting problem**
    c. **Probe for how he/she incorporates traditional explanatory models into the treatment plan**
4. How different is the psychotherapeutic relationship compared to when working with client's who do not use explanatory models of illness?
    a. Probe for whether it is harder/easier and why
5. What training did you receive that equipped you to work effectively with clients holding traditional explanatory models of illness?
6. How can training programmes be improved to equip future psychologists to provide culturally competent care?