LANGUAGE AND THE ROLE OF INTERPRETING IN SOUTH AFRICAN PSYCHIATRY: A STUDY OF INSTITUTIONAL PRACTICE IN THE WESTERN CAPE

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ABSTRACT

This dissertation describes three studies aimed at documenting the impact of language diversity on psychiatric service provision in institutional settings in the Western Cape province of South Africa. Speakers of indigenous languages other than Afrikaans invariably require the assistance of an interpreter to access services as there are very few mental health professionals (excluding psychiatric nurses) who speak a black African language. However, there are no official interpreters in state services and so *ad hoc* solutions are employed. The full extent of the need for interpreting services and the volume of use of inappropriate people to interpret in a particular health sector had never been empirically investigated. Questionnaires were therefore used to document clinical interviews that required the assistance of an interpreter at two local psychiatric institutions (Valkenberg Hospital in 1993 and Lentegeur Hospital in 1994). The analysis of these data show the impact of inadequate language resources on service provision to be profound. Semi-structured interviews were conducted with questionnaire respondents at Lentegeur Hospital to assist in the interpretation of the questionnaire data. The analysis of the interview data addresses the inter-penetration of societal discourses and discourses of public psychiatry around race, identity, alienation and community. A third study, conducted at Valkenberg Hospital in 1997, employed rapid assessment techniques and focused ethnographic methods to evaluate the effectiveness of interpreters provided to the hospital by a non-governmental organisation. Questionnaire data replicated the earlier quantitative studies, but archival data, semi-structured interviews with hospital staff and interpreters, and observation were used to explore in more detail the impact of language diversity in particular clinical settings. The effectiveness of the designated interpreters was limited by the extent of the need for interpreting and the absence of change in the overall approach to patients requiring interpreting. Multiple implicit and explicit roles for interpreters are identified and shown to express unrealistic expectations on the part of hospital staff regarding the capacity of interpreters to solve a thicket of problems that constellate around language issues. Obstacles to communication were found to be paradoxically visible and invisible in clinical work, being determined in large measure by the circumstances of institutional practice. Complex negotiations of identity in South African institutional settings are illuminated through an examination of the position of the African nurse as a culture broker. The theme of identity is explored further through the consideration of the socio-political dimensions of being 'known' in institutional contexts for black patients. Socio-political factors in the transformation of institutional identity in a post-apartheid health care environment were illuminated through a consideration of the role of language and this is also explored. Recommendations are made regarding the role of language in the development of culturally competent mental health care.

SUMMARY

This dissertation describes three studies aimed at documenting the impact of language diversity on psychiatric service provision in institutional settings. Speakers of indigenous languages other than Afrikaans invariably require the assistance of an interpreter to access psychiatric services as there are very few mental health professionals (excluding psychiatric nurses) who speak a black African language. However, there are no official interpreters in state services and so *ad hoc* solutions are employed. The full extent of the need for interpreting services and the volume of use of inappropriate people to interpret in a particular health sector had never been empirically investigated.

The first study described here adopted a questionnaire methodology to document clinical interviews that required the assistance of an interpreter at Valkenberg Hospital, a Western Cape psychiatric hospital, in 1993. Between 25% and 30% of patients admitted during the period of the study required interpreting. A significant proportion of the interviews conducted with the assistance of an interpreter made use of cleaners, family members and other inappropriate people. The vast majority of instances of interpreting took place in psychiatric assessment interviews, suggesting that speakers of black African languages had diminished access to other types of psychiatric and psychological interventions. The informal arrangement s regarding the placement of Xhosa-speaking staff (the predominant black African language spoken in the area) in the wards that required interpreting appeared to mirror the social structure of the institution. The needs of the clinicians regarding interpreting received priority in access to the few resources available, while the needs of black women were given the least priority.

A second study employed the same questionnaire methodology at Lentegeur Hospital, another Western Cape psychiatric hospital, in 1994. This study made use of an additional questionnaire in order to assist the nursing staff to document the need for interpreting. The data from the questionnaires suggested that the need for interpreting was enormous, but did not provide sufficient detail. A number of semi-structured interviews were conducted to assist in the interpretation of the questionnaire data. This combination of data showed the impact of inadequate language resources on service provision to be profound. The historical context of the

hospital influenced the number of Xhosa-speaking nursing staff available to assist with interpreting, but also the situation of Xhosa-speaking patients within the services offered. The analysis of the data draws attention to the inter-penetration of societal discourses and discourses of public psychiatry around race, identity, alienation and community within the context of mental health service provision. The hospital employed an interpreter during the last part of the questionnaire study period. However, there were preliminary indications that institutional routines to manage patients in particular ways were not substantially modified by the presence of a single interpreter.

A third study, conducted at Valkenberg Hospital in 1997, employed rapid assessment techniques and focussed ethnographic methods to evaluate the effectiveness of interpreters placed at the hospital by a non-governmental organisation. Questionnaire data replicated the earlier quantitative studies but archival data, semi-structured interviews with hospital staff and interpreters, and observation were used to explore in more detail the impact of language diversity in particular clinical settings. The effectiveness of the designated interpreters was limited by the extent of the need for interpreting and the absence of change in the overall approach to patients who required interpreting. I identify multiple implicit and explicit expectations of interpreters and show how these express unrealistic expectations on the part of hospital staff regarding the capacity of interpreters to solve a thicket of problems that constellate around language issues. I describe these in terms of four roles that interpreters are expected to fulfil: the interpreter as a 'language specialist' and 'the new member of the multi-disciplinary team'; the interpreter as 'culture specialist'; the interpreter as 'patient advocate'; and the interpreter as 'institutional therapist'.

The question of the extent to which language issues impact upon clinical work was found to be paradoxically visible and invisible. For a range of reasons, a 'language gap' between clinician and patient can be rendered irrelevant in terms of the routine production of psychiatric texts in which 'symptoms' are described and 'cases' are constructed. This results in speakers of black African languages being constructed in particular terms and aspects of patient narratives being silenced or obscured. In contrast to the way in which the role of interpreting is obscured in some hospital settings, it is highlighted in forensic settings where a different set of institutional

imperatives operate. Here the extent of the dependency of the clinician on the interpreter is more clear and this foregrounds some of the inappropriateness of the use of interpreters. Through this analysis the status of 'the patient who requires interpreting' emerges as an institutional construct, being determined in large measure by the routines of institutional practice. Thus, the requirements of the institution that the patient move through the process of a hospital admission, and the different requirements of each stage of this process, inform the decision as to whether interpreting is necessary. Furthermore, the differing requirements of the members of multi-disciplinary teams renders the status of 'the patient who requires interpreting' as variable and contested. A thread that runs through the consideration of the role of language and interpreting in contexts described above is that of the place of discourses of surveillance and control in colonial psychiatry. I consider this in relation to the negotiation of identity in institutional settings.

An examination of the position of the African nurse as culture broker opens up the question of being 'known' for black patients in institutional contexts. I explore social and political dimensions to being 'known' in their historical context. Following from this, I consider aspects of the process of the research. Through asking questions about language in institutional contexts and then interpreting what emerged in relation to issues of race and racism, socio-political factors in the transformation of institutional identity in a post-apartheid health care environment were foregrounded. Various factors that militate against on-going transformation were exposed, in particular the obstacles to overcoming silence and self-censorship.

Finally, I consider recommendations for including the role of language and interpreting in the development of culturally competent mental health care. A number of strategies to address language issues in institutional mental care are suggested, both in terms of national initiatives and in terms of what individual institutions may do to more fully recognize the language needs of service users. The role of non-governmental organisations and the imperative for service providers to learn to speak indigenous languages are also discussed.

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CONTENTS

PART III: LANGUAGE AND IDENTITY

PART IV: CONCLUSIONS AND RECOMMENDATIONS

List of Tables

List of Figures

PART I

INTRODUCTION

Chapter 1

LANGUAGE AND SOUTH AFRICAN MENTAL HEALTH CARE IN INSTITUTIONS

When I first began research into interpreting in psychiatric settings I was told the 'worst case' story that had become folklore in a South African department of psychiatry. This was a story of a Xhosa-speaking woman who presented at a psychiatric emergency service with a friend accompanying her. The woman was apparently psychotic but somehow there was a mix up and the psychiatric registrar on duty admitted her friend to the ward and the prospective patient was sent home. The misunderstanding was discovered the following morning when Xhosa-speaking nurses came on duty. The story is often told with a wry smile and is met with an amused head-shaking at how comically inappropriate psychiatric services can be in the absence of interpreters. It was only years later that I was told by someone, who had worked in the ward at the time, that the woman who was accidentally sent home was never seen again by her family.[1]

This anecdote encapsulates much of what this study seeks to address. The absence of a common language amongst the majority of doctors and patients is so much a part of the everyday experience of health care provision in South Africa as to make it almost invisible. Part of this invisibility is the way in which the struggle to speak with patients through interpreters or in broken English or Afrikaans has become a routine complication of clinical work in local psychiatric settings. It is also in the nature of institutions generally and clinical work in particular to generate routine solutions to such problems (Fisher & Todd, 1983; Herzfeld, 1992; West, 1984). Thus, the so-called 'language gap' and routinised strategies to work around it, become institutionalised, even ritualised, aspects of the everyday practice of health care (Swartz, 1991b). Occasionally, a particular 'case' will resist this process of being

[1] This story is typical of the sorts of morality tales found in medical settings and referred to as an "atrocity story" (Dingwall, 1977 in Atkinson, 1992, p. 463).

made routine and will present any number of assessment or management problems. Such exceptions, precisely by virtue of their exceptional status, remain at the margins of clinical practice. The prominence of these 'problem cases' deepens the opacity of the majority of instances that appear to present no difficulties at all. Part of the object of this thesis is to problematise the routine bureaucratisation of the management of linguistic diversity in mental health service delivery. In doing so, I will attempt to show that it is not merely the exceptions that give cause for concern about local institutional practices. The institutional products of everyday practice are themselves worthy of close and critical examination.

THE CURRENT LANGUAGE DISPENSATION

South Africa's linguistic diversity is attested to by the recent adoption of 11 official languages, and some would argue that even this is a simplification of a far more diverse picture (Makoni, 1998). The nine provinces into which the country is divided are free to specify official languages for their regions[2]. While English and Afrikaans[3] are official languages in all nine provinces, only about 32% of black South Africans speak English and 29% speak Afrikaans. A mere 9% of South Africans speak English as a home language (Schuring, 1993)[4]. In contrast to this, very few health or mental health professionals outside the ranks of nursing speak indigenous languages. The overwhelming majority are English and Afrikaans-speakers. South African hospitals differ in terms of the unwritten conventions of how the inevitable work of interpreting in this context will be accomplished. Most seem to rely upon the haphazard availability of anyone who speaks even a smattering of the patient's language (Crawford, 1995; Drennan, 1996a; Ngqakayi, 1994; Swartz, 1992a). While *ad hoc* interpreting, in the sense in which it is used by Roberts (1997), is the norm, this glib assertion can belie a considerable degree of informal organisation in particular settings (Crawford, 1994). In whatever form, however, interpreting has always been a fundamental aspect of mental health services for black patients (Campbell, 1961). However, because of being unrecognised, it has at best been left to nurses to fulfil this role, at worst to fellow patients. Even in areas where there are few whites at all and the patients are almost exclusively black,

[2] See Appendix 1 for a tabulation of the official languages in the nine provinces.
[3] Afrikaans evolved from the Dutch language brought to the Cape during each period when it was a Dutch colony. Afrikaans is distinct from Dutch and is now considered an African language, rather than a European one. Thus, when speaking of African languages here it is necessary to add the qualifier 'black' to distinguish them from Afrikaans. This term will be used interchangeably with 'indigenous languages', again, to be distinguished from Afrikaans.
[4] See Appendix 2 for a tabulation of the language demographics of the country.

the black nursing staff view interpreting as an incidental, although daily aspect of their work (Buthelezi, 1992; de Villiers, 1993).

The abolition of apartheid legislation and the establishment of a new Bill of Rights with a new Constitution presents a unique opportunity for health services in South Africa. There is the necessity now of examining what it means to provide services for all of South Africa's people, and to recognise that this entails addressing issues of linguistic and cultural diversity. The new Constitution of the country assists in this regard by having adopted 11 official languages and specified that each citizen has the right to communicate with the state in any of these languages[5]. The Western Cape has added Xhosa[6] to the previous English and Afrikaans official languages. Guidelines as to how this change in the official languages and the constitutional rights of citizens should be upheld are emerging slowly (Language Plan Task Group (LANGTAG), 1996). However, budgetary constraints and the slow process of capacity-building hamper change in the way in which citizens interact with government organisations. Evaluations of change in mental health services since the demise of apartheid have not examined the role of language in service delivery (Ensink & Robertson, in press; Freeman, Lee & Vivian, 1994), and the LANGTAG Final Report (1996) makes a passing but concerned reference to the issue of language in health care generally. The latter report calls for assessments or audits of the existing language dispensation, in terms of needs and the available resources, in order to assist with language planning. Such studies would need to be an integral part of any attempt to radically transform health care institutions following the fairly recent racial integration of health services.

A LANGUAGE PLANNING PERSPECTIVE

Language planning invariably involves a process of moving from recognising a need for a language planning intervention to evaluating the intervention. Rubin & Jernudd (1971) have identified the following five steps in the process: situation analysis; planning; implementation; feedback; and evaluation. The first, situation analysis, mainly corresponds to information gathering on the needs of respective target groups, an assessment of the

[5] See Appendix 3 for language-related aspects of the Constitution.

[6] Xhosa is spoken by the majority of black people in the region. Xhosa is in the Nguni group of languages, and is thus cognate with Zulu. The constitution of the country refers to "isiXhosa". However, current convention amongst linguists is to refer to the African languages in English without the prefixes used in the African languages (Gowlett, personal communication) and this is what I will conform to here.

sociolinguistic environment, and a description of the relevant language demographics (Smit, 1997). This project began with an attempt to gather just such information and was therefore initially focused on describing the situation of particular psychiatric institutions in relation to language diversity. However, the question of the needs of a target group soon presented itself as problematic, for the simple reason that service users and service providers both make use of language resources, but in different ways. In institutional settings the service providers typically exercise greater power to shape language services and in so doing the needs of the service providers are prioritised. This required the need for language services to be contextualised within the parameters of the clinical work, informed as it is by a whole range of medical, psychiatric, institutional and social factors.

Thus, one way of adopting a language planning perspective on interpreting in South African psychiatry, would involve an uncritical acceptance of the industry of mental health care. This approach would have clinicians do what they usually do, only more efficiently. A more cynical view is that this makes the machinery of psychiatry, often seen as a form of social control, more efficient (Waitzkin, 1989; Zola, 1981). However, in the context of South Africa's history of racial segregation and discrimination, it is all the more urgent that an examination of institutional psychiatric practices should also address the ways in which racist social discourses may be reproduced through institutional structures (Foster & S. Swartz, 1997)[7]. This alternative approach would use the opportunity of evaluating language practices to examine the way in which this throws up issues to do with race, ethnicity and the marginalisation of less powerful members of our society. From this critical point of view, there could be an interrogation of the way in which language services in mental health care, or the lack thereof, contribute towards the racialisation of disadvantage in access to health services that is obscured by the removal of overt segregation. Heugh (1995) employs the term "linguicism" to describe the systematic disadvantage of this form of racism. She quotes Skutnabb-Kangas (1988) to define linguicism as:

> *"...ideologies and structures which are used to legitimate, effectuate and reproduce an unequal division of power and resources between groups which are defined on the basis of language (on the basis of their mother tongue)"* (p. 333).

[7] As I refer frequently to the work of Leslie Swartz, I will use 'Swartz' to refer to his publications, and I will refer to Sally Swartz's publications as 'S. Swartz'.

Thus, the task of assessing institutional strategies to deal with linguistic diversity may present an opportunity to critically examine the "infra-policies" (Butchart, Hamber, Terre Blanche & Seedat, 1997) that arise in South African psychiatry, by virtue of its position in a post-apartheid society. Such a critique may contribute towards the development of psychiatric services more appropriate to a new South Africa.

RESEARCH, PERSONAL AND POLITICAL

I came to work in a hospital setting immediately following the completion of my training as a clinical psychologist. Part of this qualification involved producing a thesis and mine was a meta-analysis of translation theory and how this was being employed by South African researchers for the translation of psychological and psychiatric research instruments (Drennan, 1992). Thus, my entry into clinical work in the context of an acute admission ward for psychotic women came hot on the heels of my being very aware of the complexity of translation and interpreting in mental health work. As I do not speak Xhosa, like the vast majority of psychologists in South Africa, I had to make use of interpreting for work with Xhosa-speaking patients. I was dismayed to find that my opportunity to explore the complexities of interpreting in a clinical setting often involved using a domestic worker or a hurried nurse as an interpreter. However, when I was thinking about researching interpreting in clinical settings, I was struck by the gap between an 'ideal' clinical interview and the institutional reality. Ten-minute interviews for the sole purpose of deciding whether or not a mildly psychotic patient should go home or not, did not appear to lend themselves to long and detailed explorations of illness phenomenology and their relation to biomedical discourse. As a result, my academic interest in using triadic interactions to examine how the discourse of the life-world and the discourse of medicine (Mishler, 1984) speak to and around each other, in the context of mediation by an interpreter, was modified. I began to view these biomedical discourses as aspects of interviews that are bound up with both institutional and socio-political discourses. The correspondence between the interview as an abstract ideal and the exigencies of everyday reality appeared to diminish, and the need for a relevant and contextually based critique became more cogent. However, a sharp awareness of the institutional limitations of clinical work carries with it the possibility of being too bound by these 'realities'. MacCormack (1994) draws on Bourdieu and Passeron's use of the term "misrecognition" to describe the institutional limiting of perspective:

> *"...the process by which people cease to see a knowledge system and the power relationships it engenders as socially constructed, relative and perhaps*

> *coercive. Rather, they misrecognise it as natural, legitimate and in the best interest of all"* (p. 1232).

Swartz (1993), in a South African context, has commented on the difficulty of criticism for clinicians working in institutions, where pragmatism and various forms of formal and informal censorship may result in the avoidance of thorny socio-political issues. I will return to this issue in more detail below.

My position as a member of the institution whose practices were under research cut two ways in another respect. On the one hand it granted me access to institutional spaces and collaborative relationships that would otherwise have been very difficult to access routinely. However, I did not grasp the full implications of what it would mean to study a question that is so closely linked to the issue of race in a South African psychiatric institution, whilst being a member of that institution. The personal hazards of these political implications also shifted as the project was over-taken by history. Since 1992, the apartheid system has been finally dismantled; a new African National Congress-led (ANC) government has been democratically elected; Xhosa, along with other African languages, has been declared an official language; and finally, a new Constitution has been brought into being. From a socio-political point of view, the project has spanned a period of momentous change at many levels of society but it has also provided a window on the uneven change at institutional levels and some of the reasons for this. What this study will show is that any attempt to study language services in institutional contexts throws up issues around identity, ethnicity and transformation. Interpreters and their work constitute a particular nexus for all these factors and the cross-currents they generate illuminate the complexity of attempts to provide equitable health care in a society until recently divided along racial lines.

A NOTE ABOUT TERMINOLOGY: THE REIFICATION OF INTERPRETING

It is common to find the terms 'translation' and 'interpretation' used interchangeably in everyday discourse. I use translation as a general term referring to the transfer of thoughts and ideas in oral or written form from one language to another. Interpretation is seen as one form of translation, but refers particularly to situations of oral communication (Brislin, 1976). This definition describes interpreting as subsumed within translation, but of course translation requires the making of interpretations as to the meaning of any given text. In this sense interpretation is the generic activity and translation is the rendering of an interpretation into written form. Interpreting is thus the verbal rendering of such an interpretation of the

meaning of an utterance. Swartz (1991b) has drawn attention to other aspects of the polysemy of interpretation in psychiatric settings. While interpretation may refer to the facilitation of communication between two parties who do not share a common language, interpretation is also used to refer to a number of levels of the professional knowledge of mental health workers. Interpretation may refer to the psychiatric interpretation of behaviour or the psychoanalytic interpretation of motives or emotions. The extent to which these latter dimensions to linguistic interpretation impact upon the role of the interpreter in a psychiatric setting will be taken up later.

The term interpreter is used in two ways here. The generic use of the term refers to anyone who attempts to render the meaning of an utterance in one language into another language. The occupational use of the term refers to someone employed for the specific purpose of interpreting. This latter use has only recently come into being in state health care institutions. A central obstacle to addressing the problem of language service provision in state hospitals is the lack of a position for interpreters in the post structure for public servants[8]. However, Western Cape psychiatric hospitals have recently begun to employ people specifically for the task of interpreting, in spite of the absence of a specific occupational class for interpreters in the post structure. These interpreters have been employed as casual labour on an hourly rate or as general assistants[9].

There are also many terms for people who perform interpreting as part of their work. These reflect the wide range of tasks that are part and parcel of interpreting in certain contexts. Thus, the terms community health interpreter, interpreter-advocate, bilingual worker, bicultural worker, link worker and intercultural mediator have all been used in different contexts. I will refer mainly to 'interpreter', but will refer to 'community health interpreter' when this is appropriate.

When the research described below began in 1993, there were no interpreters employed in the psychiatric services of the Western Cape. This resulted in the peculiar situation of having no interpreters, but the activity of interpreting continuing regardless. Thus, the study began with

[8] The judicial arm of the public service have managed this problem by appointing interpreters as clerks (Heese, 1984).
[9] General assistant (GA) is the post name for cleaners, maintenance staff and security guards.

the intention of describing the institutional features of the activity of interpreting, most particularly, who was performing interpreting and how frequently. The main object of the study initially was thus the identification of interpreting, not in terms of the content of an interpreted interaction, but simply the appearance of the activity of interpreting. As the study grew the focus shifted to the place of interpreting in the overall institutional arrangement of psychiatric care for patients who do not speak either English or Afrikaans. In other words, the focus came to rest more on the biomedical and institutional strategies for providing a service to a linguistically diverse population, in the face of a relatively linguistically restricted group of service providers. This focus has, however, remained closely tied to interpreting and what this means for professional practice and identity conflicts in local institutions.

Cox (1994) argues that there is much conceptual confusion around the use of the term diversity in organisational settings. He makes an appeal for diversity to be analysed at three levels: individual, group, and organisational. This is echoed in Swartz (1998), who describes an interpreter-mediated interview in terms of four levels: interpersonal; institutional; socio-political; and international. The multi-faceted nature of interpreted interviews in biomedical settings necessitates such a multi-levelled analysis.

OVERVIEW OF THE DISSERTATION

The imperative for a multi-levelled analysis will be taken up in the following chapter through a selective review of issues pertaining to interpreting at various levels. The socio-political context of linguistic diversity in South Africa serves as a backdrop for the consideration of racism in psychiatry, internationally and in South Africa. This is followed by a discussion of international perspectives on interpreter roles in health care, with a particular focus on the place of advocacy in interpreters' work. The question of advocacy is examined from the point of view of the individual practitioner, but also the institutional level of team membership and the socio-political level of political activism. I then proceed to a consideration of language policy and health care in South Africa, the local research that is emerging in the wake of political change, and the potential both hold for contributing to the meaningful revision of psychiatric services.

The review of issues pertaining to interpreting in institutions is followed by an outline of the theoretical and conceptual approach that I will adapt to a study of linguistic diversity and its consequences in such settings. This in essence involves the methodological and analytical

tools of discourse analysis and ethnography. The particular way in which I use these and the structure of the research sequence as the study evolved will be described in Chapter 3. These first three chapters form an introductory section under the rubric of Part I. The following section, Part II, is made up of three chapters that describe three studies of interpreting in institutional settings. The data presented in these three chapters provide an overview of the institutional provision of mental health services viewed through the prism of language services. Part III takes the analysis further in a chapter examining the impact on clinical work of inadequate language resources and a chapter examining the multiple negotiations of identity that take place around the language issue for patients, psychiatric nurses acting as interpreters, clinicians and institutions. Finally, Part IV presents a number of recommendations that flow from the analysis of the data presented here.

Chapter 2

LANGUAGE, SOCIAL CHANGE AND INTERPRETING: A SELECTIVE REVIEW OF THE ISSUES PERTAINING TO MENTAL HEALTH CARE IN SOUTH AFRICA

"...language is the perfect instrument of empire." Attributed to medieval linguist Antonio de Nebrija, 1492.

Geary (1997, p. 50)

INTRODUCTION

This review has a fourfold purpose. Firstly, to situate language issues and mental health care in the context of changing South African socio-political and institutional landscapes. This will also provide a socio-linguistic context for considering the issue of race in the delivery of health care. Secondly, a focus on interpreting will be developed through a review of literature from other countries and continents on various aspects of interpreting and how this work manifests in institutional contexts. This will highlight the connection between apparently technical questions and broader socio-political issues. Advocacy in interpreting will be a particular focus because of how it crystallises the micro-political aspects of language in health care. Thirdly, I will consider the historical development of language policy (and "infra-policies") in South African health care. This third aspect will incorporate South African research on language and interpreting in health care, and psychiatry in particular. Finally, I will turn to a consideration of the potential that meaningful engagement with language issues has for transforming mental health care in local contexts.

Any attempt to contextualise a study of language in mental health care must draw on a wide range of approaches and so this review is of necessity selective. However, the study of language diversity as an axis of difference amongst groups in particular contexts renders the area doubly complex. This is especially the case in Africa where language diversity is closely connected to questions of race and racism. Studies of relations amongst groups and the racism inherent in such relations typically require analyses that incorporate an understanding of micro-level processes and the macro-level factors that frame them. Mental health care is one site at which societal processes are played out at both macro and micro-levels, but the

way in which this happens is structured in particular ways by the techniques, processes and discourses of biomedicine and psychiatry. Thus, if we want to understand the role of language in mental health care we need to conduct critical research on institutional practice and incorporate diverse intellectual strands.

THE POLITICAL ROLE OF LANGUAGE IN SOUTH AFRICA, BEFORE AND AFTER 1994.

Language has been a pivotal vehicle in the expression of the will to self-governance in Africa. It has been a rallying cry, a powerful symbol in the fight to gain autonomy and the right to self-determination from colonial powers. By the same token, language has been a source of conflict amongst groups of the colonised and the means by which to create and perpetuate hegemonic control of the resources so necessary for the exercise of political power (Mansour, 1993; Ngũgĩ, 1986). These contrasting purposes to which the currency of language can be put are strikingly illustrated in South Africa. However, in South Africa revolutionary energy towards the language of the colonisers has had to contend with two dominant languages, English and Afrikaans[1]. The political implications of this have in some ways been split and Afrikaans has been identified a great deal more with being the language of the oppressor than English. It was Afrikaner Nationalism that gave rise to the apartheid (an Afrikaans word) system, and its policies were articulated in this language. English, by contrast, was symbolic of a connection to an outside world that opposed apartheid. The voice of reason condemning the madness of apartheid could often be heard in English (Reagan, 1987). At the same time, internal opposition to apartheid amongst black liberation movements had to contend with a linguistically diverse membership and constituency. While liberation movements were trying to bring together diverse groups against a common enemy, the apartheid government was exploiting ethnic diversity for its own ends.

From 1948, and particularly from the 1960's, the National Party exploited ethnicity to justify the creation of 'homelands' for particular groups of Africans. The existence of these pseudo-

[1] Afrikaans too has had to struggle for recognition. From early in the history of the colony Afrikaans was considered to have inferior status for a range of racial and class reasons (Webb, 1992) and only achieved recognition as an official language in 1925 (Reagan, 1987). The *taalstryd* (language struggle) was a focal point for the development of nationalist sentiment and found its most powerful expression around the question of mother-tongue education (Reagan, 1987).

independent territories was used to support a whole range of social abuses, notably forced removals of communities from 'white' urban areas, restrictions of movement outside of these areas and the maintenance of a migrant labour force. Language was often the only basis for classification into the ethnic groups and hence the means by which these disenfranchising strategies could be materialised (Benjamin, 1994; van Rensburg, 1997). Essentialist concepts of culture and language were thus used to support a "divide and rule" strategy that emphasised and institutionalised differences amongst the people of the region on the basis of linguistic identity (Benjamin, 1994; Blajberg, 1993). Financial and institutional resources were mobilised to promote Afrikaans as an official language, while other indigenous languages were largely under-developed. Any government attempts to promote African languages at the time were viewed with suspicion by liberation organisations as the sowing of inter-group conflict and division, through the promotion of tribalism, was seen as the underlying agenda. Hence, the notion of linguistic diversity carried political connotations that were inseparable from the notion of ethnic diversity. It had been ANC policy since the 1950's to use English as a foil for divisive National Party strategies. It was through the state's attempt to enforce the language policy of Afrikaans as a medium of instruction that the student protests of 16 June 1976 were sparked (Benjamin, 1994). Reagan (1987) has described the three-pronged strategy of rejecting Afrikaans and the black languages in preference for English as the medium of instruction in education as "counter-ideology" (p. 138). Alexander (1989), the doyen of progressive language policy in southern Africa, suggested that English be used as a *lingua franca* in the period of post-apartheid transition, as was common in post-colonial Africa (Mansour, 1993). Thus, in the context of National Party language policies, the promotion of ethnicity and linguistic diversity came to be synonymous with defending apartheid, and some commentators have argued that this may still be the case (Manyoni, 1997; McAllister & Sharp, 1993). Many commentators expected a post-apartheid South Africa to bring with it a period of growth for indigenous languages and a commitment from government to supporting and sustaining this process. These expectations were buoyed up by the prominence of language issues in the new constitution.

However, the elections of 1994 and the recently formalised constitutional status of the 11 official languages have brought with them a more politically complicated language terrain. This is encapsulated in the "rainbow nation" metaphor that has such currency at present (Swartz, 1996). In an overview of the role of language in nationalism in Africa, Mansour (1993) has described how countries that were linguistically diverse at a national level but

largely monolingual at district level (referred to as horizontal multi-lingualism) are more easily legislated for in terms of language policies that affirm language rights. However, she describes multi-lingualism at a district level (vertical multi-lingualism) as unmanageable. Within South Africa there are some rural regions that are relatively monolingual in terms of the African languages spoken, but this certainly does not apply to urban areas. This situation is complicated by not having a single *lingua franca*. Reagan (1995) has called English the language of wider communication (LWC) and certainly this is true of many areas of public life. However, only 9% of South Africans speak English as a home language and only about 32% of Africans speak English (Schuring, 1993). Language demographic statistics further indicate that Afrikaans is the most commonly spoken second language in the country as a whole (van der Merwe & van Niekerk, 1994). Hence, no single language is overtly dominant throughout the entire region and so a policy of richness in diversity has been promoted in the task of nation building. Indigenous languages and the cultural systems they embody are each valued and are to be promoted in the rhetoric of the "rainbow nation". However, Simpson (1993) writes that the "problem in South Africa is the lack of an ethnic core around whose values (language, history, mythology) a nation could be constructed" (p. 19). There is a sense then in which the language diversity that was used to divide could once again pose a threat to the new task of nation-building if "the coercive tactics of identity politics" appropriate this diversity (Manyoni, 1997). Breton (1993) summarises the dilemma neatly: "The political choices hinge on the balance between the minimum linguistic sovereignty necessary to safeguard the interests of the native majority and to ensure easy communication and – on the other hand – the preservation of an enriching and stimulating diversity of cultures and identities" (p. 126).[2]

OBSTACLES TO LANGUAGE REFORM

The government task group, appointed in 1995 to review the language terrain in South Africa and make recommendations, were scathing of bureaucratic naïvety with regard to language policy and the public services (LANGTAG Final Report, 1996). Beukes (1996) has argued that government had failed to grasp and acknowledge the role of language in access to

[2] The problem of uniting linguistic and cultural diversity is a common one for new nation states. The identification of a transcendent discourse plays an important role in the national ideologies necessary to effect the creation of a homogeneous cultural entity. The rainbow metaphor simultaneously acknowledges and denies

services and was not taking steps to remove language barriers to such access. They called for the urgent development of a Language Code of Conduct for the Public Services, needs analyses of language requirements and training programmes for public servants. The report suggests that one possible reason for the neglect of language is a perception of language diversity in terms of a "cost" to administration. Certainly, market forces appear to be playing a large role in the emergence of a laissez-faire approach to language policy from the ANC government, both in terms of demand for access to the international community and policy decisions informed by World Bank requirements. Heugh (1995) has argued that implicit in a laissez-faire approach is a view of language diversity as a "problem" rather than a "resource". She reasons that this will result in the de facto dominance of English. Writing in relation to other African states, Mansour (1993) has observed that where English is used as a *lingua franca*, in the absence of active language planning policies that develop indigenous languages, English remains in place and in fact grows in dominance.

In addition to economic considerations in language policy, we need to weigh the influence of the recent experience of apartheid-style social engineering with respect to language. Under the National Party, language policy implementation regarding Afrikaans was experienced as draconian. Further, language policies regarding the other indigenous languages were implicated in dressing up racism as the recognition of ethnic diversity. Kottler (1990) and Swartz (1989, 1996) have written of the difficulty within psychology and psychiatry of speaking about "difference" without being seen to invoke racist discourses. Perhaps similar pressures and the desire for a vibrant democracy, inhibit the active manipulation of the linguistic terrain. In this climate, an approach to language equality as a passive right is understandable. However, language rights are "paper tigers" (Steytler, 1993) if the social structure and bureaucratic processes within which they operate are not given cognisance[3]. Through an examination of state institutional mental health care practice, I will argue that language rights and human rights converge in the daily routines of institutional practice. Passivity with regard to language inequality will be shown to coincide with a neglect of racial inequality.

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the reality of diversity. Herzfeld's (1992) sophisticated analysis of the reification of meaning in institutional settings describes this in relation to Greece. The argument can apply equally to India and other African states.

[3] See Steytler (1993) for a consideration of a similar argument in the South African justice system.

INSTITUTIONAL MENTAL HEALTH CARE AND INSTITUTIONAL RACISM

The issues of race and prejudice in the practice of medicine and psychiatry in America and Britain have already generated a sizeable body of research and writing[4]. Ahmed (1993), Law (1996), Littlewood & Lipsedge (1997) and Fernando (1991, 1995) have explored institutional racism in British health care and psychiatry's role in the "alienation" of ethnic minorities. Fernando (1991) describes the discipline of psychiatry as shot-through with an intrinsic racism.

> *"Racism within psychiatry derives from the traditions of the discipline, its history, its ways of assessing and diagnosing, the criteria it uses for designating treatment, its organisation, its involvement with the powers of the state and with Western power internationally (and the racist dimension to the exercise of power), and its struggle to be accepted as a scientific discipline. Racism in the provision of (psychiatric) services derives from the manner in which institutions are constructed and fashioned and the failure by most organisations to confront the fact of inherent and historically determined racism"* (p. 116).

Fernando (1995) differentiates between racial prejudice, which has to do with individual attitudes and generalisations, and institutional racism, which has to do with ideology as it is expressed in institutional structures. These structures and their strategies, techniques and procedures then represent, in Foucauldian terms, discursive means by which inequality is generated independent of any particular individual's attitude. The result in institutional settings is that particular groups may be systematically disadvantaged, compromised or neglected (Howitt & Owusu-Bempah, 1994). This is often seen as different from the issue of individual prejudice because individuals working in institutions may not themselves be prejudiced, but they may materialise disadvantage by conforming, with or without conscious intent, to the routines, procedures and limitations of an organisation. A number of terms have been used for this, such as institutional racism (Sabshin, Diesenhaus & Wilkerson, 1970), functional apartheid (Heggenhougen, 1995) and social discrimination (Giachello, 1995). Attempts to address such structural problems have often been tackled through the issue of language as a fundamental component of access and delivery (Howitt & Owusu-Bempah, 1994).

[4] See Ridley (1995) for a comprehensive bibliography of American publications.

A review of the international literature on language and improving access to health care suggests that a key ingredient to addressing inequitable services has been some form of commitment from government. This commitment has invariably taken a two-pronged approach. Firstly, the creation of legislation that specifies broadly what is required of service providers, and secondly, enabling economic and/or structural means by which to develop services in line with the legislation. The development of equitable access to services and the growth of the cultural competence of health services (see Cross, Bazron, Dennis & Isaacs, 1989) has thus been closely linked with catering for the language needs of service users and hence the employment of interpreters. Fortier (1997) has described the role of governmental involvement in the emergence of language services in the USA; Baker, Hussian & Saunders (1991) and Shackman (1985) in Britain; Chikhi (1997) in Belgium; and Chesher (1997) and Gentile (1991) in Australia. The advantage of legislation is that it facilitates the mobilisation of resources for the development of services towards targets and assists with the enforcement of this legislation. While the conceptualisation of the need for language services in health care in terms of a cost burden is not unique to South Africa (c.f. Fortier, 1997), insistence from government that state funded services meet requirements can encourage the formation of partnerships between role players. However, it is also too easy to bemoan a lack of support from state structures in driving institutional change and to fall back on the passivity that characterises bureaucracy (Herzfeld, 1992). Non-governmental organisations (NGOs), consumer groups and institutions themselves must provide state departments with expressions of concern for change and supporting information (Beukes, 1997). Innovative strategies that can be modelled and developed in ways that may draw support from government could build reciprocal investments in moving beyond rhetoric in building equity of access to services. I will now turn to a consideration of questions of race and language in South African health services.

Racism and language in South African mental health care

During the apartheid era in South Africa's history international reports documented gross inadequacies and inequalities of the provision of services for black patients arising out of legislated and enforced institutional racism (Stone, Pinderhughes, Spurlock & Weinberg, 1979). It was noted in such reports that there were few medical practitioners and even fewer mental health specialists who spoke indigenous languages (O'Donahue, 1989). Local reports focused on the fragmentation of services, restricted access for black patients to hospital beds,

the attention to psychotic disorders and curative factors at the expense of prevention, promotion and rehabilitation (Freeman, 1989a, 1989b). More recent local studies of psychiatric services have focused on dimensions of patient satisfaction (Ensink & Robertson, in press) and the integration of services by race (Freeman, Lee & Vivian, 1994). The former study largely neglects the role of language in patient satisfaction altogether, besides an oblique reference. The authors note the complaint from Xhosa-speaking service users that doctors do not tell patients or their families what diagnosis has been made. The latter Centre for Health Policy study, evaluating psychiatric services in the Free State (a province of South Africa), documented a levelling off in the discrepancy between the services available to black patients in comparison to their white counterparts. However, significant ways in which integration was incomplete due to differences in quality of care and access to services were noted. It is unfortunate that the multi-lingual nature of the patient population in terms of access to the services is not referred to at all in this descriptive study.

In addition to articulating structural shortcomings in services for black patients, Swartz (1986a, 1987, 1989, 1991a) has explored the development of discourses of race in South African psychiatry. Modern psychiatry in South Africa has employed a complex mix of relativistic and universalistic discourses to construct the subjectivity of black patients. Swartz has shown that the discourse of cultural relativism is used to construct black subjects as mysterious and unknowable, while the universalism of the biological discourses of mental illness is used to justify treatment in spite of this. Biological tests and treatments are seen to penetrate the mists of "African culture" (see Swartz & Foster, 1984) in a way that does not require engagement with personal narratives or social context beyond the notion of difference. However, "a crucial ingredient for the legitimation of care, though, is the clinician's construction of a story which is passed off as the patient's" (Swartz, 1991a, p. 243). In the most crass form this occurs through observation of the patient and the identification of signs and symptoms which infer a biological and psychic reality for the patient. This can then serve as a justification for intervention. While the practice of psychiatry is seldom so literally "veterinary" (Kleinman, 1977), a superficial and bureaucratic engagement with illness narratives is more likely to be the norm. However, it is precisely through psychiatric assessment procedures that are "administrative" (Swartz, 1991a, 1998) that racist discourses are reproduced. Swartz has been careful in his numerous published writings on the reproduction of racist discourses in South African psychiatry to clarify that this occurs in institutional settings in spite of explicit commitments to non-racist or liberal values on the part

of the individual practitioner. However, individual practitioners are constrained partly by the fact of working within institutions in the larger socio-political context of South Africa, but also by virtue of simply working within a biomedical institution (Swartz, 1992a).

The dominance of the discourses of biomedicine cannot be under-estimated in analysing the discursive products of institutional psychiatry. In addition, one of the central features of the culture of modern psychiatry is the enormous pressure to perform the 'work' associated with any given patient in as short a time as possible, whether this be in a meeting or over the course of a patient's admission to hospital. American medical anthropological literature on psychiatric settings, and the socialisation of medical training, places great emphasis on the role of pressure to 'process' a patient in as short a time as possible (Atkinson, 1992; Light, 1980; Mizrahi, 1986, 1987; Rhodes, 1991). While issues of class are addressed in this literature, little attention has been given directly to issues of race in this regard. Barrett (1996) analyses the production of patient subjectivity in an Australian psychiatric institution with reference to biomedical and psychiatric discourses. Drawing on the work of Goffman, he demonstrates how the "footing" of statements that can be made and understood in organisations is partly a product of the particular institution but also the product of a psychiatric institution in general. The socio-political context of the institution, the way in which the institution is shaped by being situated in an Australian city is not overtly present in the analysis. Swartz (1985) has commented on the ease with which analyses of South African situations are seen in the light of this society, but how wider societal influences may be obscured in international writing. This may arise out of the ease with which notions about race in South African society can be 'constructed' on the basis of reductive polarities, such as white – dominant, black – subjugated, white – racist, black – victim. While I have argued thus far that an analysis of institutional practice in South Africa must give consideration to how these contexts have been, and continue to be, racialised, a 'post-modern' approach to questions of identity is necessary in the contemporary South African state (see Thornton, 1996).

I will now turn to a discussion of interpreting in relation to medical services, before considering the dispensation regarding language in South African health services.

GENERAL APPROACHES TO INTERPRETING

Interpreting is a generic activity, much like healing. There are no necessary or inherent methods by which the goal may be reached. Guidelines as to what is expected of an interpreter have arisen out of a combination of context and the appropriate interpreting style. Conference interpreting (Gile, 1995) and court interpreting (Channon, 1982) have been well described in the international literature. Increasingly, the category of community interpreter has also come into focus. In an overview of community interpreting, Roberts (1997) considers community interpreting to be an overarching description from which court, medical and public service interpreting are emerging. She draws on a number of definitions of community interpreting to show how the notion of assistance to the client (as opposed to service provider) is always either explicit or implicit in what is expected of the interpreter. In addition, culture brokering and advocacy are also prominent in descriptions of community interpreting. Strikingly, culture brokering is emphasised at times above the linguistic aspect because of the stress placed on the need for the interpreter to clarify implicit cultural meanings and assumptions to the interlocutors. Advocacy too emerges out of the normative context of community interpreting services, where refugees or immigrants to a developed country may require advice regarding their rights, additional information of various types and the mediation of prejudice. Fundamentally, this places an onus on the interpreter to be active in empowering the client in access to services and resources. In spite of her sympathy to the social and historical aspects of these roles for interpreters in community settings, Roberts (1997) expresses caution regarding the hazards they hold for the interpreter. Multiple functions increase the difficulty level of the interpreters' task and may even compromise the professionalism with which the interpreter performs the core task of interpreting.

The historical origins of medical interpreting in community interpreting can be seen to have influenced the struggle to clarify the roles of a medical interpreter. While legal interpreting has emerged as a distinct form of professional language practice, medical interpreting has been slower to crystallise a clear set of professional expectations. I will argue here that the distinction between medical interpreting and community interpreting is an important one and that the fudging of the distinction has important implications for debates around medical interpreting and the shape that this practice takes. As the literature on psychiatric interpreting is scant, much of the consideration given to the theoretical aspects of clinical interpreting will be drawn from the medical interpreting literature.

INTERPRETING IN HEALTH CARE

There is a discrepancy between seemingly nihilistic philosophical approaches to translation and the apparent ease with which interpretation takes place in everyday cross-cultural communication. From the Sapir-Whorf hypothesis (Whorf, 1956) to Quine (1960), there has been support for Nida's (1964) oft cited observation that translation is the most difficult task in the world. This stands in stark contrast to the apparent ease with which cross-cultural communication is accomplished in a wide range of health care contexts. This is similar to the surprise expressed by many writers as to the scant regard given to the mediating role of the interpreter in medical contexts in the literature (Hasselkus, 1992; Sluzki, 1984). The substantial body of work on doctor-patient interactions across a range of disciplines from sociology to psychiatry can make passing reference to the role of cultural differences in clinical communication[5]. However, little of this work has applied itself to the position of the interpreter in these interchanges (Hasselkus, 1992; Kaufert & O'Niel, 1995). The neglect of this aspect of health care may be seen to arise out of the way in which situated communication acts are able to simplify communications, which if taken out of their context, are fraught with uncertainty and indeterminacy. Everyday communication is built upon a pragmatic confidence, correct or otherwise, that sufficiently accurate comprehension for the tasks at hand is a routine accomplishment. In this approach, errors of communication either do not make a difference or are able to be corrected. The exceptions prove the rule. However, a concern for communication errors has been a point of departure for much of the caution expressed in literature on medical interpreting over the use of untrained interpreters.

Most published papers on interpreting in medical contexts provide suggestions as to how doctors may manage interviews with untrained people serving as interpreters, and usually provide anecdotal evidence to support arguments as to the sorts of "errors" made by such interpreters (Marcos, 1979; Vasquez & Javier, 1991). Occasionally, the errors made by doctors in their use of untrained interpreters are also referred to (Dias-Duque, 1982; Sluzki, 1984). Price (1975) and Launer (1978)[6] provide research evidence for the sorts of difficulties

[5] See Kuipers, 1989; Mishler, 1984; Ong, Haes, Hoos & Lammes, 1995; Pappas, 1990; Roter & Frankel, 1992; West, 1984 for reviews.

[6] The only published African study known to me that has analysed a series of audio-taped transcripts of medical interactions.

encountered with medical orderlies regularly used as interpreters. Unfortunately, these approaches confound training and experience. As Price's study particularly showed, "on the job" experience does not necessarily guarantee the on-going acquisition of skills and expertise. There is also wide disagreement as to what constitutes interpreter skill and expertise. Launer (1978) describes legitimate and illegitimate deviations in the interpretations rendered by interpreters. Vasquez & Javier (1991) describe five types of interpreter errors in psychiatric work: omission of components of a message; addition of information not expressed by the patient or clinician; condensation in the sense of simplification and explanation; substitution of concepts with others; and role exchange. This latter error occurs when an interpreter asks a self-initiated question. In contrast to how Vasquez & Javier (1991) describe these features as errors, others support greater freedom for interpreters. These approaches parallel developments in sociology with what Heritage (1984) describes as the "sociology of error", where focusing on a narrow conception of inaccuracy obscures the remarkable accomplishments of actors in their routine production and recognition of everyday communications. McIvor (1994) and Richter, Daly & Clarke (1979) emphasise interpreter initiative at the level of linguistic issues. Kaufert & Koolage (1984); O'Neil (1989); Sanders (1991) and Shackman (1985) all take the question of interpreter initiative a step further by emphasising the interpreter's role as a patient advocate. The question of interpreter roles requires elaboration.

Interpreter roles

It has long been acknowledged in anthropology (Werner & Campbell, 1970) and sociology (Anderson, 1976) that interpreters are invariably subject to the stresses attendant on fulfilling a function for which there is a lack of definition. These stresses constellate around the twin problems of "role overload" and "role conflict" (Anderson, 1976). Both bring with them the onerous responsibility of considerable power to shape and influence communication between two parties. This power arises out of being the only party in a triangular interaction who is in a position to understand all that is said, and to selectively convey information without detection by the other interlocutors. The question of power in addressing role conflict will be taken up in what follows.

Linguistic aspects

The most basic level at which the role of the interpreter is described is that of linguist. This signifies that the role involves the bilingual capacity to render statements in one language into another. Not moving beyond this aspect results in the construction of the functioning of the interpreter as that of a naïve language machine (Pergnier, 1978). Such a construction of the interpreter's task implies an empiricist theory of language (Good & Good, 1981), and lacks the recognition of the complexity of socially situated discourse. In a clinical context this would require the interpreter's role to be that of the "invisible interpreter" (Swartz, 1998) or "black box" (Westermeyer, 1990). The underlying conceptualisation or model of language in use will influence the extent to which the complexity of the task is grasped by the clinician making use of an interpreter's services (Corsellis, 1997; Swartz, 1998). This will impact upon the manner in which an interview is conducted and possibly on the clinician's degree of satisfaction with the interpreter.

Culture brokerage

The anthropological history of experience with interpreting is revealed in another role often expected of the interpreter, that of the culture broker. Culture brokerage was introduced to the anthropological literature in the 1950's and has been closely linked to health care services and advocacy in subsequent writings (Herselman, 1994). Clinicians who use interpreters may expect them to fulfil a culture brokerage function, by explaining and clarifying the cultural context and indigenous beliefs of particular patients. This is because language is sometimes seen as a portion of the cultural gap between doctors and patients and so interpreters are often expected to fulfil the role of culture broker for both parties. Even the interpretation of behaviour or experiences most readily labelled psychotic in psychiatric contexts is compromised without being situated in the cultural context that informs this (Westermeyer, 1987).

In the South African context this has led Herselman (1994, see also de Villiers, 1993[7]) to suggest that this more inclusive concept of "culture brokerage" be introduced as an official part of nursing duties, with clear delineations as to what this would entail. Herselman

[7] Herselman previously published under the name of de Villiers.

suggests the following strategies for culture brokering: cultural assessment of the patient; negotiation between patient and provider when subtle differences in connotative meanings of communications are missed; representation of members of the culture the nurse speaks for to authorities; mediation of inappropriate treatment plans in order to forestall problems such as non-compliance; an informant for patients and doctors; and finally, an analyst who provides information and insight. Herselman (1994) argues that nurses are uniquely placed to exercise these strategies and functions. The very notion that nurses should have built into their work an explicit expectation to be culture brokers is a controversial suggestion that would not necessarily meet with unanimous support, even amongst nurses. Nurses already carry a considerable workload and the increasing emphasis in South Africa on primary health care has seen an even greater expectation for nurses to fulfil many roles (Holdsworth, 1994; Swartz, 1998). Personal choice and resistance to the institutionalisation of what is arguably the exploitation of nurses could be further reasons for opposition (Mgoduso & Butchart, 1992). The considerable expectations implied by Herselman's daunting list of strategies would surely serve as a powerful disincentive. Nevertheless, the idea of introducing culture brokerage as a part of nursing duties begs the question of introducing interpreting as a part of official nursing duties.

Advocacy

Closely linked to the idea of culture brokerage has been the role of patient or client advocate. Advocacy has arisen in the context of community interpreters who found that in the course of their interpreting work they were uniquely placed to assist clients in accessing social services. More than this, there have been descriptions of situations were community interpreters felt impelled to intervene on behalf of clients to stop various forms of racism, discrimination and marginalisation (Roberts, 1997). Thus, not intervening in such situations would have placed moral burdens on interpreters that justify the over-stepping of the principle of neutrality esteemed in interpreting. In Britain for instance, interpreter services have been provided by central agencies for a range of social services (Baker et al., 1991; Shackman, 1985). The autonomy from service providers allows the community interpreter to be client-oriented and proactive in identifying and meeting client needs. The duties of a community interpreter under these circumstances include needs assessment, user empowerment and input into policy making (Sanders, 1991). The inclusion of this role in interpreting work is an attempt to address the relations of power that constellate around exclusion on the basis of language. The

analysis of power relations is an important dimension of health care and thus requires careful consideration in relation to interpreting in medical contexts. It is important to note however, that there is a distinction made in Britain between a community interpreter and a link worker (Raval, 1996)[8]. While the tasks may overlap, the skills and responsibilities involved may differ. I will return to the advocacy issue in more detail below.

Multi-disciplinary team membership

A further important dimension to the interpreter's role in health care has been the inclusion of the interpreter as a member of health care teams. The recognition of teamwork in interpreted medical interviews has been acknowledged since the publication of a paper by Bloom, Hanson, Frires & South (1966). Increasing specialisation and the resulting divisions of the labour of health care, and particularly mental health care, have inevitably seen the interpreter's functions added to that of other team members. The notion of teamwork between medical professional and language professional is an evocative one. However, when confronting the bewildering range of options as to how an interpreter should function, the invoking of a team metaphor can obscure more than it reveals. It suggests a harmonious collaboration in which the members of the team work out solutions to problems together in a way that is efficient and satisfying, without actually having to specify how this will take place (see Faust & Drickey, 1986). Freed (1985) refers to mastering the "art" of interviewing, but the two best interpreters she discusses were a psychologist and social worker. Westermeyer (1990) writes of the more likely bilingual worker model in which the interpreter is a "junior clinician". However, the junior clinician model can be used in two ways. This can involve the patient being interviewed by the service provider with the language capabilities, who then reports to the 'senior' health care professional. The ethical and legal responsibilities lie with the clinician that is, for all intents and purposes, supervising the "junior clinician". Westermeyer speaks of, for instance, social workers under this rubric. However, he goes on to include in this discussion refugee assistants who can also provide a "junior clinician" function. This second use of the term possibly refers to the way in which interpreting the significance of a patient's utterance requires the application of clinical skills and insight. Swartz (1998), for example, illustrates the importance of clinical skill when interpreting the

[8] The concept of link workers arose in the context of the "Asian mother and baby campaign" in British hospitals and included interpreting (Sanders, 1991). Parsons & Day (1992) distinguish link workers from health

speech of a psychotic person. Psychotic discourse may be very difficult to interpret literally in terms of content but the interpreter may choose to interpret in terms of the style of speech. Another example would be when a clinician asks questions that are meaningful to a clinically trained interpreter but which the interpreter will have to find a way of asking the patient. Various forms of medical jargon fall into this category and 'shortcuts' such as 'is the patient orientated?' are commonly put to interpreters. A nurse interpreter would be able to act in a junior clinician role, but not all interpreters have sufficient clinical background to deal with this expectation.

Reporting on research in South African magistrates' courts, Steytler (1993) describes the effect of role diffusion for court interpreters. The interpreters were seen to perform functions literally as court orderlies, and functions outside of the surveillance of the court more consistent with that of a lawyer, magistrate, and prosecutor. Much of this role confusion arises out of being a 'team player' in the conduct of the business of the court but of low status in the legal bureaucracy.

Similarly, in health care there are a number of problems with the 'team member' role for interpreters. Firstly, there is the question of how this may compromise the interpreter's commitment to the service user. Critics of the team member approach in health care argue that to be service-oriented, physically located in the agency, and accountable to it fundamentally obscures the interpreter's perception of exclusion and marginalisation in access to services (Sanders, 1991). Secondly, and related to the first point, is the way in which the team metaphor masks power relations within teams. Team membership may constrain an interpreter's freedom to challenge or question service providers. Thirdly, there are no clear guidelines as to which circumstances allow clinical responsibilities to devolve to the interpreter, and how the clinician should retain overall accountability.

Having considered the various roles in general that interpreters may take up or have imposed upon them, I now turn to an elaboration of the issue of advocacy.

advocates, but Raval (1996) describes a link worker as assisting clients to make informed choices regarding services, identifying the needs of clients, and interpreting for clients.

SOCIO-POLITICAL CONSIDERATIONS IN MEDICAL INTERPRETING: THE ADVOCACY DEBATE

The Winnipeg Group: support for interpreter latitude

Dr. J. Kaufert and his colleagues, working at the University of Manitoba, Winnipeg, have made a significant contribution to the conceptual clarification of interpreter issues in medical settings. Beginning with a seminal paper on role conflict amongst interpreters (Kaufert & Koolage, 1984), they have articulated a great many of the issues that face interpreters and interpreting services in medical settings. The 1984 paper in particular carried the terms of the debate that continues to rage in relation to culture brokerage and patient advocacy, into medical health care settings. I will consider the writings of this group in some detail, giving particular attention to the terms of the advocacy debate that they articulate. In the interpreting literature their writings occupy an invaluable space because of the combination of factors they have represented. The group has produced a number of papers that show a development over many years of experience in service delivery and extensive research. The analyses they present are politically and socially aware, whilst also being clinically informed. However, the published papers provide a body of knowledge that can be taken up in South African settings as imported authority. I hope to show how the capacity for empowering service users implicit in the advocacy approach may be hampered under certain circumstances.

Kaufert & Koolage (1984) outline the interpreter roles discussed in the previous section. Their starting point for problematising how interpreters were being perceived in the clinical situations they researched, was a recognition that clinicians did not want interpreters to censor or in any way distort patients' replies to questions. This issue reflects the perennial concern for clinicians regarding who is in control of an interview when an interpreter mediates, originally articulated in Bloom et al. (1966). They go on to show that hostility from clinicians for deviations from what the patient has said is misplaced and inconsistent with the expectation that interpreters also provide relevant cultural information. The mediation of cultural information would be necessary for both clinician and patient. However, in raising the advocacy role, Kaufert & Koolage (1984) describe a situation where a medical procedure was performed without a patient's consent. The interpreter involved responded to this by challenging the clinicians involved. This foregrounded a primary loyalty to the member of his

or her ethnic community and raises issues to do with loyalty conflicts for interpreters. The expectations clinicians and patients have of interpreters may be at odds with one another and as such both parties may place pressure on the interpreter to conform to their agendas.

Explanatory Models and interpreting

This basic argument is elaborated on in another paper by O'Neil (1989), which makes an important shift in conceptualising the place of interpreters in health care through introducing critical medical anthropological concepts. This study situates medical interpreting for Inuit communities in Canada in a macro-political and economic context. O'Neil (1989) also counter-points the experiences reflected in his research with the Explanatory Models (EM) paradigm (Kleinman, 1980). Kleinman has articulated in his numerous writings that clinical work would be enhanced if there were something of the attitude of an anthropologist in each clinician (Kleinman, 1987, 1996), not only when working with someone from a different socio-economic, class or ethnic group, but with all patients. Interestingly, Pappas (1990) has suggested that Kleinman's basic metaphor for doctor-patient interaction is language, in that the "theory's simplest statement regards problems in the doctor-patient interaction as problems of 'translation'" (p. 202). This is because Kleinman would have doctors ask a set of questions to do with clarifying the patient's conceptualisation of an illness episode in a way that is usually neglected in medical encounters. Typically, doctors 'interpret' patient discourse in biomedical terms without explaining this to patients or acknowledging what of the patient's experience may be lost in the translation (c.f. ten Have, 1991; Mishler, 1984). Kleinman would have doctors reintegrate biomedical constructions with those of patients' for more successful communication and understanding (see Good & Good, 1981 for an illustration). But critics of the consensual approach suggested by Kleinman's model, including Pappas (1990) and Lazarus (1988), argue that conflict cannot be overcome simply by more egalitarian communication, as structural inequalities and societal conflicts continue to influence the shape of a medical encounter. Lazarus (1988) has drawn attention to the idealism of the EM paradigm in the face of institutional realities of the practice of biomedicine.

In the context of scepticism about the EM approach, O'Neil (1989) argues for and illustrates the necessity for interpreters not to remain neutral but to advocate actively for patients if "even basic clinical information is [to be] presented and translated" (p. 331). He identifies

two strategies for this, explicit advocacy and implicit advocacy. Explicit advocacy can take place when the interpreter has sufficient authority and the confidence born of structural support. Implicit advocacy takes place when the lack of capacity or opportunity to be overt about shaping an interaction drives this underground. Interpreters alter patient statements "to enhance or diminish the broader political context of the patient's complaint" (p. 332). O'Neil (1989) suggests that interpreters may:

> *"...emphasise or suppress the contextual implications of each statement in an interview depending on their perception of the relationship between the patient, themselves and the doctor or nurse, as well as their perception of the relevance of the wider social and cultural issues to the encounter"* (p. 339).

O'Neil acknowledges that this interpreter activity may result in problems as well, but that the benefits of countering cultural marginalisation and racism inherent in medical practices may be substantial.

The interactionist model and interpreters

Kaufert (1990) undertakes to develop the theoretical conceptualisation of medical interpreting by adapting the EM approach and the social interactionist framework (Lazarus, 1988; Waitzkin, 1989; Zola, 1978, 1981) to include the presence of interpreters. The interactionist perspective on medical consultations broadens the focus to include an analysis of the power relationships that are produced and reproduced in such encounters. These dynamics are micro-political in that they arise in the process of a relatively more powerful medical practitioner interacting with a relatively less powerful and dependent client. This relationship reproduces macro-political and economic structures with their potential for various forms of social control. Kaufert (1990) adapts the interactionist perspective through an analysis of how interpreters exercise power through their control of the flow of information between client and clinician. I will reproduce in some detail here the factors observed in the Winnipeg group's research that contribute to the power of interpreters in interactions.

1) *the interpreter's capacities to explain the identities and functions of health workers;*
2) *their role in explaining rules of medical institutions and norms governing the interaction between clinicians and patients;*
3) *their role in eliciting, collecting and integrating information on a client's medical history;*
4) *their function in creating "choice points" in which the client is appraised of alternatives and informed of their right to refuse treatment;*
5) *their function in feeding back information about both the content and process of proposed diagnostic and treatment options;*

6) *their capacity to visibly or invisibly assume advocacy functions on behalf of either the client or health care institution;*
7) *their role in developing appropriate terminology and maintaining linguistic quality control;*
8) *their function of exercising informal peer review of the ethical and professional standards of other health workers.* (pp. 228-229)

The interpreter-advocacy functions that Kaufert (1990) describes here all "contribute to the legitimacy and power of the interpreter within situations involving cross-cultural communications" (p. 229)[9]. While O'Neil (1989) expresses concerns regarding the EM approach, Kaufert (1990) tries to illustrate the value of interpreters in both the EM approach and the interactionist paradigm. This latter analysis of interpreter functions seeks to legitimate the potential in the work of interpreters for re-dressing power imbalances in cross-cultural clinical encounters. Kaufert (1990) acknowledges that this formulation does not address wider organisational and socio-political constraints on interaction. However, important as it is that the power of interpreters is made visible, it is also important that interpreters are not seen to be outside of the critique of the interactionist perspective. The Belgian experience of providing "intercultural mediators" has demonstrated the dual consequences of the power exercised through interpreting (de Ridder, Lefére & van Dessel, n. d.). Service users may be assisted or disadvantaged through the use of an interpreter, and the latter occurs most frequently when the interpreter is over-identified with the service provider (de Ridder, 1997). de Ridder (1997) joins Solomons (1997) in emphasising the importance of transparency on the part of the interpreter. They anticipate that this would allow interpreters freedom to prioritise the creation of meaning in interaction, rather than striving for a depoliticised and decontextualised neutrality. I will return to this issue below.

Ethical codes and interpreters

In a more recent paper, Kaufert & Putsch (1997) have drawn on more than 20 ethical codes developed for interpreters in USA and Canadian settings and illustrated their shortcomings. Using case examples and the theoretical position outlined above, they show how principles such as confidentiality, accuracy and completeness, non-judgementality, and client self-determination in the ethical codes are difficult to maintain in particular situations. They

[9] A number of papers emanating from the Winnipeg group have illustrated the value of this perspective in relation to informed consent and cultural issues around death and grief (Kaufert, Lavallee, Koolage & O'Neil, 1996; Kaufert & O'Neil, 1995; O'Neil, Kaufert, Kaufert & Koolage, 1993).

suggest that the codes as they stand do not do justice to the complexity of the tasks and to the loyalty interpreters may feel to their communities' beliefs and value systems. There is a sense in which the Winnipeg group are correct. Inconsistencies do arise between what interpreters encounter in their work and what is laid out in ethical codes. Besides the gap between ethical codes and the realities of everyday practice, there may also be a conservativising influence in these codes that silence challenges to biomedical hegemony. However, it is on the issue of accountability and medico-legal responsibility that these arguments are most vulnerable. Hence, in a response to the paper, Solomons (1997) cautions against a delay in the development of professional standards as proposed by Kaufert & Putsch (1997). She suggests that sufficient transparency on the part of the interpreter as to what they are doing and saying would go a long way towards addressing the anxiety clinicians have about too much latitude for interpreters. Concerns regarding interpreter latitude and advocacy are explored below.

The argument for circumscribing interpreter latitude

There can be few writers in the area of interpreting who are not aware of the multiple tasks that fall to interpreters in health care. It would be simplistic to characterise the advocacy debate as arising out of distinct approaches to the question of interpreter roles. Rather there appears to be disagreement on where to place the emphasis or what to prioritise in choosing amongst roles. Dowling (1995) for example, writing in the USA, acknowledges that interpreters are often expected to function as culture brokers, advocates and even escorts. However, he argues that the principal responsibility to mediate communication as accurately as possible can be lost in the welter of conflicting responsibilities. While acknowledging that mediation, cultural education, consciousness-raising and advocacy may be necessary in the contexts in which interpreters work, Dowling expresses concern that the primary task may be compromised or lost if too much is expected of the interpreter whilst interpreting. Backing up this concern with analyses of transcripts of clinical interviews, Dowling (1995) shows how interpreter errors or "bad habits" surface when the interpreter exercises too much latitude in mediating between two parties. Dowling's (1992) formulation of interpreter roles in terms of what they *should not do* could not be more different from that of the Winnipeg group. He states emphatically that an interpreter does not:

> *"...take a direct part in the dialogue between the principal parties (except when necessary to request clarification); does not filter out 'irrelevant' information; does not explain things to the patient, or advise either patient or provider, or advocate for either party. A competent interpreter does not enter*

> *into dialogue with one party while the other is left waiting"* (p. 7, emphasis in the original).

Thus, Dowling articulates an orthodox position in relation to interpreter functions that emphasises the invisibility of the interpreter and fidelity of interpretation of what the other interlocutors have said.

Corsellis (n. d.), writing in England, takes a broader perspective, in terms of the effect on interpreters, but also in terms of patients and providers. She briefly outlines four major areas of concern with the advocacy notion in health care.

- Firstly, the accuracy of information exchange may be reduced as a result of an interpreter who is selective of the information they convey without sufficient medical competence to take these decisions, resulting in sub-standard services. Too literal a grasp of a patient's intentions when consulting a health practitioner may also result from the interpreter's simplification of communication. This is an important consideration in relation to psychiatric interviews.
- Secondly, there may be disadvantages to patients. Besides the point made above, dependency on health care providers may simply be transferred to interpreters, reducing the chance to gain control and negotiate for themselves.
- Thirdly, health professionals may be disadvantaged by increased medico-legal risks, decreased rapport with patients, decreased credibility with service users, and importantly, decreased motivation to develop cross-cultural service provision sensitivity and skills.
- Finally, Corsellis draws attention to the equally significant medico-legal risk of advocacy work for interpreters. She emphasises that the stress of advocacy work is considerable and that career development opportunities may be poor. Like Dowling, she raises concerns about the risk of a diminution in interpreting skills. Particularly pertinent from the point of view of the argument developed by the Winnipeg group, is Corsellis' suggestion that interpreters may be exploited in the health care system and that the system may be less likely to change because certain advocacy functions may mask the systemic deficiencies of services to minority groups in the UK.

I want to consider two further aspects to the terms of the debate outlined above. Firstly, what are the implications for the nascent interpreter industry in South Africa and secondly, what aspects of the work of psychiatry may need further consideration?

Potential difficulties with the advocacy model in South African settings

By contrasting two approaches to the question of advocacy by interpreters it was not my intention to polarise the debate as two mutually exclusive positions. While there are important differences in terms of how interpreters' work is defined, there is a fundamental commonality in terms of the overall project of improving access and equitability of services to groups disadvantaged on language or ethnic grounds. The differences emerge in relation to the role of the interpreter as a front-line troop in this struggle.

The advocacy model has great appeal in South Africa, with the legacy of exclusion and disadvantage outlined above, in that it promises an immediate avenue of intervention in institutional contexts. However, the question of expertise is of concern. The experience and maturity of vision required to make an advocacy approach in medical interpreting work involves a considerable degree of expertise. In a phase of capacity-building, too many responsibilities on the individual practitioner may disperse energies rather than focus them. A second issue has to do with the 'fine print', so to speak, of the advocacy model put forward by the Winnipeg group. While many of their remarks and recommendations refer to the accomplishments and modifications of technique in interviews, they do make reference to how interpreters have been supported in institutional contexts. The papers from the group, O'Neil et al. (1993) in particular, refer to the structural and professional support given to interpreters. Over a period of time this allows the interpreters to grow in confidence and assists the institution to grasp the benefit of the way the interpreters work. Kaufert & Putsch (1997) make the point that the individual interpreter is restrained by "wider institutional, professional, structural forces, such as a hospital's programme directives, its funding arrangements, and how interpretation programs are represented at management level" (p. 72). Access to administrative hierarchies is clearly imperative if a language service is to incorporate the types of organisational consulting that meaningful advocacy work may require. The apparent success of the advocacy model described by the Winnipeg group indicates that organisations were engaged with at two levels: the micro-level of particular interactions, but also the macro-level of access to management and support from other professionals.

In South Africa, where there may be limited access to organisational hierarchies and bureaucratic structures, there may be little of the macro-level support for advocacy

approaches to interpreting. It is a moot point as to whether it is possible to import the micro-level aspirations of the model without being able to deliver the macro-level supports. Interpreter projects initiated by South African non-governmental organisations such as the National Language Project are under pressure, once they have gained access to hospitals, to demonstrate their value to hospital managers and health care providers. Pilot projects of this nature funded by foreign agencies must look to local government if they are to become established (Erasmus & Mathibela, 1996; Ntshona, 1997). This constructs the interpreters as aspirant team members rather than challenging advocates in the health care system.

O'Neil et al. (1993) relate the details of engaging in a research process of observing the work of interpreters. In this they note the importance of a "bilateral surveillance" (p. 229), observing not only the work of interpreters, but also the functioning of their medical colleagues. It is appropriate that a wide range of organisational factors be taken into account when evaluating the functioning of interpreters, as their work will be significantly impacted upon by the practices of those with whom they work. However, the way in which Kaufert (1990) describes interpreters as having a particular focus around reviewing the ethical conduct of health professionals informally raises a thorny issue. While the problem of monitoring racism in institutions is a difficult one, it does not seem appropriate to set interpreters up as a sort of 'clinical police' in this regard. An inversion of the medical gaze through covert surveillance of the medical profession would do little to foster trust and mutual respect.

The role of political activism in South African psychology and the forms it can take have long been the subject of debate (de la Rey, 1997; Manganyi, 1991; Nicholas & Cooper, 1990; Swartz, Gibson & Swartz, 1990). Wetherell (1994), writing in Britain in a special edition of the Journal of Community & Applied Social Psychology devoted to related topics, makes the observation that there may be two yardsticks for evaluating the words of the powerful and the powerless. Through this, research itself may be a form of advocacy but coherence may be compromised.

> *"But one implication for methodology is that social psychologists adopt a broadly humanistic metatheory and do cc [sic] research, or something similar, searching for mutually acceptable descriptions of what is really experienced with those with whom they agree, want to support, or see as oppressed, while simultaneously deconstructing and critically interrogating from a post-structuralist standpoint those with whom they disagree or see as inappropriately powerful"* (p. 306).

In an effort to democratise the research process and empower interpreters the Winnipeg group's critique of what interpreters do may not be as thorough-going as the critique that biomedical approaches are subjected to. The approach of the group to describing the work of interpreters and then formulating a theory as to how they function suggests that 'interpreters are as interpreters do'. This sits well with the way in which the writings of the group convey a respect for what interpreters accomplish and an acceptance of their perspective on why they may deviate from protocol when compelled by a sense of loyalty to their communities. However, while the medical interpreting field is at an early stage of development in South African settings, this may not be an appropriate platform from which to base the development of professional practice guidelines and negotiate entry into health care institutions. The work of interpreting and the work of addressing racism in health care are too important to conflate in a way that may risk the integrity of both.

Multi-disciplinary teams and psychiatry

Much of the work of psychiatry is performed in multi-disciplinary teams. The implications of some of the features of advocacy as described above may present particular problems in psychiatric settings. In a review of team dynamics in mental health settings, Yank, Barber, Hargrove & Whitt (1992), list features of dysfunctional teams. These include role confusion, competition for authority, conflict or uncertainty over the team's tasks, treatment philosophies, models of care, and inadequate leadership. The potential for divisiveness if an inappropriate style of patient advocacy was adopted by a low status member is obvious. Two other sources of conflict may arise that are relevant here. Team values and beliefs must be sufficiently congruent with those of the parent or umbrella organisation if cohesion is to be maintained. Further, the external supervision and lines of authority of the team of professionals welded together must also sufficiently support 'team functions', as opposed to 'profession-specific functions', if functionality is to be maintained. The complex dynamics within teams, and particularly in teams that work in psychiatric settings (Mohr, 1995; Toseland, Palmer-Ganeles & Chapman, 1986), do not appear to have been considered in the current conceptualising of the role of advocate for interpreters. Conflicts between medical professions and others, like social work, with quite different ethos can be managed, if not resolved, in teamwork (Mizrahi & Abramson, 1985). Much may be learnt from the older professions in dealing with these issues, but a covert agenda in this process is doomed to result in a short-lived collaboration.

It is also important to consider that psychotherapeutic interviews are a sophistication of generic clinical interviewing skills. There are a number of types of therapies that may be performed in mental health care settings, each of which may require different skills and styles from interpreters. Raval (1996) elicited a range of advantages and limitations to work with interpreters from clinicians who were engaged in family therapy. His realistic appraisal acknowledges that no work would be possible at all without the interpreters, but that a number of the aspects of therapeutic encounters taken for granted in interactions between same language speakers were absent or distorted in interpreter-mediated therapy. Bradford & Munoz (1993) have considered a number of the issues confronting therapists and interpreters when trying to work psychodynamically in individual psychotherapy. I will not expand on this complex area of interpreting further here. Suffice it to say that psychotherapy is a complicated communicative act between two parties at the best of times and the addition of a third party increases this exponentially. Models of interpreter technique require careful consideration in psychotherapeutic contexts[10]. Fortuny & Mullaney (1998) have drawn attention to the complexity of performing neuropsychological tests with the assistance of an interpreter. This aspect of professional specialisation also requires attention in local contexts.

Having considered a range of theoretical and practical issues in relation to interpreting in other settings, I will now review the existing research on interpreting in medical and psychiatric settings in South Africa.

LANGUAGE, LANGUAGE POLICY AND HEALTH CARE IN SOUTH AFRICA

Even though South Africa has always been a multi-lingual society this has not been reflected in national policies or in health care institutions. In the late nineteenth century it was Afrikaans, ironically from the perspective of 1998, that was to struggle with having the status of an official language with inferior social standing. Marks (1994) in her history of nursing in South Africa points out that as early as 1889 there were clashes between English-speaking nurses and administrations which insisted on a degree of proficiency in the Dutch language, later to become Afrikaans. She also observes that no one insisted that a black language be

[10] See Amati-Mehler, Argentieri & Canestri (1993) for a review of the issue of bilingualism in psychoanalytic treatment.

learnt. From 1948 proficiency in English and Afrikaans has been a requirement of state employees, although in practice a degree of proficiency in one language was usually sufficient for a professional person. As a consequence, interpreting from black African languages for doctors and other professionals in state service has always been an aspect of the health system (Campbell, 1961, 1994).

In a recent analysis of archival records from around the turn of the century, S. Swartz (1996a) described the historical origins of colonial psychiatry as they manifested in particular institutional practices and texts at Valkenberg Hospital, a psychiatric hospital in Cape Town. Through an examination of hospital records, she was able to show the discursive production of a homogenised black population through the suppression of linguistic, cultural and social diversity. Simultaneously, however, the black patients of the hospital were identified as distinct from their white counterparts.

> *"To textualise the Cape insane as homogeneous, and at the same time to develop institutional practices which divided groups according to racial and gender classification, was the central feature of the emerging colonial psychiatry"* (p. 155).

The restricted range of diagnostic categories employed by the doctors at the time and the paucity of information in documents regarding black patients is attributed in a large degree to the monolingualism of the doctors. Armed with a small number of diagnostic labels, but without any significant engagement with the patient's personal and social background, the clinician could construct the black patient as "known" to have a disorder or particular "habits". The patient, however, remained profoundly unknown and unknowable as a social being. It is in the context of these forms of social engagement that the use of interpreters in South Africa has developed.

LOCAL RESEARCH ON INTERPRETING IN HEALTH CARE

Wood (1993) reviewed the literature on interpreting in medical settings in order to summarise and make accessible to local practitioners the main guidelines to work with interpreters. Interpreting services in institutions are most frequently referred to as *ad hoc* (Drennan, 1996a; Ngqakayi, 1994; Swartz, 1992b). This is most certainly the case, as a lack of organisation predominantly characterises the interpreting landscape. Interpreting in health care is often performed by family members, clerks and fellow patients. However, Drennan (in press-b) has drawn attention to the informal organisation of interpreting that may be masked by the lack of

overt structure. A number of recent studies have attempted to describe the way in which existing interpreting needs are met in health care, although not all have had interpreting as a primary focus in the research. These will be reviewed here to highlight: sources of data; the ways in which health care institutions have evolved to cope with linguistic diversity; and the implications for doctor-patient relations and inter-professional relations.

The majority of studies have employed interview methodologies to examine the interpreter issue. Interviews have been with service providers (Buthelezi, 1992; Hobson, 1996) and two have interviewed patients as to their perceptions (Crawford, 1994; de Villiers, 1993)[11]. Smit (1997) used structured questionnaires to gather data. Two studies have analysed transcripts of interpreter-mediated interviews (Buthelezi, 1992; Muller, 1994), and one drew data from attendance at ward rounds where interpreter-mediated interviews were conducted (Swartz, 1989, 1991b). This latter study and de Villiers (1993) included ethnographic dimensions to data gathering but both referred to language in the context of broader foci, without focusing on language per se. The methodological issues are important here as there may be substantial differences between what service providers and interpreters say they do and what they actually do (see for instance Dowling, 1992, 1995), but this has not received attention locally. The situation of language issues in overall service provision structures is also a neglected area. Most researchers have examined general medical settings, with Swartz and Muller as exceptions through their focus on psychiatric contexts. These factors, and the relative paucity of information on how patients in local settings respond to interpreting, illustrate the enormous gaps in our knowledge base at present.

Buthelezi (1992, 1996) focused her interview-based data on nurses providing interpreting across a range of departments in a large Kwazulu-Natal hospital. The analysis of the data from this study was organised according to the roles that the nurses saw themselves fulfilling as interpreters: translating, interpreting, explaining, advocating. Explaining was used to describe aspects of medical education, which would often take place outside of actual interpreting contexts. When nurses edited either doctor or patient statements to conceal negative attitudes to each other this was seen as advocacy. So too was "junior clinician" work

[11] Crawford (1994) interviewed patients in Xhosa, whereas de Villiers (1993) interviewed in English and Afrikaans.

and attempting to elicit information on attendance at traditional healers. Nurses' communication styles were described as formal, semi-formal or patronising when the nurses were perceived to be over-controlling. Ten audio-taped doctor-patient interviews using nurses as interpreters were also analysed briefly. The analysis is largely descriptive and in terms of established categories. However, aspects of the organisational structure of health care around language can be seen in such statements as:

> *"...though doctors and patients in this study are of different cultural and racial groups, the nurses appeared to be in control"* (1992, p. 106).

Nurses are primarily responsible for meeting patients' health care needs outside of consultations with doctors and this carries over into the consultation. While Buthelezi does not use the term "junior clinician" for nurses, this would appear to best describe what takes place.

> *"Advocacy is inherent in the nurse's role of representing the patient; in that the patient at no time speaks directly to the doctor. Everything the patient says is listened to, translated and interpreted by the nurse. The nurse filters out what she thinks is not conducive to help by the doctor"* (1992, p. 100).

And further,

> *"...the nurses in this study generally reported their findings in summary form and the doctor would delve further if there was a need"* (1992, p. 103).

Buthelezi describes the extent of the nurse's control as influenced by seniority and qualification, confirming an impression that interpreted interviews were a loose form of supervision of the nurses' primary clinical work. Not all doctors it seems appreciated the nurses' attempts to process the patient's complaints in this way. It is easy to see how, in this context, interpreting can be seen to fall within the ambit of nurses' work.

The description of how nurses mediate for patients in biomedical environments by Buthelezi is similar to that of de Villiers (1993). In a medical anthropological study of a hospital in the Eastern Cape, she describes how nurses routinely interpret for doctors but that this is embedded in an over-arching involvement with patients.

> *"Consequently the nurses are frequently called upon to assist Xhosa-speaking patients to orientate themselves in the hospital, to interpret and thus to facilitate communication, to explain medical procedures, to deal with fears and insecurities, and to transmit messages between patients and kin in the township"* (p. 271).

De Villiers calls this direct and indirect interpreting and suggests that this is part of being a culture broker for patients. This gives rise to a primary connection between the nurse and

patient and a secondary consultative function on the part of the doctors in this setting. This contributes to the 'naturalising' of the distance between doctors and patients of different ethnic groups. One doctor interviewed by de Villiers believed that nuances of communication were missed through interpretation, but that this was not significant as Xhosa-speaking patients were:

> *"...less dependent upon a doctor for emotional and psychological support than white patients, and they are therefore, less inclined to transmit subtle messages through nuances"* (1993, p. 229).

The social organisation of the system of care in place in the setting described by de Villiers creates the impression of a seamless and unproblematic arrangement. The style of mediating for Xhosa-speaking patients adopted by the nurses perhaps for a range of reasons may serve to maintain social distance.

Crawford's (1994) study in the Western Cape found greater levels of dissatisfaction with the organisation of health care around language issues. Crawford (1994) also interviewed medical doctors and nurses[12]. In is important to note that Crawford (1994) found that day hospitals or primary health care clinics were more organised for interpreting needs than academic or tertiary settings. This was perhaps through their location in the community and the sheer weight of numbers requiring interpreting. Clinic routines had been adapted to allocate nurses or nursing assistants to particular doctors to work as interpreters. Respondents approximated that up to 80% of the nurse's time was spent interpreting, although this was not corroborated by independent data gathering. The negative aspect to this organisation is in what appears to be the open exploitation of nurses as interpreters. Academic hospitals did not show this degree of organisation and the resulting situation for interpreting was far more chaotic. By virtue of the structure given to meeting interpreting needs in the clinics, doctors interviewed there were able to identify problems in the system of using nurses as interpreters, and similarly the dissatisfaction of the nurse interpreters could be explored. From the point of view of the expertise of the interpreters, doctors complained of reductive summaries in interpreting and moralistic and prescriptive attitudes expressed by the nurse interpreters. Cultural differences between the patients and doctors were another feature. It is important to note that all of these concerns were informed by the pressure of time on the nature of the

[12] Crawford (1994) is exceptional, along with de Villiers', in that she was able to interview patients as to their experiences with interpreting in medical encounters but did not report on these finding in this paper.

clinical encounter. The pressure generated by functioning under massive time constraints was the justification by nurses of the conflict with doctors over summarising patient statements. The nurse interpreters also expressed feelings of inadequacy when translating certain dialects of the local language (Xhosa) and the lack of terminology. The main complaints regarding being used as interpreters involved the emotional burden of interpreting and the lack of recognition, pay and status for this. Survival in a demanding service delivery context appears to be an important dimension informing the nature of the interpreting provided.

Hobson (1996) also used interview methods to elicit information from doctors and a range of people serving as interpreters on their experiences. This study included data from state hospitals, as is the norm in local research, but added important information on doctors working in private practice settings in areas that are predominantly populated by Xhosa-speakers. Significantly, private practice settings were as unsatisfactory as state hospital work. Doctors described how they would use patients from the waiting room and a secretary was employed with bilingualism as a job prerequisite. Hobson analysed her interview data in terms of two categories affecting interpreting: linguistic and extra-linguistic. The extra-linguistic factors were fundamentally informed by the informal arrangements available to meet interpreting needs. Hence, Hobson lists seven elements that a doctor would seek in an interpreter, ranging from linguistic ability to personality, but the most decisive factor in the choice of interpreter was availability. Clearly, ideal factors in the choice of an interpreter take second place to pragmatic considerations. The linguistic factors involved the way in which nurse-interpreters describe managing the complexity of communication in an interview, the lack of terminology, and the problems of metaphor and taboo areas. It is interesting to note that nurses reported more difficulty in translating Xhosa concepts into English than the other way around. Buthelezi's (1992) subjects reported a similar difficulty[13].

Smit (1997) conducted research on language needs at an East Rand hospital in Gauteng. The research was, like that of Hobson, conducted towards a post-graduate degree in Applied Linguistics. Smit's study was focused on the initial stages of a language planning approach, namely situation analysis. Smit requested doctors, speech therapists, pharmacists and nurses to complete questionnaires on a wide range of topics related to language planning. Thus data

[13] Current terminology development initiatives in the health care area are focused on terminology development in African languages (Jooste, 1997).

were gathered on various aspects of the language demographics of the staff and patient population. Both these groups show a wide spread of languages. This is particularly important in Gauteng, where language demographics are typical of a large urban commercial capital (Mansour, 1993). For example, there were mother tongue speakers amongst the nursing staff of six African languages over and above Afrikaans. Unfortunately, the language profile of the other professional staff was as poorly representative of the general population as elsewhere in the country, with only one of 55 able to speak a black African language. A strength of this study can be found in its attempt to go beyond merely describing the current language situation in the hospital studied, to asking respondents for their opinions on possible solutions to the language problems. So respondents were asked whom they thought should interpret and what should be included in interpreter training. Of 56 respondents from the medical, speech therapy and pharmacy departments, 84% thought nurses should be trained as interpreters, 25% indicated that cleaners should be interpreters and only 9% saw a need for professional interpreters to be employed. It is striking that fewer than half of the 86 nurses who responded (48%) expressed a willingness to be trained as interpreters. Only 14% of respondents thought that additional training in languages was necessary for interpreters, but 80% wanted training in medical terms to be included.

An area in which the methodology of Smit's study placed limitations on the data was that the questionnaires asked respondents to approximate the proportion of patients who require interpreting. Similarly, respondents had to answer in terms of yes or no whether communication through the interpreters they used was successful. The importance of ethnographic data to enrich the description of the language dispensation is highlighted through this. Following the features presented in published papers on problematic interpreting (Vasquez & Javier, 1991), Smit required of respondents to say whether interpreters provided summaries and elaborations of what patients said. The author was surprised to note that small percentages of the respondents were opposed to interpreters using their discretion in this regard. In spite of the preferences expressed by respondents from the professional staff to have nurses act as interpreters, Smit concludes that nurses should only be used to interpret as a short-term strategy. She argues that interpreters should be appointed who have been trained as medical interpreters, suggesting the National Language Project model (Ntshona, 1997) of employing bilingual matriculants.

Swartz (1989, 1991b) has situated the interpreter issue in the context of discourses of race and culture in psychiatry in South Africa. Ritualised introductions to interviews demonstrated the subordination of the position of interpreter in ward rounds, even when the interpreter was a clinician. Nurse interpreters subverted this subordination through 'acts of resistance', which may be as simple as deviating from instructions on how to start any given interview. By conceptualising such acts as resistance, Swartz draws attention to the expression of power dynamics in clinical settings but without suggesting that these manoeuvres be elevated to the level of technique. Muller (1994), in a wide-ranging study based on the detailed transcript of a single interpreter-mediated interview, has shown how clinical pressures compel interpreters to manage and control interviews in ways that contradict accepted standards of practice in other settings. The analysis uses ethnomethodological principles to show that all of the 'errors' identified by Vasquez & Javier (1991) appeared in the interview but that these served to expedite the work of the interview. This demonstrates how the routinised cultural and biomedical accomplishments of the interpreter are made consistent with clinical and institutional objectives. Thus, institutional imperatives to 'manage' patients efficiently (Fisher & Todd, 1986; Mizrahi, 1987; Rhodes, 1991) are as powerful in shaping interpreter discourse as they are in shaping psychiatric discourse.

Swartz, Drennan & Crawford (1997) organised the seemingly chaotic interpreter landscape in health care into two basic models of provision. The "add-on" model describes approaches that recommend the appointment of interpreters in health care settings, which could take the form of the three-tiered approach outlined by Carr (1997) and Fortier (1997). The current practice when appointing designated interpreters in local contexts has been to hire someone at the organisational level of a cleaner. This places serious constraints on the expertise available and limits the extent to which the more ambitious expectations regarding advocacy and culture brokerage described above may be met. The "add-in" model is used to describe approaches that would have existing staff formally include interpreting into their duties. This may involve nurses at best but may also include other categories, such as cleaner. The addition of interpreting to nurses' work would address a number of problems regarding expertise, training and logistics simultaneously. There is a parsimony to this model in organisational and financial terms that potentially has great appeal. The development of the "add-in" model would also not exclude supplementing services with an "add-on" approach where necessary. However, the absence of any attempts by government to put the question to nurses as to whether they want the task of interpreting to be formalised is quite striking. If

this question were to be put to nurses, there is a substantial risk that the current taken-for-granted use/exploitation of nurses could collapse. A decision to refuse the responsibility in spite of incentives has the potential to paralyse the health care system as it stands today.

In the face of advantages and disadvantages in both the "add-in" and "add-on" models, Swartz et al. (1997) suggest taking a broader view in the form of a cultural change model. Rather than seeing the language issue as a technical problem to be resolved by tacking on interpreters, they suggest that it presents an opportunity to re-vision the provision of mental health services more dramatically. Key aspects of this model would involve confronting the way in which institutional structures and procedures are shot through with apartheid inequalities and alienation, how the training and professional socialisation of service providers maintain such systems, and how these factors constellate around the language issue. This process would imply the initiation of change in institutional identities. This is dealt with in the following section.

RACE, LANGUAGE AND INSTITUTIONAL CHANGE IN HEALTH CARE

Invoking a notion of cultural change in South Africa may sound little more than a *cliché*. Much has changed in a relatively short period of time both within and outside of health care institutions. However, the concern expressed at the start of this discussion in relation to the homogenising influence of nationalism, is perhaps even more applicable in biomedical and psychiatric settings. These disciplines are to a great extent predicated on the capacity to universalise and decontextualise human experience. While this capacity is in many respects a strength in terms of conceptual clarification, this has been a source of limitations in service delivery and in the recognition of institutional racism. Universalising approaches to health care have been noted to give rise to "colour blind" or assimilationist service delivery (Padilla et al., 1991). Howitt & Owusu-Bempah (1994) list colour-blind strategies and decontextualisation amongst manoeuvres made by institutions to take a 'business as usual' approach to the problem of racism.

In Britain discussion regarding the route towards institutional change on the issue of racism has centred on the debate over "ethnic sensitivity" in health care or "anti-racism". Both these frameworks attempt to move beyond "colour-blind" approaches or assimilationist policies. Approaches to "ethnic sensitivity" emphasise multi-culturalism through training service

providers to recognise and understand cultural differences in clients presenting for treatment (MacLachlan, 1997). Stubbs (1993) summarises the scepticism about the ethnic sensitivity approach as a skewing of priorities in particular ways. Firstly, an emphasis on the culturally "other" highlights the exotic in non-western traditions. Thus, essentialist notions of culture can be propagated though stereotypes and over-simplified cultural identities. Secondly, colonialist agendas in relation to normative lifestyle choices can be the focus of health education programmes informed by the framework. Thirdly, an over-emphasis on link workers and interpreters as the means by which to improve services for minorities in Britain is "based on a benevolent model of health service provision in which the solutions to problems are essentially technical and professional rather than political" (Stubbs, 1993, p. 40). This is similar to arguments advanced by the interactionist approach outlined above. However, there is scepticism as to the capacity of interpreters to mediate communication and avoid the reproduction of particular social relations, just as is the case with medical professionals.

Anti-racist perspectives take racism and not culture as their starting point (Stubbs, 1993). Three inter-related levels reflect racialised inequalities: interpersonal, institutional, societal/structural. What a focus on racism adds to the analysis of health care is direct links between societal levels of discrimination and institutional practices. Issues to do with representative employment and training are also foregrounded (Howitt & Owusu-Bempah, 1994). Differential forms of social control in the society at large are also seen to penetrate organisations, or even require them to materialise relations of subordination and surveillance (Law, 1996). While anti-racism also has its own conceptual and ideological pitfalls, it tries to address the shortcomings of the "ethnic sensitivity" approach listed above. Law (1996) points out that research informed by an anti-racist agenda has failed to pinpoint racially discriminatory practice. The question of whether language services in South African health care settings materialise discrimination and institutional racism will be a central focus of the analysis of the data presented below.

The terms of initiatives in health care in the USA appear to be less contentious, and "cultural competence" has emerged as the primary descriptor. The all-inclusiveness of how cultural competence is conceptualised appears to transcend the terms of the debate in Britain by incorporating the strengths of both approaches. Roizner (1996) describes cultural competence in mental health care as addressing the impact of racism, discrimination, immigration, and

poverty on the users of mental health care facilities. Attention is paid to adapting services to accommodate differences in how families are structured, what clients expect, client preferences, help-seeking behaviour, and world-views. The elimination of geographic, linguistic, and other barriers that restrict access to services by clients of diverse ethnic and cultural backgrounds is a priority. On-going cultural competence training for service providers is a key component.

The cultural competence paradigm has given rise to assessment tools that examine organisations in terms of existing conditions and operating procedures to make recommendations for improved services to ethnically and culturally diverse consumers. Giachello (1995) refers to a continuum of organisational cultural competence, starting at the negative pole with "cultural destructiveness". Apartheid institutions would typify this type. This is followed by "cultural incompetence" illustrated when particular groups are given subtle messages that they are not welcome or that less is expected of them. "Cultural blindness" claims to be neutral middle ground. In practice such institutions encourage the assimilation of the culturally different into the mainstream. Aspects of how psychiatric hospitals have been integrated in South Africa reflect an attempt to portray this (See Drennan, in press-b; Swartz et al., 1997). "Cultural precompetence" is next on the continuum. Here tokenism is a possible pitfall. Aspects of how interpreters are being employed in local Western Cape hospitals suggest this and will be taken up in what follows. This is followed by "basic cultural competence" and "advanced cultural competence". The markers of development serve as starting points for changing the culture or identity of an organisation.

The cultural change model put forward by Swartz et al. (1997) arose out of a sustained and intense engagement with language issues in mental health. They comment on the pressure to subsume this focus into a more broadly cultural focus. However, I would argue that what would be lost in this slippage between language and culture is the difference between the so-called 'language gap' and the 'cultural gap'. Aspects of the discourse around interpreter services can be used to illustrate what I mean by distinguishing between a language gap and a cultural gap. Much of the discussion on the subject of interpreter roles, in particular culture brokerage and advocacy, appear to assume that these are inevitable and immutable dimensions to an interpreter's work. In situations where health service providers are in regular and sustained contact with particular cultural groups, as they are in South Africa, it is not unreasonable to expect that practitioners should learn about the cultures in question. Of

course practitioners do not learn or do not learn enough and this needs to be addressed at the multiple levels described above in the anti-racist paradigm. However, to formalise certain interpreter roles around culture brokerage and advocacy is potentially collusive with this resistance to learning and tantamount to institutionalising otherness.

Here I wish to return briefly to the enduring value of Kleinman's (1980) explanatory models approach. Kleinman's approach could be characterised as placing too much emphasis on cultural aspects to clinical work. However, it could also be seen to address a training issue in so far as it has the potential to inculcate, from an early stage of professional development, a curiosity and willingness to engage with the cultural frameworks of patients. The emphasis on the particularity of each patient's explanatory model in terms of how they make use of the cultural material available to them may assist in avoiding essentialist and reified notions of culture. A rigorous and sophisticated grasp of how to work with an interpreter to elicit each patient's explanatory model would be a cornerstone of such a project. The argument advanced by critics like Scheper-Hughes (1990) that structural changes do not come about through individual doctors communicating better with their patients notwithstanding. It is also true that white patients do not depend on the munificence of individual practitioners to get the same deal as other service users. However, this is not to say that caring individual practitioners in bureaucratic systems do not make a difference.

In this chapter I have situated language issues in health care in a broader socio-political framework. I have also discussed language issues in relation to institutional racism both locally and abroad. Of the many roles that interpreters may assume in health care settings, I have examined the terms of a debate regarding advocacy in interpreting. The choice of this focus was prompted by the currency that political activism has in South Africa and the problems that interpreter services face in getting established as part of formalised health care services. Both these considerations may present particular problems in a South African context that does not make for the smooth importation of models developed elsewhere. Language services are a significant aspect of non-racist health care, but it is important to recognise that these services must be framed by an over-arching process of transforming health care services following the apartheid era. The full extent of the transformation that is necessary and the institutional reality of the language gap in South African settings will be described in what follows.

Chapter 3

METHODOLOGY AND RESEARCH STRUCTURE

Introduction

The impetus for the research to be described in this thesis came from my wish to move beyond the anecdotal information available in 1993 on interpreting in South African settings, and to do this initially through an investigation of the institution in which I worked. There were a number of parameters that were of interest, such as the frequency of interpreter-mediated interviews, who was providing the interpreting, and how often an interpreter service was unavailable. The research was thus fundamentally informed by a practical intention to create information that would be of assistance in developing language resources in institutions in three ways. Firstly, through describing the extent and magnitude of the problem, I hoped to raise awareness within institutions but also amongst policy makers. Therefore, implicit in this description would be indications as to how the problem could be addressed. A third more ambitious aim was to identify obstacles to addressing the situation, whether they be practical, institutional or social. These aspects formed a type of needs analysis in the context of linguistic diversity for a particular institution. Approaching the issue of linguistic diversity in this way meant treating language as a form of institutional resource in the performance of its work. In other words, reifying language as a technology or an object. Of course, this involves the sleight of hand referred to in Chapter 1, in that it is bilingual and trilingual people who are the institutional resource. However, the process of identifying who the interpreters are was precisely one of the questions that I sought to investigate. By tracking the appearance of the activity of interpreting, I intended to identify the elusive interpreters.

As the research progressed to asking the same questions at another hospital in the same metropolitan region, it became clear that a description of the context within which interpreting took place was of paramount importance, if one was to understand interpreting. This resulted in the addition of interviews with hospital staff in order to clarify the context of the use or otherwise of an interpreter. Through these interviews it became clear that the context of the use of interpreters was not only the availability of bilingual staff, but included contextual features as diverse as local norms regarding psychiatric practice, the history of the institutions,

and socio-political influences. As interviews are limited in the degree to which they can clarify these issues, it emerged that the methods of medical ethnography were necessary to provide sufficient breadth to the types of factors considered. Before situating this study in relation to medical ethnographies, it is necessary to consider the way in which I use the concept of language and its relation to discourse.

DISCOURSE AND INSTITUTIONAL SETTINGS

> *"Institutions create shadowed places in which nothing can be seen and no questions asked. They make other areas show finely discriminated detail, which is closely scrutinized and ordered. History emerges in an unintended shape as a result of practices directed to immediate, practical ends. To watch these practices establish selective principles that highlight some kinds of events and obscure others is to inspect the social order operating on individual minds"* (Douglas, 1986, p. 69-70).

The examination of language in the discourse analysis paradigm is a useful method for the study of institutions and how they create places of light and shadow. Discourse analysis adopts a particular approach to language. Firstly, language is not seen as a transparent medium through which communications about a single underlying reality are accomplished. Language itself is understood to shape accounts of reality that can come into being through social actors drawing on the available "interpretative repertoires". Discourse analysis "denaturalises" language to show how particular accounts come into being and not others, but it also indicates the consequences of the use of particular repertoires and the purposes that these constructions may serve (Marshall, 1994). In this formulation language itself is a form of social practice, embedded in society and conditioned by the forms that society takes. This is, however, a dialectical relationship as language also conditions social phenomena (Fairclough, 1989). This approach to language and language practices is particularly relevant in the study of institutions as it situates institutional practices in a network of societal discursive practices.

A further contribution to the study of institutions made by a discourse analytical approach arises through a shift in the unit of analysis (Marshall, 1994). Instead of examining institutional practices from the perspective of the individual, it seeks to identify regularities and recurring patterns, not only across individuals, but across contexts and circumstances. Discourse analysis eschews a focus on what individuals may have meant or intended, a subjectivist analysis, for a focus on overarching culturally and historically embedded

discursive products. Mumby & Clair (1997) identify two approaches in research on organisations. The first is an approach that seeks to identify social patterns in these settings that is more traditionally anthropological in its interest in metaphor, ritual, storytelling, and generally the production of shared meaning. This they refer to as a cultural or interpretative approach. The second, a discourse analytical approach, they characterise as "critical organisation discourse analysis" in that issues of power, control and ideology are overtly considered. This considers not only the production of shared meanings but that the production of meaning is a site of struggle to shape the social reality of the organisation[1].

Van Dijk (1993) describes discourse analysis at both a surface level of institutional texts, and in terms of "deep structure", the underlying discourses that are seen to shape everyday interaction, talk and texts in institutions. Mumby & Clair (1997) argue for parallel levels in the analysis of relations of power and inequality in organisations. Fundamental to discourse analysis is the theoretical contribution of Foucault's (1980, 1982) "new economy of power relations", and the contribution of Gramsci with regards to hegemony (Lears, 1985). Clegg (1994) has outlined the Foucauldian contribution to the analysis of organisations in terms of the key concepts of power, values, rules and discretion. He argues that professional training is an important avenue for the inculcation of a dominant set of professional values and rules. The discipline of particular modes of practice is internalised, creating a "synaptic regime of power", controlling from within the social body, not from above it (Foucault, 1980). Control is not total, nor is it necessarily coercive. It operates through consent. Contradiction and resistance are, however, features of the institutional economy of power relations because there is always a gap created by the agency of the subject.

For Foucault members of social institutions are not passive, bureaucratic robots acting in conformity to institutional rules; nor are they free agents whose actions mean nothing more than their intentions. At the micro-level, individual acts expressive of agency are intentional and planned, but only in a sense that is limited to the particular context of their occurrence. Discourse analysis requires a shift from this micro-level intentionality, to macro-level products. At a macro-level of analysis, individual expressions of power or resistance are aggregated to form a "global strategy", they "sum together vectorially; they have an overall

[1] Yet another perspective on the relation between institutional and individual levels of explanation is developing in the psychoanalytic tradition (Czander, 1993; de Vries, 1991; Menzies Lyth, 1988; Obholzer & Zagier Roberts, 1994).

direction" (Krips, 1990, p.175). Thus, individual acts, whatever the local intentions of the actor, can reproduce dominant discourses or forms of resistance. Knorr-Cetina (1981) warns against assuming that the discursive products arise as a result of an aggregation of instances (the aggregation hypothesis) or as a result of unforeseen consequences (the unintended consequences hypothesis), but rather that the macro-order resides within micro-episodes. This shift, however, between individual actions, micro-episodes, and macro-issues in the identification of discourses and discursive products is not unproblematic in practice (Fisher & Todd, 1986; Knorr-Cetina & Cicourel, 1981). As I will show, the articulation of racist discourses in local clinical settings is fraught with the potential for explanatory models that do not do justice to the complexity of discourses in institutions.

Burman, Levett, Kottler & Parker (1997) acknowledge that a challenge to the application of discourse analysis in South Africa lies in how well it will travel. Discourse analysis has developed in "monolingual contexts" (p. 9) like the UK and so there is not a great deal of experience in applying it to situations of linguistic diversity. This complication is immediately evident in relation to the double distanciation (to borrow from Riceour) of users of psychiatric services who do not share a professional language with practitioners, but who also do not share a language of everyday communication. At the interpersonal level (Swartz, 1998), this involves the issue of language or languages, and the role of interpreting in the production of meaning for both parties in such exchanges. At the institutional and socio-political level, this involves the issue of linguistic diversity. At this level of analysis the role of interpreting is that of an institutional resource or technology. This study will be concerned with the types of meanings that come into being in interpreter-mediated interviews, but also with the institutional implications of who has access to interpreting and under what circumstances. The data for the analytical approach described above will be gathered through a range of strategies I will subsume under the rubric of ethnography.

ETHNOGRAPHIC METHODS IN BIOMEDICAL INSTITUTIONAL CONTEXTS

Kuipers (1989) has identified three traditions in research on medical discourse, each underpinned by a meta-theory of language. The first is largely referential and lacks an account of how ideology and interaction work together to produce meanings in medical settings. The second, arising out of Foucauldian approaches, examines the social and ideological dimensions of biomedical practice but relies on "decentred texts", thus neglecting to employ grounded contextualised discourse. The third approach examines medical

discourse as situated interaction. These studies often involve conversation analysis and are criticised for lacking generalisability and a limited consideration of macroscopic issues of ideology and power (Kuipers acknowledges notable exceptions to this typology). In so far as the paper is a call for a regrouping of research initiatives, Kuipers suggests a concerted effort to produce studies that are a combination of the second and third approaches. He quotes Atkinson (1988) in a request for "relevant ethnographies" that incorporate multiple institutional contexts. In this way medical discourse can be "entextualised", augmenting micro-analysed individual interviews with the details of institutional and social context, functioning in dialectical relation to each other. MacCormack (1994), in a broad overview of ethnography's historical and conceptual contribution to the study of medical sciences, is also optimistic that ethnographic studies can guide us through the micro-and macro-political aspects of providing health services. Lazarus (1988) makes the important point that ethnographies of medical settings can also include in their analyses the intermediate-level of the conditions within particular institutions.

In an example of such a study of medical interpreting, O'Neil (1989) video-taped clinical interviews opportunistically over a one year period, attended and video-recorded local and regional health policy meetings, interviewed doctors, nurses, interpreters and administrators, and conducted an archival review of newspaper articles and public documents. The political and social factors relevant to patient satisfaction were then subjected to a multi-level analysis.

Ethnographies of psychiatric settings such as those by Barrett (1996) and Rhodes (1991) are more extensive than the focus here, but I will draw on their emphasis on the contextualisation of biomedical practice in institutional settings. These works demonstrate the paradoxes and "discretion" (Clegg, 1994) in the identities of biomedical institutions and the clinicians that work within them. There is increasing recognition that focused ethnographies in health care contexts, while not as wide-ranging, are valuable in their own right (Rhodes, 1993c). While the principles of ethnography informed the data gathering in the study described in Chapter 6, these were adapted along the lines described in the rapid assessment techniques (Manderson & Aaby, 1992; Pelto & Pelto, 1997; Shawyer, Sani Bin Gani, Punufimana & Seuseu, 1996). Rapid assessment techniques utilise the strengths of ethnography such as multiple sources of data and flexible adaptation to particular conditions (Hammersley, 1992). They have been developed to evaluate programmes in areas where funding, time and personnel resources are all in short supply. Clearly, a great deal may be lost in the haste with which they are

conducted. This is a trade-off with the speed at which results emerge. I relied upon my familiarity with the hospital setting, routines, procedures and clinical work to circumvent some of the compromise in spending less time (Manderson & Aaby, 1992). In this regard, the ethnographic method described here is what Hammersley (1992) has termed "practitioner ethnography". While not without disadvantages, practitioner ethnographies are seen to be valued as relevant to practice and strengthened in validity by the insider perspective.[2]

The question of the insider perspective is significant here. An important part of the ethnographic technique is the acknowledgement of the person of the ethnographer. I will make use of this perspective in two ways. One, conducting research in institutions of which I am a member, and a society of which I am a member, requires a consideration of how this informs the research and interpretative process (Cheater, 1987; Ngubane, 1991). Traditional psychoanalytic approaches in anthropology have been exposed as deeply problematic in post-modern anthropology (Ewing, 1992). However, psycho-analytic perspectives on reflexivity may have more to offer, particularly with reference to approaching clinical phenomena (Brody, 1981; Good, Herrera, Good & Cooper, 1985). Aspects of psychoanalytic thought have also been revived to assist in the conceptualisation of the ethnographer's experience in research. This draws not on psychoanalytic 'grand theory' but on the contribution of psychoanalytic approaches to understanding "experience-near" phenomena in relationships (Cohler, 1992). This will inform a second facet of reflexivity in the analysis that follows.

METHODOLOGY

The first in a series of three studies required clinicians working at a particular Western Cape psychiatric hospital to complete a brief questionnaire each time they either used someone as an interpreter or would have done so had someone been available. Thus, the questionnaires reflected both interviews that took place with an interpreter and interviews for which there was no interpreter. Under the latter circumstances the interview either proceeded without an interpreter or did not take place because there was no interpreter. This questionnaire study was repeated at another Western Cape psychiatric hospital, with the addition of a questionnaire for nursing staff to reflect their language service needs. This second questionnaire study did not sufficiently reflect the extent of the language needs of the

[2] The ethnographic components of the study could also be described under the general category of processual ethnography (rather than encyclopaedic ethnography), and particularly a cross-sectional ethnography of daily activities (Werner & Schoepfle, 1987).

institution and so a number of interviews with hospital staff were conducted to clarify this. For the third study I returned to the first hospital and conducted a focused ethnography of language at the institution. This study subsumed an evaluation of a programme to place two trained interpreters at the hospital, and made use of the same structured questionnaires employed in the first two studies and the semi-structured interviews employed in the second study. The methodological components of the three studies will be described here briefly but will be expanded upon in greater in the chapters describing the respective studies.

In overview, the developmental sequence in the research described above has resulted in an eclectic mix of quantitative and qualitative methodologies. The range of data types generated through the research seeks to address the multiple levels of the issue of language in psychiatric institutional contexts. All three studies have employed structured questionnaires. These yielded data that have been summarised in terms of descriptive statistics.

Research interviews have also been conducted with hospital staff using a key informant approach to identifying candidates for interview (Morse, 1992). The interviews were semi-structured as there were particular questions that I was pursuing in relation to interpreting, language problems in service provision, and the organisational structures to deal with these problems. However, the interviews were with diverse groups of involved people, ranging from consultant psychiatrists to nursing assistants and interpreters, and from English-speakers to Xhosa-speakers. This required considerable flexibility in interview structure in order to explore the differing perspectives and experiences of the interviewees (Gilchrist, 1992; King, 1994). In two of the three studies the qualitative data from interviews was used to augment the quantitative data from the questionnaires.

The focused ethnography of language undertaken at one of the hospitals involved interviews with hospital staff and interpreter project staff. Weekly statistics regarding the number of patients who required interpreting in each ward that the study took place were also gathered. Hospital folders of patients identified during the period of data collection were reviewed to track the role of language in the process of a hospital admission. I also attended multi-disciplinary team meetings in the relevant wards over the study period and documented discussions about patients and interviews with patients who required interpreting and others who did not.

The programme evaluation component of the third study involved a comparison with quantitative data from the 1993 study at the same hospital. This served as baseline data for the programme evaluation. The first study generated data on interpreter utilisation prior to the employment of a person to fulfil this specific function and overlaps with the period when a single untrained person was employed on a part-time basis by the hospital. A replication of this previous study provided data on a third contingency: the employment of two trained interpreters. A replication study therefore created a data series reflecting three forms of language service provision:

1. Informal service provision in the absence of an official interpreter.
2. Service provision with a single untrained interpreter.
3. Service provision with two trained interpreters.

I will now move onto Part II of the thesis in which I describe and interpret the results of the three studies in separate chapters.

PART II

RESULTS

Chapter 4

MAKING LANGUAGE VISIBLE IN INSTITUTIONAL SETTINGS – VALKENBERG HOSPITAL

UTILISATION AND NEEDS ASSESSMENT AT VALKENBERG HOSPITAL

This chapter describes the findings of an assessment of the utilisation of and need for interpreting at Valkenberg Hospital (VBH) and the psychiatric emergency service at a nearby general hospital. The study sought to make the interface between psychiatric services and the languages of the users of the services visible. This is presented here in terms of answers to three fundamental questions regarding language needs in the institution.

- Who provides interpreting?
- What types of psychiatric work are interpreters used for?
- How available are interpreting services?

The question of missing data is also addressed along with the qualitative features of the information gleaned from the questionnaires. This overview of the impact on service provision goes beyond the fragmentation of the anecdotal accounts of individuals, making the implications of linguistic diversity visible in a range of institutional contexts.

DESCRIPTION OF VALKENBERG HOSPITAL

Valkenberg Hospital is a Western Cape teaching hospital, and part of the University of Cape Town/Groote Schuur Hospital (GSH) complex. At the time of the study it was a 960 bed psychiatric facility serving the Cape Peninsula and coastal areas up to Knysna (a distance of 400 kms). The hospital has served as a psychiatric facility for over 100 years as it was initially opened to house white patients in 1891. It began to admit black patients in 1916, but they were housed separately across the Black River (S. Swartz, 1995). The 'white side' of the hospital was referred to as the Observatory side (because it neighboured on a suburb of that name) and the 'black side' was referred to as the Pinelands side (for the same reason). The forensic wards, and most notably, the imposing maximum security unit (built much later), were on the same side of the river as the wards for black patients. The wards for black patients were all double-storey Victorian buildings typical of asylums of that time. The

Observatory side used the Victorian buildings as closed wards[1]. A number of newer wards built in the 1980's were free-standing, single-storied buildings and served as open wards for white patients. The racial integration of the hospital began in 1991, when black patients were moved over to the respective units on the Observatory side. The old 'black side' continued as wards for forensic patients regardless of race.

The hospital admitted approximately 300 patients a month and was staffed by multi-disciplinary teams. The study took place in ten acute admission wards at VBH, and at the 24-hour emergency psychiatric service (C23), based at GSH, that triages patients for local psychiatric hospitals. Besides C23 at GSH, the other wards involved were parts of units at VBH. The Male Admission wards comprised three closed wards. The Female Admission wards comprised two closed wards. Both these units shared an open ward for patients prior to discharge. The Forensic Unit comprised two wards. An open ward for rehabilitating patients diagnosed with psychotic disorders, a psychotherapeutic ward for patients with non-psychotic disorders and a ward for geriatric patients were also included.

At the time of initiating the study there was no one employed as an interpreter by the hospital. After one month of the questionnaire study a part-time person was appointed. This development will be described in more detail below.

METHOD

This study was conducted on all week days in October and November 1993, a total of 43 working days, following a two-week pilot study in two wards.

The dimensions along which interpreter utilisation was measured were:

- the number of patients requiring an interpreter during their assessment and treatment;
- who was providing the interpreter service and to what extent were they available;
- how much time was involved;
- in what contexts the service was required;
- which languages were involved;
- the gender of the participants[2].

[1] The term 'closed ward' or 'locked ward' is used for wards that patients may not move freely in and out of.
[2] See Appendix 4 for Questionnaire 1.

Data were gathered through requesting service providers to complete a questionnaire each time they either used someone as an interpreter or would have chosen to use an interpreter were this service available. All categories of staff could complete questionnaires (e.g. nurses, cleaners and clerks) but information came primarily from consultant psychiatrists, psychiatric registrars[3], social workers (SW), psychologists, psychology interns[4] and occupational therapists (OT).

Following the completion of the questionnaire component of the study, patients identified as requiring interpreting were followed up through a review of their hospital folders. The number of interviews documented in the hospital folders were counted to ascertain as far as possible the number of interviews not documented through the questionnaires.

OVERVIEW

The bulk of the data presented here is drawn from four units: psychiatric emergency at GSH; Female Admission wards (FAWs) at VBH; Forensic Unit (FU) at VBH; Male Admission wards (MAWs) at VBH. Clinicians[5] in three other wards were asked to complete questionnaires but no interviews with speakers of black African languages were conducted during the study period. This is the first in a series of silences or gaps in questionnaire data that are an important aspect of the wider implications of the study.

Twenty nine clinical staff had used interpreter services during the time of the study and they returned 299 completed questionnaires. Through the questionnaires, 147 patients were documented as having required interpreting services. This constitutes between 20% and 30% of patients admitted to these units during the study period, depending on the ward. The bulk of this was for Xhosa-speaking patients, but a smattering of Afrikaans (2), Zulu (2), Sotho (3) and Tswana (1) speakers required interpreting.

[3] Psychiatrists in training.
[4] Psychologists in training.
[5] I use the term 'clinician' to refer to consultant psychiatrists, psychiatric registrars, social workers, psychologists, psychology interns and occupational therapists. This follows an implicit distinction made in this hospital between nurses and other mental health professionals. The term 'therapist' is also used to distinguish between the list of mental health professionals specified above and nurses. This hierarchical ordering of the mental health professionals, with nurses occupying the lowest rung, can be seen to exclude nurses' clinical and linguistic abilities in important ways. This is taken up in Chapter 9.

Table 4.1: Overview of the returned questionnaires.

	Respondents	Questionnaires	Patients requiring interpreting	Total Admissions	%
C23	4	80	53	268	20%
FAWs	6	71	20	108	19%
FU	12	31	17	55	-[6]
MAWs	7	117	57	200[7]	28%
TOTAL	29	299	147	631	

There were two wards included in the study that did not yield any questionnaires. The psychotherapeutic ward for non-psychotic patients and the open ward with its functions split between an acute admission ward for psychotic patients and a rehabilitation component. It is not insignificant that there were no returns from these units and this will be taken up later. The geriatric ward documented interviews with a patient from the former Yugoslavia, but who also spoke German. Coincidentally, three of the clinical staff members in the ward also spoke German and so communicated in this language and some English. Staff informed me that a Xhosa-speaking patient had been discharged from the geriatric unit shortly before the study began, but that there were no Xhosa-speakers during the study period. The presence of the Xhosa-speaker in the geriatric unit was remarkable as an exception rather than as an illustration of a routine difficulty encountered in the unit.

WHO ARE THE INTERPRETERS IN PSYCHIATRIC SERVICES?

The questionnaire specified twelve categories of person who may provide an interpreter function. The data from the questionnaires have been summarised into seven categories and represented here as a percentage of the number of interviews documented.

[6] There were 55 admissions to the FU during the study period. However, the FU houses long-term patients and acute admissions together and so the utilisation of interpreting was for both these groups. It would thus not be appropriate to specify the percentage of admissions requiring interpreting over the period of the study on the basis of this figure as some of the interpreted interviews took place with patients admitted before the start of the study.

[7] This is an estimate based on a review of the book that records admissions and patient transfers because there were no official figures available for these wards.

Table 4.2: Amount of interpreting (%).

Category	C23	FAWs	FU	MAWs (Oct)	MAWs (Nov)	Totals
Professional Nurse	34	50	53	81	46	52,8
Staff Nurse[8]	30	11	15	10	5	14
General Assistant	7	18	5	4	5	8,7
Student Nurse	-	14	-	-	9	4,9
Interpreter	-	-	-	-	31	5,1
Family	15	-	-	-	-	2,8
Other	11	7	27	5	2	10,7

Clearly, the bulk of the responsibility to provide interpreter services fell to the nursing staff (67%), with a definite preference for Professional Nurses (PN) as interpreters being expressed by clinicians. General assistants interpreted almost 10% of the time. The category of "other" provided 10,7% of the interpreting. Included in this category were a range of *ad hoc* solutions to the need for interpreting. There were instances of security staff and administration clerks interpreting. Patients were asked to interpret for their spouses or domestic partners in conjoint interviews. Visitors and strangers to the patient were asked to interpret. Psychotic patients interpreted in group settings. Respondents documented their dissatisfaction with these situations on the questionnaires. It was usually noted that they occurred when nursing staff were unavailable. However, Xhosa-speaking nursing staff were routinely expected to interview in Sotho or Tswana, and vice versa, namely that speakers of other African languages were asked to interpret in Xhosa. The category of "other", taken together with cleaners and family members, constitutes 22, 2% of the total interpreting for the study.

Overview of utilisation by unit

Psychiatric Emergency at Groote Schuur Hospital (C23)

The emergency unit at GSH is a 24-hour service that triages patients presenting for the first time before they are referred on to the appropriate hospital should in-patient treatment be required. At C23 total utilisation was 17,5 documented hours, with 10% of questionnaires missing data on the duration of the interview and only three documented instances of some interpreter being completely unavailable. The two categories of nursing staff, professional

[8] Nursing assistants in C23.

nurse and nursing assistant, accounted for 67,5% of the interviews. This included using a nursing sister from a nearby ward on one occasion. This nursing sister refused the second request for interpreting. There were five interviews in which the interpreter was coded as "other". The comments provided by the clinicians indicate that an administration clerk and a security guard were used. Two other instances involved the patients interpreting for their family members, as described above. There were no documented instances of interviews with fellow patients acting as interpreters. However, the following comment appeared on a questionnaire:

> *Initially thought interpreter was a family member, but turned out to be visiting another patient.*

Valkenberg Hospital

At VBH there was a total of 76 hours of interpreted interviews in the eight-week period.

Female Admission Wards

There was a total of 21,8 hours of interpreting in the FAWs[9]. This figure for the duration of interviews is drawn from only 51 interviews of the 75 returned questionnaires because of the number of interviews that did not take place. Professional nurses accounted for 53% of the interviews; GAs for 12% and student nurses for 12%. The latter two percentages are the highest for any unit. This is consistent with the shortage of Xhosa-speakers on the staff of this unit[10]. The average length of interview with a professional nurse was 24 minutes, while for the GAs this is 40 minutes. The greatest impact of the unavailability of a service was felt here where there was a delay in the interview in 40% of cases and 14 interviews did not take place at all. This partly reflects the fact that the "open" pre-discharge ward that the unit shared with the MAWs did not have a Xhosa-speaking staff member for one entire month of the study.

Forensic Unit

The two forensic wards used interpreters for 18,9 hours[11]. In spite of the comparatively low number of interviews in the unit (one week with no documented interviews), the total duration

[9] There was little missing data on the duration of interviews in this unit.
[10] See Appendix 5.
[11] This may be under-estimated by approximately five hours as eight questionnaires did not specify duration.

of use is similar to the other units because of the significantly longer interviews being conducted here. The average length of an interview with a PN was 50 minutes and that with a SN 55 minutes compared to 18 minutes (PN) in MAWs and 25 minutes (PN) in FAWs. "Others" here included nursing assistants, medical students, and nurse aids. Staff in the FU appear to make themselves very available for interpreting as, according to the returned questionnaires, there was no instance of an interview not taking place due to there being no interpreter[12].

The durations of interviews were longer in the FU and this may be attributed to the rigour of the psychiatric assessment expected. The consultant psychiatrists attached to the units are required to write detailed reports to the courts regarding patients referred for psychiatric observation. These reports must clearly state whether the patient is fit to stand trial and understand court procedures and whether mental illness played a role in the alleged offence. The psychiatrists are also often called upon to defend these assessments in a court of law under cross-examination. Under these circumstances much more care is taken with the details of the patient's mental state and the patient's account of the offence, symptoms and social circumstances. There is almost always a Xhosa-speaking nurse on duty for ward rounds[13]. The assessment arrived at as a result of the ward round case presentation and interview with the patient was the cornerstone of the process. It is important to note, however, that clinicians conducting interviews before the ward round had more haphazard access to interpreters. Staff with no psychiatric training, such as general assistants, were called upon to provide interpreting in these circumstances.

Patients admitted for observation following a criminal charge were interviewed by the hospital staff but also by "panel doctors", who were psychiatrists appointed by the courts as independent assessors. The bulk of the responsibility to complete questionnaires following interviews fell to the interviewing clinician. This was difficult to encourage with the panel doctors and so there were only three documented interviews with them. As there were 17

[12] There was one instance clearly documented in a patient's hospital folder of an interview being postponed for one day due to the unavailability of an interpreter.

[13] Ward rounds at this hospital took place once or twice a week and would involve all the members of the multi-disciplinary team and representatives of the nursing staff. At each ward round three to five patients would be 'presented'. A clinician or therapist would have prepared by interviewing the patient to be presented and taking a detailed psychiatric history, including a mental state, and arriving at a provisional diagnosis. All other relevant information, such as collateral from family members, blood tests, special investigations, etc. would also be

patients who required interpreting during the study the use of interpreters by panel doctors may be under-represented.

Male Admission Wards

There were 32,2 hours of interpreter utilisation documented in these units[14]. Professional nurses and staff nurses accounted for 72% of the interpreting over the period of two months. Nursing staff appeared to make themselves very available to requests for interpreting here. However, there were the most comments on the duration of wait from clinicians in these wards. The employment of the interpreter in November 1993 created an opportunity for comparison with the previous system and this will be discussed in more detail below.

WHAT ARE INTERPRETERS BEING USED FOR?

Interpreting was required most for psychiatric assessment interviews. A total of 247 assessment interviews were documented (81,6% of the total number of questionnaires returned). Family interviews (15); ward round interviews (14); group therapy sessions (9); and psychometric assessment interviews (2) accounted for an additional 13,4% of the rest of the documented instances of utilisation[15]. The remaining questionnaires indicated the category of "other" (12 instances) and were made up of requirements such as telephone collateral, explaining a lumbar puncture to a patient, discussion with a patient of transfer to another ward and a medical examination. It is not insignificant that on one questionnaire of the 299 returned the clinician had made a note that the "*patient requested to talk*".

The instances of interpreter utilisation in contexts other than a psychiatric assessment interview will be considered in more detail below.

included. This is followed by an interview with the patient usually conducted by the consultant psychiatrist. On the basis of all this information a diagnosis and treatment plan would be formulated.

[14] A number of questionnaires omitted to specify the duration of the interview. An estimate of the amount of time that would have been added were the questionnaires completed was arrived at by multiplying the average duration of interview in the respective units by the number of interviews for which the duration was omitted. Thirteen percent of the questionnaires (15) did not specify the duration of interview, suggesting a further 4 hours of interview time on average.

[15] See Appendix 6 Table 4.4 and Figure 4.1.

Psychiatric assessment interviews

The fact that the vast majority of the documented interviews took place in an admission ward or a forensic ward immediately circumscribed the nature of the interview that could take place. Interviews in settings such as these are routinely administrative in their function (Swartz, 1998). They are primarily about obtaining a diagnosis and initiating treatment. It would also appear from the questionnaire data that there was an inverse relationship between length of interview and professional qualification of the person interpreting. Thus, interviews in which a professional nurse interpreted were shorter. Interviews with cleaners as interpreters were longer. Administrative functions can be accomplished more quickly with a nurse who knows what the doctor needs in order to make a diagnosis, initiate treatment and monitor improvement in symptoms (using the "junior clinician" model discussed in Chapter 2). This would take longer to arrive at with an unqualified and psychiatrically naïve person. Furthermore, the pressure of time on the interview with a nurse precludes the possibility that these interviews could develop into more overtly therapeutic interviews. However, even when the interviews were longer with unqualified staff, the lack of professional insight on the part of the interpreter would inhibit the therapeutic possibilities of the interview. In addition, patients interviewed with a cleaner acting as interpreter, for instance, would perhaps be less likely to disclose certain types of feelings or information.

Ward rounds

The largest amount of ward round utilisation occurred in the FU. The unit requires that each patient accused of an offence and referred for 30 days of psychiatric observation by the courts be seen at a ward round. However, long-stay patients are also accommodated in the units, elevating the total number of patients requiring interpreting but not seen in ward rounds during the study time. In the MAWs only six of the 57 patients identified in the study were seen in a ward round. For one of these interviews a visiting social worker performed the interpreting as there were no Xhosa-speaking staff on duty that day. Had the social worker not been present the patient would not have been interviewed. There was no ward round utilisation of interpreting in the FAWs. The question of ward round interviews for Xhosa-speaking patients will be taken up for discussion later.

Group therapy sessions

The nine questionnaires completed for group therapy contexts suggest that Xhosa-speakers are included in group therapy available to other patients. This is misleading. The two groups in which interpreting took place in the FU required fellow patients to do the interpreting, even when the patient doing the interpreting was also psychotic. The seven questionnaires referring to group therapy in the FAWs were more a reflection of groups that were taking place from which Xhosa-speaking patients were excluded. The occupational therapist completing the questionnaires made one attempt at the start of the study to include Xhosa-speakers in a group therapy session. In the group were two Xhosa-speaking patients, one who spoke English and who interpreted for the other Xhosa-speaking patient. However, the patient/interpreter did not understand Afrikaans, which was also being spoken in the group. The occupational therapist made only one attempt at this and, due to the difficulties described, in subsequent groups it was simply noted that Xhosa-speaking patients were excluded from groups. These group therapy instances were also confined to occupational therapy groups, which tend to be instrumental and practical in orientation when provided in the admission units. Xhosa-speaking patients were always excluded from support group therapy sessions on the basis of the communication difficulties.

Family interviews

Of the 15 interviews coded as with family members, half involved short interviews (5 – 20 minutes). This suggests they were interviews to gain collateral on a patient's condition. Six of the interviews were longer (between 45 and 90 minutes) suggesting that they may have been therapeutic interviews, although the three interviews in the FU were likely to also have been collateral interviews. In one psychiatric assessment interview the female patient presenting at the emergency unit had to interpret for her husband in a five-minute interview. In a longer conjoint therapy session with a social worker another female patient interpreted for her boyfriend.

Psychometric assessments

Two questionnaires indicated psychometric assessments were done. It appears that these were errors in the completion of the questionnaires. The absence of psychometric assessments for Xhosa-speakers may reflect wider problems in the country as a whole around the availability

of tests in African languages. The hospital had no translated psychometric tests available at the time of the study.

HOW AVAILABLE IS INTERPRETING?

The question of the availability of people to interpret was a key focus of the assessment of the need for interpreting. It appeared from the questionnaires returned that there was someone to interpret immediately in 68% of instances, while 22% of the time the interview was delayed due to the unavailability of interpreters. The delays ranged from 15 minutes to two hours. In 31 instances (10%) the interview was delayed by more than one day due to the services of an interpreter being unavailable (in one instance this included a patient not being seen in a ward round)[16]. The variability across unit in availability of interpreters was clearly a function of the provision of Xhosa-speaking professional nursing staff[17]. However, even well-provisioned units experienced delays in interviews.

The impact of an interpreter in the Male Admission Wards

For the purposes of the study the employment of the interpreter in November was both a help and hindrance[18]. It meant that there was less time to collect data on the old system and therefore less surety of having a sufficiently comprehensive picture to allow generalisability. With respect to the new arrangement similar limitations apply. Generalising from one month's data, especially during the interpreter's first month of work in that capacity, is far from satisfactory. However, the presence of the interpreter did serve as an unexpected and potentially useful contrast with the previous arrangement.

October and November's statistics for the MAWs were separated to isolate the impact of the interpreter's presence in these wards[19]. The interpreter accounted for 31% (13 interviews) of the documented time spent interpreting in the month of November. This may have been partly as a result of needing time to settle in but other factors may have impacted upon this figure. On entering the workplace, with no training or orientation period, he was not given a

[16] See Appendix 6 Table 4.5 and Figure 4.2 for further detail regarding these figures.
[17] See Appendix 5 for details of Xhosa-speaking staff.
[18] I was not informed by the hospital administration on the employment of the interpreter. I learnt of his presence there while visiting the ward to check on the completion of questionnaires. The consultant psychiatrists and clinical staff were also not informed or consulted about the interpreter's appointment.
[19] See Appendix 13 Figures 6.2 and 6.3 for a graphical representation of the comparison between the two months.

clear brief on what was expected of him or how to make himself available. The clinicians themselves and the nursing staff were not informed about his presence or how to integrate him into the previous arrangements. The interpreter was also appointed to work for only four hours a day, which limited access to his services. Clinicians were also familiar with using nurses and would therefore have built up working relationships, with the trust so necessary in using an interpreter at an acceptable level. Following from this, there may have been hesitancy in using someone with no formal training.

The interpreter's average length of interview was over 30 minutes, compared to the PN and SN average duration of 18 and 14 minutes respectively. The interpreter also had interviews as long as 60 and 90 minutes, whereas interviews with nursing staff rarely exceed 30 minutes and were never longer than 45 minutes.

Comparing the two months, it appears that the presence of the interpreter halved the amount of time that nurses spent interpreting in the previous month. Nursing staff involvement did not stop but some of the strain was alleviated. Clearly the interviews in which the interpreter was involved were longer on average. Paradoxically, the presence of the interpreter may have made requests for nursing to interpret more problematic as there was someone working in the unit for the task. The unfortunately short employment hours meant that there were times during which the interpreter was not on duty and interpreting was required. There was thus a tacit implication that other staff should still provide interpreting during these times.

ORGANISATIONAL COMPLEXITY

Interpreting by day across units

The data were re-organised from highlighting the returns of each respondent in each unit individually, to highlighting utilisation in each unit on every day that the study ran. This looked at utilisation and need on a daily basis across the whole system, rather by unit for the entire period[20].

What emerged from re-organising the data in this way was that the need for interpreting was a daily one and that it consumed a significant portion of time in each unit on an almost daily

[20] See Appendix 6 Figure 4.3.

basis. Interpreting appeared as potentially a daily need in all the units surveyed. Thus, there were no days on which one could be sure that there would be no need for interpreting in any unit. In so far as the absence of interpreting services was a burden for clinicians and nurses alike it was constantly present as an element of the organisational landscape. What the data also suggest is the futility of employing one person to meet this need across the entire system. The MAWs, where the interpreter was placed, are the site of the most intense demand for interpreting but this does not address the need in the other units. Even within the MAWs, interpreter-mediated interviews were happening simultaneously and at times when the interpreter was not on duty, showing that the need for others to interpret was only eased and not eliminated by a part-time employee. This situation would have been alleviated by a re-organisation of when clinical interviews took place in accordance with the availability of an interpreter.

HOSPITAL FOLDER REVIEW

A review of the available hospital folders of the patients documented in the study was undertaken to identify, where possible, the number of interviews that were not documented by the clinicians in the questionnaires. This did not include C23 folders as the assessments in this unit are largely one-off interviews before referral to a local psychiatric hospital.

The 219 questionnaires completed at VBH referred to 95 patients. Of these 95, 74 folders were reviewed for missing data. The review of the folder entries identified 182 entries (62%) for which questionnaires had been completed and 20 instances (7%) where the use of an interpreter was noted in a folder but not documented in a questionnaire. In 90 entries (31%) there was no questionnaire completed and no indication as to whether an interpreter was used or not in the hospital folder notes[21]. One can not assume that if an interpreter was used on one occasion that they would have been used in subsequent interviews with the same patient. The question of when an interpreter is used and when they are not will be taken up in more detail in Chapter 7.

[21] These figures are presented in more detail in Appendix 6 Table 4.6.

COMMENTS ON QUESTIONNAIRES

A space was provided at the bottom of each questionnaire for clinicians to enter comments or remarks. These comments were grouped under two main headings: interpreter skill and the consequences of the unavailability of a structured interpreter service.

Interpreter skill

There were 12 comments noting a negative or critical view of the abilities of the person who interpreted in any given interview. Many of these comments referred to when psychiatrically unqualified people interpreted and there was a perception on the part of the clinician completing the questionnaire that the linguistic abilities of the interpreter, psychiatric insight or interview technique was deficient. There were 24 comments that were complementary of the interpreter. This may have been influenced by the fact that so much of the availability of interpreting on the part of nurses depends on a favour system. If clinicians are perceived to be arrogant, entitled or ungrateful in their requests for interpreting, nursing staff are less willing to oblige the clinician when they ask for interpreting assistance.

Unavailability of interpreting service

There were 16 comments expressing concern at who was used to interpret and 14 regarding the duration of wait for someone to be available. Three comments indicated that the person approached to interpret was unwilling. The largest group of comments by clinicians (37) recorded negative consequences to how the interpreting was performed or negative consequences to the unavailability of an interpreter.

Illustrations of the sorts of comments made by clinicians add a perspective that is not represented by the numbers above.

> *Interpreter speaks Swazi and the patient remarked that he did not understand her Xhosa.*
>
> *Interview interrupted because the interpreter was off duty. He was replaced by another nursing assistant.*
>
> *Group with 2 Xhosa-speaking patients. Patient interpreted but not effectively as he was not entirely apsychotic.*

Interpreter had other duties during interview intermittently, struggled to get translation without interpretation, difficult to assess mental state, especially thought disorder.

Interview went well but it was difficult to get a rich account of patient's thought disorder.

Sister wanted to go to tea – needed to change interpreters, this did not however prove to be a problem.

These comments illustrate how chaotic the access to interpreting can be and how fragmenting this is to the process of psychiatric interviews. The remarks also typify the way in which expressions of concern about what took place around the interpreting concentrate on the difficulty for the clinician of working under these circumstances. There were also expressions of concern for the overworked staff who must interpret but very little overt acknowledgement of how distressing the communication difficulties in interpreted interviews might have been for the patients involved.

Despite patient being able to speak English, spoke to patient via interpreter to ensure better understanding.

Patient able to converse in Afrikaans but would have managed better in her home language.

These were the only two comments that appeared to express overt concern for the patient's experience in the course of being interviewed. Other comments may be seen to imply a concern for the patient involved but also overlap with concern regarding professional practice. The comments regarding the patient who interpreted for her husband in her own conjoint interview was an example of this latter type.

THE IMPLICIT SOCIAL ORGANISATION OF INTERPRETING

The proportion of patients who required interpreter services at the C23/VBH units during the course of this study is significant. The figures suggest that between 25% and 30% of admissions required interpreting services. This corresponds to approximately 70 or 80 patients per month.

Hospital staff who speak a black African language appear to make themselves very available to clinicians on the whole, in spite of the fact that interpreting is not explicitly part of their work. Personnel with psychiatric insight and education are clearly preferred as interpreters and the bulk of the responsibility for providing interpreter services fell to professional nurses.

A significant proportion of patients (22%) were psychiatrically assessed through the use of family members, cleaners and other inappropriate people.

The FU appeared to routinely have a Xhosa-speaking staff member available to interpret for patients in ward round interviews, and it may have been an unwritten nursing responsibility to ensure that this was the case. However, because the responsibility was unwritten there were occasions where visitors to the unit interpreted in a ward round. Informal arrangements in the FU appeared to address the need for interpreting more comprehensively than elsewhere in the hospital. This may acknowledge to a certain extent the seriousness of the assessment and the implications of an inaccurate assessment in this unit. However, the implication of this is to devalue the seriousness of a non-forensic assessment in other units. The MAWs were also recognised by the hospital authorities as a site of dense interpreting needs and there was an informal attempt to ensure a greater proportion of Xhosa-speaking staff until November 1993 when the interpreter was appointed. This was not the case for the FAWs, which were without Xhosa-speaking staff for a number of days in any week. The MAWs and FAWs appeared not to have an informal arrangement regarding access to Xhosa-speaking staff for ward rounds. There was at least one incident were the patient could not be interviewed in a ward round due to the unavailability of a Xhosa-speaking member of staff.

Interpreting was made use of in the vast majority of instances for psychiatric assessment interviews. The proportion of family interviews represented in the sample of interviews was small. As there was a general ethos in the hospital that encouraged the inclusion of family members in patient assessment and management, this was clearly compromised for the Xhosa-speaking group of patients. While language factors may not have been the only reason for this, communication difficulties may constitute a significant factor around which other obstacles constellate. Support group therapy was a treatment modality that Xhosa patients were denied access to. The simple fact of being a Xhosa-speaker was often a criterion for exclusion of the patient from a group.

It is highly significant that for one month of the study there was no Xhosa-speaking staff member placed in the open ward serving both MAWs and FAWs. There was one female Xhosa-speaking patient in the ward during this month and two weeks went by without the clinician being able to interview the patient meaningfully. This has hidden implications for Xhosa-speaking patients admitted to a closed ward. When the clinician is not able to

interview a patient in a particular ward because of the absence of Xhosa-speaking staff and the patient is not able to participate in group sessions in that setting, all the usual clinical indicators for transfer to an open ward may be superseded. With these constraints the patient is likely to remain in a closed ward. Depressed and non-psychotic patients find the closed wards an extremely distressing and frightening experience. In addition, the restrictions imposed on patients in closed wards and the conditions that prevail in them seriously compromise the rights of patients admitted voluntarily (under Section 3 of the Mental Health Act) or with another's consent (under Section 4 of the Mental Health Act).

A related issue was illustrated through the absence of interpreter utilisation in the hospital psychotherapeutic ward and the rehabilitation ward for psychotic illness. The absence of interpreter services at these wards means that Xhosa-speaking patients with depression or other non-psychotic disorders such as anxiety and post-traumatic stress disorder are either kept in a closed and extremely disturbing environment or they are discharged from the hospital without psychotherapeutic interventions being offered.

An earlier report on these findings (Drennan, 1996a) indicated the "opportunity cost" to the hospital of using staff for interpreting purposes when they are not employed in that capacity. This appeared to be a trivial sum over a two-month period. However, what was emphasised was the hidden cost to the system as a whole that the absence of adequate and appropriate interpreting services entails. With respect to patients, being a Xhosa-speaking patient of a psychiatric hospital constantly entails the risk of being denied access to professional assessment by a qualified person, bound by a code of ethics, capable of empathic enquiry and assumed to be trustworthy.

Even though Xhosa-speaking patients were more likely than not to be interviewed with the assistance of a psychiatrically trained person, there appeared to be a type of trade-off involved. Something which held true across all units was that the further away one moved from the professionally trained person the longer the interviews became. It was a constant bone of contention amongst hospital employees that nurses were taken away from their duties in order to interpret. Nurses often resented the imposition of an "unofficial" task for which they were untrained, unappreciated and unrewarded. While the clinical skills that a professional nurse brings to an interview with a patient are invaluable and clearly in great demand by clinical staff, it is a source of concern that the pressure of other responsibilities

may significantly impact on the time and commitment to a thorough and empathic assessment that a professional nurse would be able to make. Furthermore, the fact that there were unwritten agreements with regard to the distribution of Xhosa-speaking nursing staff in wards known to have a high proportion of Xhosa patients adds to the sense of an exploitative system in which Xhosa-speaking nurses, ironically, are muted in their response to being used as interpreters.

The way in which this took place suggests that a compromise was struck in the institutional arrangement of access to interpreting. By allowing the informal interpreting arrangements to continue, nurses co-operated with the system and expressed concern for the plight of their patients. However, by asserting the pressure of their other responsibilities, they resisted the system of exploiting and appropriating their status as bilinguals without recognition. It is significant that nurses were in a position to assert themselves in this way. This was a reflection of their organisational resources and their position in the professional hierarchy of the institution. Access to interpreting as a whole appeared to reflect degrees of power in relation to the institutional distribution of resources, or at least the capacity to mobilise implicit institutional resources. The needs of clinicians appeared to create pre-eminence in access to interpreting. The demands on clinicians in a forensic setting and the requirements of the judicial process were accommodated to a certain extent in the informal interpreting arrangements. The pressure created by very high admission rates and the demands of managing admission wards for male patients resulted in the placement of an interpreter in the MAWs. The wards for women appeared to be the least resourced for interpreting. This hierarchy of access to interpreting mirrors the economic and social subjugation of blacks generally, but most especially that of women. This illustrates how wider societal discourses penetrate institutional settings and are expressed in relation to language issues. I will take this up in greater detail in the following chapter.

Chapter 5

MAKING LANGUAGE VISIBLE IN INSTITUTIONAL SETTINGS – LENTEGEUR HOSPITAL

Introduction

This chapter describes the results of a study conducted at another psychiatric hospital in the Western Cape. This study had the same objectives as the first; namely to quantify the need for interpreter services through counting the number of interviews that took place with an interpreter and the number of interviews that could not take place because of the unavailability of an interpreter over a two-month period. The interview component of the study arose out of the need for additional information to clarify the data from the questionnaires. They explored in more detail how the need for interpreting was being met at Lentegeur Hospital (LGH) and what implications this had for service provision. I will contextualise the study through a description of the hospital's history and the organisation of service delivery. I will then describe the method employed for the study and the results of both studies before embarking on an interpretation of the findings.

DESCRIPTION OF LENTEGEUR HOSPITAL

Lentegeur Hospital is situated approximately 25 km from Cape Town in the historically coloured[1] area of Mitchell's Plain. It also borders on Khayelitsha ("new home"), a sprawling black township estimated to have half a million inhabitants. Lentegeur Hospital opened in 1986 under the control of the House of Representatives, the government body set up under the tricameral parliament to serve the coloured community of the country. LGH was therefore, in the crass terms of the apartheid era, a coloured hospital for the Western Cape, and the only one of its kind in the country.

[1] During the apartheid era the term 'so-called coloured' was used to indicate a rejection of the racist classification system in place at the time, which distinguished between whites, blacks, coloureds and

However, from the outset the management of the hospital made a commitment to providing non-racial mental health services. It had approximately 1500 beds and was divided into a rehabilitation centre for mentally handicapped[2] people and wards for acute and chronic psychiatric illness. Specialist units[3] attracted patients from all race groups but there were much smaller numbers of black and white patients.

When the Western Cape mental health services were integrated by race, the Cape Peninsula and inland areas were divided up amongst the three psychiatric hospitals in greater Cape Town. A number of townships, including Khayelitsha, fell within the LGH catchment area and so patients who had previously been accommodated at VBH were admitted to LGH from April 1992. Prior to the racial integration of regional services LGH had particular wards that were responsible for admitting patients from specific areas. This policy continued with the allocation of historically black areas to a particular ward in the hospital in the new dispensation.

At the time of initiating the study there was no one employed as an interpreter at LGH. Earlier in the year of the study there had been labour unrest at LGH and one of the issues high on a list of staff grievances was the situation of the hospital being without interpreters. A number of negotiations had taken place and the local government had approved the appointment of a full-time interpreter against the post of a general assistant in May 1994. The new interpreter began work two weeks before the end of the study, and was a coloured person formerly employed as a security guard in the hospital.

METHOD

The questionnaire study

The questionnaire study was conducted in six wards and the Out-Patient Department (OPD) of the hospital. As particular wards at LGH are allocated catchment areas,

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Asians. Since the election of a democratic African National Congress-led government in 1994, the prefix 'so-called' appears to have been dropped from common usage of the term 'coloured'.

[2] Mental handicap is the term still in use locally as it has not yet been replaced by 'learning disabled', the term favoured in Britain for instance.

[3] Of note were the Drug Rehabilitation Unit and the Child, Family and Adolescent unit.

there were particular units that were likely to be the sites at which interpreting was required. Two wards for acute and sub-acute male admissions for Khayelitsha (MAW1 & MAW2), and one ward for women admitted from Khayelitsha (FAW1) were included. Very disruptive patients from this ward were contained in a smaller acute unit (FAW2) which it shared with the patients admitted from Mitchell's Plain (FAW3). The ward admitting male patients from Mitchell's Plain was included in the study as informants said that interpreting was occasionally required there but no questionnaires were completed for that ward.

Patients seeking psychiatric assistance were all assessed in OPD prior to admission. It was the responsibility of the doctor on duty to make a preliminary assessment and allocate the patient to the relevant ward. Psychotic patients were sent to the acute and sub-acute wards initially but moved on to the rehabilitation unit when this was deemed appropriate. Other wards dealt with substance dependence, crisis management or psychotherapy. Interpreter utilisation in anything other than the wards dealing with psychosis was not undertaken as hospital staff informed me that this service was never required in the other wards[4].

The questionnaires were completed over eight calendar weeks or 40 working days and 16 weekend days during September and October 1994. In order to replicate the VBH study I required clinicians[5] and nursing staff to complete a questionnaire each time they used someone as an interpreter or would have had someone been available. The questionnaire required basic information about the interview[6]. Significantly, at this stage a senior nursing staff member indicated that the questionnaire was not appropriate to nurses in this setting as interpreters were required so often that they could not complete a questionnaire each time. They felt that this would result in the under-representation of the need for interpreting. Consequently, a separate questionnaire for nurses was drawn up, in consultation with nursing staff, requiring one person in each ward to complete a questionnaire each day summarising their

[4] Night calls were not included in the study and only nurses completed questionnaires for weekends.
[5] For the wards included in the study this refers to consultant psychiatrists, psychiatric registrars and social workers.
[6] See Appendix 7 for Questionnaire 2.

situation by specifying how many Xhosa-speaking patients were in the ward, how many Xhosa-speaking staff were on duty, and how many patients required an interpreter for a ward round interview[7].

The interview study

This involved interviews (tape-recorded where possible) with 12 staff members, who had either participated in the questionnaire study or who had worked in the relevant wards. These interviews took place from December 1994 until July 1995. The categories of staff interviewed were as follows[8].

Table 5.1: Interviews with hospital staff.

Clinicians (Interviewees 1-6)	6
Xhosa-speaking Professional Nurses (Interviewees 7-8)	2
Non-Xhosa-speaking Professional Nurses (Interviewees 9-11)	3
Interpreter (Interviewee 12)	1
Total	12

QUANTITATIVE DATA ON INTERPRETER UTILISATION

Clinician questionnaires

Returns on questionnaires from clinicians were generally low. In the admission ward for women from Khayelitsha (FAW1) the psychiatric registrar documented 20 interviews with 11 patients. An interpreter was available for 12 of these interviews. One professional nurse did all the interpreting, except for two documented occasions when a patient was used. The same nurse interpreted three times for nursing colleagues. The registrar indicated on one questionnaire that there was a week during which there were no nursing staff members available to act as interpreters. There were four patients identified during this period as requiring an interpreter for all communications and so assessments were made using observation only without attempting to interview the patients. Interviews in FAW1, when they did take place,

[7] See Appendix 8 for Questionnaire 3.
[8] The outlines of these semi-structured interviews can be found in Appendix 9.

were of 30-45 minutes duration. There was one incident noted where a patient was not able to be assessed on admission to the ward during the day, who later that day collapsed and was communicated with via a fellow patient, who herself could only manage very basic questions. The ward for the temporary containment of behaviourally disturbed women patients (FAW2) documented six interviews with four patients, three of which were with an interpreter. One was for a physical examination that involved using a fellow patient. The returns from OPD hopelessly under-represented the need as only six questionnaires were completed, an interpreter being used once.

Table 5.2: Clinician questionnaires.

Ward	Questionnaires	Patients	Days	Interpreter available	Interpreter unavailable
FAW1	23	11	14	15	8
FAW2	6	4	6	3	3
MAW1 & 2	25	21	7	18	7
OPD	6	6	6	1	5
TOTAL	60	42		37	23

Table 5.2 specifies the number of completed questionnaires in each participating ward and the number of patients who required interpreting and who were identified through the questionnaires. The number of days during the study on which an interpreter-mediated interview was documented is also indicated, along with whether an interpreter was available or not.

In the male admission wards for patients from Khayelitsha (MAW1 & 2) 25 questionnaires were completed, documenting interviews with 21 patients. These questionnaires were completed on seven of the 40 working days that the study ran. Of the 18 interviews for which someone interpreted, 15 were with one student nurse during the period that this student was working in the ward. Only three questionnaires documented interviews with nursing staff acting as interpreters. All interviews were specified to be of 10 minutes duration. The extent to which this under-represented utilisation can be seen from the fact that only 25 interviews were documented with 21 patients. The questionnaires showed that 17 patients were seen only once for 10 minutes each. Added to this is the mere seven days on which questionnaires were completed.

Twelve days before the end of the study, the full time interpreter began work at the hospital. There is only one questionnaire that records an interview with him.

Nursing questionnaires

Table 5.3 indicates that 50 questionnaires were completed in FAW1. These questionnaires indicated that for 28 days there were no Xhosa-speaking nursing staff on duty. The period indicated on the psychiatric registrar's questionnaires of having no one to interpret emerged on the nursing questionnaires as nine consecutive days without a Xhosa-speaking staff member. Overall, on about 50% of the days for which the study ran there were no Xhosa-speaking staff in the units. The daily average of patients who required interpreting across FAW1, MAW1 and MAW2 were 3, 14 and 6 respectively. This figure includes the statistics for weekends when patients are sent home or have been discharged, substantially decreasing the number of patients in the wards.

Table 5.3: Nursing questionnaires.

Ward	Questionnaires	Patients[1]	Days with Xhosa-speaking staff	Days without Xhosa-speaking staff
FAW1[2]	50	6	24	28
MAW1	15	14	7[3]	6
MAW2	5	3	3	2

[1] Average number of patients per day, including weekends.
[2] FAW2 & 3 did not complete nursing questionnaires.
[3] There were two days during which the Xhosa-speaking nurse worked for half a day.

The nurses working in MAW1 completed only 15 questionnaires but fortunately 11 of these were done on consecutive days. The nursing staff in this ward documented that there were 26 clinical interviews for which there was no interpreter, and only one for which there was an interpreter. This is in striking contrast to clinician-completed questionnaires. The 15 questionnaires from MAW1 indicated that there were six days with no Xhosa-speaking staff on the ward, seven with one Xhosa-speaking professional nurse, who also worked twice for half a day. MAW2 completed five questionnaires and had a Xhosa-speaking staff member on three of the five days.

From the two sets of questionnaires two things emerge clearly. Firstly, that clinicians were completely dependent on the availability of nursing staff to interpret and that the availability varied enormously from ward to ward. Secondly, that the availability of nurses to interpret, and indeed much of the nursing service, was dependent on the single Xhosa-speaking professional nurse allocated to duty in each of the two main wards serving the Khayelitsha catchment area. In accordance with a shift system, the Xhosa-speaking nurses were available in each ward for approximately 50% of time[9].

Comments

While the questionnaires did not provide a numerically comprehensive picture of the language problems at the hospital, comments on the questionnaires suggested something of the nature of the work that could take place under such circumstances. The absence of the only Xhosa-speaking staff member from a unit for nine consecutive days during the time of the study and the psychiatric registrar's comment that "*observed behaviour*" was relied upon during this time is an important example, referred to above.

Other comments included on clinician completed questionnaires were:

> *It is impossible to judge elements of the mental state as the patient/interpreter does not understand the meaning of it.*
>
> *This patient was treated as MR[10] only because of the fact that loose associations and form of thought could not be picked up.*
>
> *Impossible to initiate treatment without a diagnosis.*

These comments suggest an extremely impaired ability to maintain clinical functioning in the absence of interpreting services and the small number of Xhosa-speaking nursing staff employed by the hospital.

[9] Hospital informants indicated that there were six Xhosa-speaking nursing staff available to work in these wards. However, a questionnaire survey conducted at the hospital in 1994 had indicated that 22 of 798 nurses spoke Xhosa (Jwili & Barnado, n. d.).

[10] MR refers to Mental Retardation in the American Psychiatric Association (1994) Diagnostic and statistical manual of mental disorders (4th ed.).

There were few comments on the nursing questionnaires but among them were very strong statements of the need for interpreters.

> *An interpreter in ward [MAW2] is essential and we need one every day of the week including weekends.*
>
> *We need a full-time interpreter...*
>
> *A black patient in the ward was able to communicate in English but found it difficult to communicate in Afrikaans.*

These statements are striking for two reasons. Firstly, by asking for an interpreter over the weekends, they express a wish to have the need for interpreting extended beyond the interview between a doctor and patient into nursing interactions as well. This implies that the presence of significant numbers of Xhosa-speaking patients in the hospital are seen to create the need for extensive interpreter services to facilitate nursing interactions. This can also be seen through the three documented interviews in FAW1 where the Xhosa-speaking staff member interpreted for nursing colleagues. The alternative implication - that the hospital requires more Xhosa-speaking nursing staff - is not raised or foregrounded. The second striking aspect is the implicit expectation that Xhosa-speaking patients should not only be proficient in English but also in Afrikaans in order to be able to communicate effectively with hospital staff.

LANGUAGE AS A DOMAIN OF INSTITUTIONAL CONFLICT

In comparison to the VBH questionnaire study, the number of questionnaires completed at LGH appeared to make the study unsuccessful. The number of interviews requiring language services for which questionnaires were completed was only a fraction of the possible interviews that could have been documented. In this way the study had massively under-represented the need for language services. However, at the time of the questionnaire study, the admission wards for Khayelitsha at LGH did not have the numbers of clinical staff that admission wards at VBH had. The registrars were primarily responsible for taking histories and managing patients and were the main respondents for the clinician questionnaires. The actual numbers of questionnaires generated by each registrar compared favourably with the VBH study and yet there was a sense that compliance with the requirements of the study was poor

on the whole[11]. Consequently, the information from the questionnaire study was an inadequate representation of the language terrain at the hospital.

The reasons for poor compliance with the study can in part be attributed to the same factors that dog the service as a whole: structural inadequacies and serious staffing shortages. In addition, some of the staff will have been aware that an interpreter had been appointed and was possibly joining the staff[12]. In at least one ward this was an explicit reason for compromised motivation to complete questionnaires as the perception was that there was no longer a need for the research[13].

Beyond these plausible and acceptable reasons for the problems of the data collection lie the possibility that the sensitivity of the issues involved compromised a straight-forward compliance with the requirements of the study (Renzetti & Lee, 1993). In the first instance, because of how fundamental language is to the practice of mental health care, the question of how service providers do or do not communicate with their patients strikes at the heart of institutional functioning. An examination of inadequate language resources threatens to expose the possibility of concomitantly inadequate clinical services. This may invoke a wish to conceal or disguise aspects of institutional functioning, and poor compliance in four out of the five units involved may be attributed to this factor.

However, a further dimension to the issue at LGH is suggested by how vocal the staff at the hospital had been about the language issue. In labour disputes prior to the initiation of the research, language problems and the need for interpreters had been high on a list of worker grievances. Venuti, writing in the area of literary translation, has observed that "to make translation visible today is necessarily a political gesture" (1992, p. 10). In this instance, participation in the study may have been a political act for the staff at LGH. However, part of the nature of this political act could have been

[11] Completion of the nursing questionnaires was particularly mixed. The number of days on which questionnaires were completed ranged between 50 and 5.
[12] It emerged later that an interpreter had been appointed previously but that the funding had been withdrawn before the person took up the post. The possibility of having an interpreter may not therefore have been considered a certainty in spite of the promise of one.
[13] There is a widespread view that an interpreter in a hospital is a panacea to all language-related difficulties.

to resist a reductionistic attempt to address these complex problems in a simplistic manner. This may have created a complex relationship with the research. It could have been a vehicle for expressing such sentiments as " *we need* [an interpreter] *every day of the week including weekends*", while at the same time creating a paradoxical invisibility to the details of the need for interpreting. A growing awareness of the complexity of the language issue at LGH allowed me to formulate a working hypothesis, that the response to the research was expressing something about the difficulties around the racial integration of the hospital. In order to clarify the sorts of questions raised by the questionnaire study, a series of interviews were conducted with the hospital staff who had been involved in the questionnaire study.

Interviews with hospital staff[14]

The extent to which the language problem pervaded clinical and organisational functioning was more far-reaching than had been anticipated, and as will be shown later, this even had implications for the study itself that had been unanticipated. In a sense, my experience of the unfolding insight gained through the interviews reproduced something of the experience of the people working in this system. One of the interviewees conveyed a sense of how painful it had been to acknowledge the extent of the problem when he said that at LGH it had been difficult to say "*the emperor has no clothes*". This provided an organising metaphor for the interview data and a perspective on the possible dynamics of confronting this issue.

HISTORICAL DEVELOPMENT OF THE NEED FOR LANGUAGE SERVICES AT THE HOSPITAL

What emerged from the interviews was a sense of the historical development of the difficulties around racial integration. There seems to have been an initial unhappiness regarding a lack of consultation in the allocation of catchment areas. As one person put it, the Xhosa-speaking patients were "Valkenberg patients". Another felt that there were strong unhappy feelings about the change in the system of allocating patients to hospitals.

[14] A full ethnography was not undertaken. This would have required much more wide-ranging and detailed data capture and the hospital had not been approached to authorise an ethnography.

> *"...it was like an anger you see, there was like an anger. 'Why did you take Khayelitsha, what for, why didn't you take another part of the catchment area?' "* (Interviewee 3)

Much of the discomfort had to do with the unaccustomed difficulty of working with large numbers of Xhosa-speakers. The clinician quoted above expressed the conflict of having new groups of patients with different needs in the following way:

> *"...and all of a sudden, in their own place, the place where they have been working for a good few years you see, and all of a sudden* [there is] *somebody who's fully entitled to be here, who's not a foreigner. He's not here as a guest ..., he is here in full citizenship rights ... and you can't understand this person."* (Interviewee 3)

Other interviewees felt that there was an effort to cope with the crisis presented by having large numbers of Xhosa-speakers to treat and a commitment to making the system work. This enthusiasm could not last, however, when the crisis seemed interminable. Initially perhaps staff did not realise the full implications of the change and tried at first to continue with a 'business as usual' approach. However, a mounting sense of failure, fatigue and despondency eventually emerged.

Almost everyone interviewed said that language as a barrier was the largest single problem in the two main wards studied. Interviewees spoke of burn-out and the high turn-over of nurses in these units. Non-Xhosa-speaking nursing staff found they had to manage psychosis with patients they could not talk to. Doctors had to assess and treat patients with the barest minimum of information. This was described as a constant source of strain and anxiety. An interviewee expressed the frustration in the following way:

> *"You see a patient and then the patient will* [say] *something* [and] *you have no, absolutely no idea what is he talking about. You try to read something* [about] *what it could be. This feeling of being lost, this feeling of being angry..., there was a mixture of all negative feelings."* (Interviewee 3)

The few Xhosa-speaking nursing staff employed at the hospital were thought to have role overload. They were required to perform functions associated with social work, such as accompanying the patients home, conducting interviews with family members, etc. As the only Xhosa-speaking nurse did a great deal of the work of the psychiatric team for a particular group of patients the wards were paralysed without that person.

In essence, the old divisions of labour in the system appeared to have collapsed. This placed tremendous organisational burdens on all sectors of the multi-disciplinary team.

Implications for patients

Xhosa-speaking patients were considered by interviewees to be multiply disadvantaged. It was felt that the rehabilitation programmes available in the two wards for patients from Khayelitsha were significantly compromised in comparison to that of other wards. One element of this was the perceived absence of occupational therapy in these units as a result of the problems of running groups in three languages simultaneously without an interpreter[15]. It was felt that Xhosa-speaking patients who were recovering from psychotic illnesses had less access to the appropriate rehabilitation ward. Even more disquieting was the perception that non-psychotic Xhosa-speaking patients did not have access to the appropriate psychotherapy or drug rehabilitation unit. Interviewees were of the opinion that these patients were either not admitted or were housed in the wards for psychotic patients. Staff described a re-admission rate for the female ward serving Khayelitsha as twice that of the equivalent ward for Mitchell's Plain. This was attributed directly to the impact upon the service that was offered to these patients in the absence of adequate language services.

Doctors described conducting only short interviews during which mental state examinations were done and some features of the presenting problem were elicited. Communication could be so impeded that it was occasionally not possible to find out where the patient lived. Doctors and nurses alike lamented that there was no attempt to educate or even inform the patient's family of their relative's admission. One doctor characterised the management they offered as a "*surrealistic*" caricature of what they believed psychiatry should be.

[15] Hospital reviewers of an earlier draft of a paper for publication (Drennan, in press-a) challenged the perception that occupational therapists were absent from these wards, but acknowledged that there were problems with running OT programmes there. It was felt that the nature of the patient population, and not only language, contributed to the difficulties in these wards. Since this study the hospital has initiated programmes to increase OT involvement in both in-patient and out-patient settings for Xhosa-speaking patients.

The period of questionnaire data collection revealed a sequence of nine days during which there was no Xhosa-speaking staff member in the female ward for Khayelitsha. Prior to the study there had been periods of up to one month without any Xhosa-speaking nursing staff in a particular ward. During these times assessment was reduced to observing the patients through the glass partition which separated their common room area from the nursing station. There was a focus on 'observables', i.e. the level of aggression, whether the patient was mute, not eating, showing bizarre behaviour or extra-pyramidal side effects to the neuroleptic medication. As one doctor expressed it, without language as the tool or instrument of psychiatry:

"...one might as well be practising veterinary science." (Interviewee 1)

The absence of language services impacted upon the nursing duties in the following way. The nurses prepared for ward rounds by having some insight into each patient's mental state. If they were not able to discern this through English, Afrikaans or observing the patient, the nurses would undertake to interview the patient in Xhosa. Usually a fellow patient would be enlisted, occasionally a staff member. This partly explains the need expressed by nurses in the questionnaires for interpreter services. Pressure on the doctors' time often meant that they saw only problem cases, for which nursing staff said they would always have an interpreter. However, doctors felt that nurses did not bother them with the patients they could not speak to.

The Xhosa-speaking nurses interviewed both prefer to interpret in their ward; they usually refuse to go to other wards for this however. Similarly, non-Xhosa-speaking nurses and clinical staff preferred to have nurses interpret, but wish to avoid being exploitative. It appeared that conflict around who was responsible for interpreting cast it as being outside of the nurses' role. Institutional obstacles to doing interpreting arose, even when the nurse was willing.

DISCURSIVE THEMES AND INSTITUTIONAL OBSTACLES

The preceding description of how the hospital functions as a mental health care institution for Xhosa-speaking patients in the absence of language services indicates how overt obstacles to accessing mental health services constellate around the language issue. They are overt obstacles in so far as they constitute routine institutional strategies for managing Xhosa-speaking patients. The difference this

makes to the management of Xhosa-speaking patients demonstrates contradiction and inconsistency with the apparent racially integrated status of the hospital, and the mental health services as a whole. Even though the hospital itself may have an explicit commitment to non-racialised care, the implications of inadequate language resources create a contradictory practical reality. While only one interviewee felt that the hospital should refuse to operate the wards for Khayelitsha at all under these circumstances, the majority of professionals who choose to continue would not be able to avoid reproducing racial inequality in spite of all intentions to the contrary.

The question of how to respond to this dilemma is a complex one. One of the Xhosa-speaking nurses interviewed described an occasion on which another ward had requested interpreting which this nurse was happy to provide. A senior colleague had been unsupportive of the request saying that if nurses left their own wards in order to interpret they would be held responsible if anything untoward happened in their absence. While it would be easy to label the senior colleague pejoratively for depriving an individual patient of an interpreter, it is also possible to see that the senior colleague was prioritising a different set of institutional imperatives. Within the logic of the institution and its history this may have been a defensible position to take. While the rationale of the senior colleague is not known, it is possible that they were attempting in a small way to challenge the invisibility of the difficulties faced. This scenario reproduces complex paradoxes in the struggle with linguistic diversity in institutional settings.

While there were clearly substantial overt attempts at integration in LGH, the residual overt obstacles inevitably co-exist with covert impediments to equitable care and integration. The covert obstacles to integration are a combination of discourses that may be unique to the practice of psychiatry in South Africa but may also be found elsewhere.

Alienation, community and access to services

The first and most striking of these discursive themes was the palpable sense in which Xhosa patients could be seen to be aliens in mental health care. In a letter to the South African Medical Journal, Dr. G. Campbell (1961) lamented that there was no pressure

on South African doctors to learn an African language to practice, and likened this to the absurd situation of a foreign doctor in Britain being unable to speak English and having no intention to learn. Three and a half decades later local institutions still operate on the premise that either English or Afrikaans is normative. British writings dealing with the obstacles for immigrants to equitable mental health care discuss problems that are remarkably similar to those confronting indigenous people here (Fernando, 1995; Littlewood & Lipsedge, 1997). With the exception of psychiatric nurses, mental health professionals are overwhelmingly white, do not speak the home language of most black patients nor share similar experiential backgrounds. In so far as LGH is a western psychiatric hospital Xhosa patients have the status of immigrants or members of a minority group, and they are therefore 'other' and alien[16]. Swartz (1989) has suggested that the discourse of "otherness" in western psychiatry in southern Africa constellated around notions of culture. But more recently he has argued that culture may have been subsumed as an organising metaphor by the idea of community (Swartz, 1996). In the broader socio-political discourses of the day 'linguistic communities' may be the new lines of identity and boundedness which must be simultaneously maintained and transcended. However, in institutional contexts where particular languages and world-views are so dominant, patients who have particular needs but who have the status of a minority group may be subsumed rather than accommodated. Daubenton (1994) and Swartz (1996) have highlighted the irony of the loss of particular types of services to black patients through integration of services by race.

The partitioning of wards by catchment area at LGH was a strategy in place before official integration and was explicitly intended to maintain continuity of care between the hospital staff and community resources. As this was retained with the addition of new catchment areas the risk of reproducing the apartheid structures and marginalising Xhosa-speaking patients was considerable. However, given the small number of Xhosa-speaking staff and the even more limited language resources, the strategy may have served to contain 'the language problem'. Implicit assumptions around the

[16] In the Western Cape Xhosa-speakers are in a minority, although with migration this is likely to change. However, there are many places in the rest of the country where the speakers of indigenous languages other than Afrikaans are not in a minority but for whom the same argument would hold.

notion of community may also have been instrumental in the implementation of this system.

It was interesting to note that the Xhosa-speaking nurses interviewed resisted the use of the interpreter. There was some disagreement amongst the interviewees, both those who spoke Xhosa and those who did not, as to whether interpreting was part of nurses' work. One Xhosa-speaking nurse felt that interpreting was an integral part of mental health care by nurses, another felt that interpreting was not part of nursing duties but chose to do it out of concern for misunderstood patients. This suggests that interpreting could be something some black staff do, not as an identification with a nursing role, but as an identification with a community of Xhosa-speakers. There was no question, however, that nurses should not interpret for a doctor who could not speak Afrikaans to patients. These apparent contradictions in what nurses should do in hospitals are not unique to LGH. Nationally there is a lack of clarity as to whether the diversity of languages spoken by nurses automatically extends to nurses acting as interpreters in doctor-patient interviews.

The 'language problem' at state hospitals can therefore be seen to have two facets. In so far as the hospital cannot function as it did prior to racial integration there may be a recognition that communication difficulties were a significant factor. One interviewee remarked that on the days on which the single Xhosa-speaking nurse was not in the unit there was "*a real problem*" (Interviewee 9). However, when the institution generates routine solutions to the problem of communication such that service users are able to be constructed as patients who can be admitted, managed and discharged, the language issue ceases to be the institution's problem. One informant remarked on the ease with which a patient can be managed in OPD if there is no interpreter because one can just write: "*patient can't communicate*" (Interviewee 1). The patient is then transferred to a ward for black patients. This constructs the problem of communication as the patient's; it is the patient's lack or deficit that results in non-communication. I wish to take up here in more detail the question of how such a mental health care system constructs patients that are able to be managed, if necessary, without reference to language at all.

Veterinary psychiatry

Rhodes (1993a) outlined two levels at which one can look at the field of action in psychiatry. One is that of the caring professionals using the techniques and technology at their disposal to ameliorate human suffering and the consequences of social pathology. The second characterises the practice of psychiatry as itself a social pathology, with psychiatrists as agents of social control. Elsewhere she draws on Gordon's analogy to illustrate the practice of psychiatry in an emergency service as a swamp of action, with distant and sometimes tenuous connections to the theoretical high ground. In the everyday realities of clinical practice a range of interventions may be available but which of these is selected will often depend upon pragmatic institutional imperatives (Rhodes, 1993b). Swartz (1991a) too highlights the contradictions that arise when ostensibly non-racist, liberal psychiatrists reproduce racist discourses when working with particular patients. The patients who are difficult to manage or categorise by virtue of the language they speak or their social class are most likely to generate the use of diagnostic approaches which do not require engagement with the patient's illness narrative and the use of primarily biological interventions. Swartz identifies these strategies as a type of "veterinary psychiatry", reworking Kleinman's (1977) term, partly because they emphasise the behavioural control of patients, but also because they are accomplished without much likelihood that patients will object or challenge their treatment in any coherent or systematic manner.

There was anger, anxiety and resignation in the voices of the clinicians I interviewed who literally spoke of having to practice *"veterinary psychiatry"* (Interviewees 1, 2 and 4). The example given above of nurses observing patients through the glass panes of the nursing station in order to monitor their treatment serves as a metaphor for the situation of black patients (c.f. Foucault, 1977). This is a dramatic illustration of Foster & S. Swartz's (1997) observation that sovereign forms of surveillance have not been transcended in the social organisation of mental health care in South Africa. While black patients may occupy the same physical spaces as their white counterparts through the racial integration of services, without meaningful communication they occupy different discursive spaces that profoundly impact upon the meaning of those physical spaces. Besides obvious issues of material access to services, questions of

psychological access, alienation, identification and connectedness are not addressed through the powerful but invisible barrier of impeded communication. These sorts of issues are faced by all who must negotiate patienthood in institutional contexts, but the weight of this burden and the implications for failure are that much greater without ready access to the medium of language to communicate.

While of a completely different order, staff too are compromised in their access to patients, when biology and medication are the primary interventions. All categories of staff adopted a motto of 'treat first, ask questions later' and main reason given for using interpreters was to ensure that patients were given the correct medication. The presence of a single interpreter may thus serve to facilitate biological interventions and even obscure the need for additional forms of treatment.

While it would be absurd to suggest that nothing had changed or improved with the employment of an interpreter at the hospital studied here, there were preliminary indications that the extent of the changes that would be effected through this would be restricted by institutional routines and discourses such as those articulated above. The following chapter will take up this issue through the assessment of a programme that placed interpreters at Valkenberg Hospital.

Chapter 6

MAKING LANGUAGE VISIBLE IN INSTITUTIONAL SETTINGS – A FOCUSED ETHNOGRAPHY AT VALKENBERG HOSPITAL

Introduction

In the preceding two chapters studies to make the issue of language visible in institutions were described. The first study began as a needs assessment and employed orthodox questionnaire techniques of data gathering. This method, when applied in a different setting, was seen to yield certain information but obscure other important perspectives. Interview data with hospital staff were thus added to the quantitative data. Even here, however, the complexity of the issues that aggregate around the language issue were seen to be incompletely illuminated by the lack of a more extensive ethnographic approach that took multiple perspectives and types of data into account. This suggested that an ethnographic study was necessary to examine the range of complex factors that cluster around language diversity.

An opportunity presented itself two years after the study at LGH when the National Language Project (NLP), a local non-governmental organisation (NGO), took on the task of providing language services at Valkenberg Hospital. The NLP required a programme evaluation of their intervention and I seemed well placed to do this. However, as I had become aware from the study at LGH of the sensitivity of the issues that are touched upon by asking even simple questions about language, any further study of the issues would have to be negotiated with the institution involved in a way that would permit an 'informed consent'[1]. As I had presented the findings of the previous studies within the Department of Psychiatry at Valkenberg Hospital (Drennan, 1994a, 1994b, 1995), I had reason to believe that the authorities were

[1] This aspect will be expanded upon in Chapter 8.

aware of my interests and my accountability as a member of the institution. I had also, however, been involved in advising the NLP in the establishment of their programme. This granted a degree of credibility with that organisation and its members. Within positivistic research traditions both these affiliations might have been construed as sources of bias or partisanship. In more overtly politicised research contexts, loyalties and vested interests have become important to acknowledge, rather than disown in an attempt to portray oneself as a neutral observer. This has become a familiar issue in research, and particularly programme evaluation, that has sought to address questions of access to services for minority groups. In a review of social and political aspects of programme evaluation in multi-cultural societies, House (1993) refers to the development of "stakeholder evaluations" (p. 155). Here the competing interests of different groups may not be cancelled out or neutralised, but through making them explicit, House argues that they may at least be prioritised to protect the interests of socially disadvantaged groups.

My description of this third study will fall into three parts. Aspects of the programme evaluation will be described here, while Chapter 7 will take up issues to do with clinical records and Chapter 8 will deal with the negotiation of identity in institutions.

PROGRAMME EVALUATION AND ETHNOGRAPHY IN INSTITUTIONS

Programme evaluations may take the form of experimental designs, where various techniques are employed to quantify change while isolating the relevant variables as far as the research context permits (Fitz-Gibbon & Morris, 1987). These methods have been adapted to mental health care settings (Bickman, Guthrie, Foster, Lambert, Summerfelt, Breda & Heflinger, 1995; Fink, 1993; Milne, 1987). Through quantitative data and a comparison with baseline data from the first study (Chapter 4) aspects of these research designs were employed here, but an awareness of the research process outlined above created the need for alternative approaches to augment this. Again, a degree of eclecticism arose out of the different dimensions to the questions being addressed and the levels at which I sought to examine them. Part of the evaluation was focused on the impact of the community health interpreters placed at the institution. Evaluations of community health workers (CHWs) typically involve quantifying outputs, defined here as number of interpreter-mediated interviews, but also include opportunities for the CHWs to contribute their own views (Walt, 1990). This was thought to be important here as the evaluation was of a pilot study and therefore formative,

but also because the views of the community health interpreters would assist in the development of support and supervision structures. Interviews with the community health interpreters introduced the possibility for a more discursive analysis of how they understood their role and positioned themselves in relation to the institution. This aspect meshed well with the other focus to the research, that of the institution, its procedures and structures. Qualitative research methods and discourse analysis are increasingly being recognised as valuable in programme evaluations in institutional settings (Fetterman, 1991; Louis & Turner, 1991; Morrissey, 1995). These developments allow links with the strengths of ethnographic studies of medical settings to be made more easily. I will show here the value of ethnography as an over-arching approach, within which dimensions of quantitative data and programme evaluation may be subsumed.

Interpretative ethnography

Baum (1991) draws attention to three anthropological observations about the 'culture' of organisations. Firstly, that the culture of an organisation is represented in how members talk about the organisation and the ideals towards which the organisation strives, but that it is also inherent in the activities of the members. There may, however, be incongruence between the articulated identity of the institution and the meaning of institutional practices. Secondly, that the culture or beliefs within an organisation and its social structure have a reciprocal influence on each other. Thirdly, that the meanings of institutional practices, structures and narratives are both conscious and unconscious. "Both the 'invisibility' of unconscious meanings and their incongruity with conscious meanings add to the ambiguity of situations" (Baum, 1991, p. 267). These gaps or incongruities result in a certain ambiguity in the life of an organisation that give rise to domains of conflict and contested identity. Institutions undergoing transition in the context of momentous social change are particularly likely to manifest such disparities, as was illustrated in Chapter 5.

The emerging need for a more comprehensive method in the exploration of the embeddedness of language in broader institutional issues mirrors the development of methodology in organisational research. Ethnography has emerged as a flexible method for approaching the complexity of organisations, analysing both what people say and what they do (Hammersley, 1992; Schwartzman, 1993). In particular, medical settings have required the capacity of ethnography to accommodate micro and macro-levels of analysis, as discussed in Chapter 3.

In addition to these considerations, ethnography has increasingly been recognised to be of value in research that seeks to inform policy. This approach allows contradictions between practice and official policy to emerge, and accommodates diversity in the perspectives of those affected by policy. The emergence of the unexpected is more easily accommodated with a flexible methodology, but most importantly, contextualised examinations of process and outcome allow for interpretation at the level of institutional discourses (Hammersley, 1992).

The second VBH study was organised around the evaluation of an interpreter project at the hospital. Before describing the study I will provide background to the project and how it came to be in the hospital.

National Language Project and the Community Health Interpreter Training and Employment Programme

The National Language Project (NLP) is an NGO that promotes language issues in a broad range of areas. Most of their work has been in the areas of education, the promotion of multi-lingualism, the stimulation of progressive language policies and networking. However, a growing awareness of the impact of multi-lingualism in health care led the organisation to conduct a needs assessment in 1994 in general health care settings in the Western Cape. Through connections with the London Interpreting Project they secured funding, primarily from the Belgian Government, for an interpreter project, with smaller amounts from major South African companies and a Canadian development organisation.

The project was called the Community Health Interpreter Training and Employment Programme (CHITEP) and began with the employment of a director and a training co-ordinator. Entrance requirements for interpreter candidates were that the person should be a Xhosa-speaking matriculant[2] and unemployed. Initially six women were trained as interpreters over a two-month period. The training involved one month of theory and a month of supervised practical experience. Six months later 14 more interpreters were trained. The training covered the four key areas outlined in the interpreters' job description: interpreting;

[2] The educational equivalent of 12 years of schooling.

health promotion; advocacy and lay counselling[3]. Finally the interpreters were placed at ten health care sites throughout the Cape Peninsula, with a spread of primary, secondary and tertiary health care sites represented. Two interpreters were placed at VBH, a tertiary care hospital, on a full time basis[4]. CHITEP was funded as a pilot project, with the intention that over a three-year period the interpreters would be employed by the health institutions that they had been working for. It was a stipulation of the funding agreement that the project should be evaluated. The evaluation described here was one of three, while the others were smaller in nature and conducted at secondary and primary sites.

FURTHER DESCRIPTION OF VALKENBERG HOSPITAL

The study took place in nine wards at VBH: three Female Admission wards (FAWs), two wards comprising the Forensic Unit (FU); and the four Male Admission wards (MAWs). These were the wards in which the interpreters worked.

In addition to the overview of VBH provided in Chapter 4 it is necessary to outline the ways in which psychiatric services were structured. Firstly, the use of teams must be made clear. Secondly, the way in which the work of a team was structured by a series of meetings and thirdly, the range of patient activities involved in treatment must be discussed.

Teams

The services for male patients were provided by two multi-disciplinary teams, called firms. Each firm had a ward that was their 'home base' and they shared two other wards. One was a 'high care' closed ward for very behaviourally disturbed patients and the other was an open pre-discharge ward. The firms admitted patients on alternate days. The FU had two teams as well, but both operated in both forensic wards. The FAWs had only one team but was spread across three wards. The male interpreter was allocated to cover the same units that he had been responsible for before joining CHITEP, viz. all the MAWs and the forensic wards. The female interpreter was allocated to the FAWs.

[3] See Appendix 10 for more details regarding the interpreter's job description.
[4] The part-time employment of an untrained interpreter had continued at VBH since the 1993 study. This person was taken on by CHITEP, trained and increased to a full-time capacity.

Staff Meetings

Each team had a routine of meetings that covered their patient and teaching responsibilities. Each ward would have at least one, if not two feedback[5] meetings a week. A feedback meeting was a review of all the patients in a ward to discuss progress and problems regarding each one. Interviews with patients could take place during feedback meetings. In the MAWs the feedback meetings of the two firms could happen simultaneously in different wards. Each team would have one ward round[6] a week and while one firm was having a ward round the other firm was responsible for the admission of patients. Patients were seen by their case managers in any time that the clinician could find between meetings and teaching commitments. It is significant that at the time of the evaluation there was little clearly structured time set aside explicitly for interviewing patients in the wards involved. Each team also had an administration meeting and perhaps a staff support group meeting.

Patient Activities

A variety of groups were run in each ward for the patients. These involved community meetings, occupational therapy groups such as anxiety management and social skills, education groups and support groups. Some of these groups were run by nursing staff and so could happen simultaneously with other staff meetings. Many of the groups happened when case managers, who were not involved in the group therapies, were interviewing patients in another ward. For example, there may have been a support group run by a psychologist while psychiatric registrars were interviewing patients in another ward.

Research Objectives

The evaluation of the CHITEP intervention at VBH was done along two dimensions.

- Changes in quality of service provision[7].

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[5] Feedback meetings involved the whole team and are meetings in which the management issues with respect to each patient are discussed.

[6] A ward round was discussed in Chapter 4 and will be taken up again in Chapter 7.

[7] A client satisfaction study was not undertaken. The language service offered as part of a clinical service is embedded in a much larger bureaucracy that clouds any straight-forward access to client perceptions. A recent study of client satisfaction at VBH has addressed the wide-ranging issues raised by this in a much more comprehensive way than would be possible within the limitations of this project (Ensink & Robertson, in press). Service users' perceptions were however included in part of the CHITEP evaluation performed by a colleague. The results of this study were unavailable at the time of writing. Clinical outcomes were also not assessed for improvement. While this is an area of tremendous importance, assessing clinical outcomes requires extremely

- Evaluation of changes in hospital process[8].

The needs assessment at VBH in 1993 identified the following parameters as particularly problematic:

- the load on nurses as a result of interpreting;
- the extent of the use of inappropriate people as interpreters; and
- the volume of interviews that could not take place because of the unavailability of an interpreter.

The evaluation was intended to document the extent to which all three of these parameters are altered by the presence of designated interpreters, but also to look more broadly at institutional strategies for dealing with linguistic diversity. Thus, a focused medical ethnography of language service provision subsumed the programme evaluation.

METHOD

The questionnaire study

This methodology was successfully employed in the first study at VBH. Questionnaires were completed by clinicians each time they either used or would like to have used an interpreter in order to conduct a clinical interview[9]. This part of the study ran for a two-month period (nine weeks) from June to July 1997.

Focused medical ethnography

The ethnographic data was drawn from a number of sources. I kept records on a weekly basis of the total number of patients in each ward, the number of black patients, and how many of these patients required interpreting. The nursing staff provided the information as to which patients were black and which required interpreting. Archival data was drawn on through examining the hospital records of patients admitted during the period of the questionnaire study. I attended ward rounds and, where possible, case discussion meetings in the three units

comprehensive data-gathering, including base-line data and a wide range of variables, of which language service provision is but one. For similar reasons evaluations of CHW programmes typically do not attempt to link programmes explicitly with outcomes (Walt, 1990).

[8]Studies of the process aspects of a programme are traditionally more descriptive than evaluative. However, a certain degree of evaluation of process will be possible by virtue of the comparisons that will be able to be drawn with the data from the first study.

[8] See Appendix 11 for Questionnaire 4.

involved over the period of the questionnaire study. This involved record keeping with regard to procedures and management strategies (i.e., admission procedures, assessment procedures, observation procedures, therapeutic interventions, disposition strategies). Interviews with patients during these meetings in which interpreters were used were recorded by means of hand-written notes taken during the interview, and expanded upon later.

Semi-structured interviews were conducted with key informants. I have grouped the interviewees into five categories.

Table 6.1: Interviews.

Clinicians[10] (Interviewees 1-10)	10
Xhosa-speaking nursing staff (Interviewees 11-18)	8
Non-Xhosa-speaking nursing staff (Interviewees 19-22)	4
Hospital administration staff (Interviewees 23-25)	3
CHITEP staff: 2 interpreters, 1 co-ordinator (Interviewees 26-28)	3
Total	28

The interpreters were both interviewed twice. A number of informal discussions and conversations also took place.

RESULTS

General

A total of 17 clinicians completed and returned 109 questionnaires. This was fewer than the 25 who completed 219 questionnaires in the previous VBH study[11]. The number of patients identified by the completed questionnaires as requiring interpreting amounted to 60. Indigenous languages other than Xhosa for which interpreting was required were Afrikaans (11 patients), Zulu (1 patient), Sotho (1), Pedi (2), Tswana (1)

Folder review

In the process of identifying the ward patient statistics on a weekly basis, a comprehensive database of the Xhosa-speaking patients passing through the units in the two-month period of

[10] Includes psychiatric registrars, consultant psychiatrists, psychologists, social workers, occupational therapists.

the study was established. This served to identify patients that may not have been identified through the questionnaire study. The folders of patients identified in this way were reviewed for information relevant to the provision of language services and hospital management strategies.

A total of 88 folders were reviewed. Ten folders were not available. From this, 53 patients in the male wards, 14 patients in the female wards and seven patients in the forensic wards were identified as requiring interpreting. This is 14 (23%) more than the number identified through the questionnaires completed by the clinicians.

From the folders it was clear that the nursing staff are more accurate at reporting which patients require interpreting than the clinicians. Of 53 male patients, the clinicians did not use interpreters for 18 patients when a review of the folder notes suggested that an interpreter was required (18 false negatives). The nursing staff in contrast only identified two patients as requiring interpreting who could justifiably be treated without interpreting (two false positives). In addition, it was evident that clinicians would often use an interpreter for one interview with a patient, for example a long clerking interview, but would then not use the interpreter again in subsequent interviews. This will be discussed in greater detail in Chapter 7.

Through the 88 Xhosa-speaking patients' folders, 267 interviews or group sessions were identified that may have required interpreting services. Only patients who clearly required interpreting were included in this total[12]. 64 of the interviews documented in the questionnaire study were identified in the hospital folders reviewed. This is 24% of the total number of group or interview sessions noted in folders. However, 32 folder entries noted that an interpreter had been used, but a questionnaire was not completed. In 152 (57%) entries it was not clear from the notes whether an interpreter had been used or not. A further 19 entries clearly indicated that an interpreter had not been used[13].

[11] The previous study included the psychiatric emergency unit at GSH. The figures from that unit have been removed from the figures quoted here.
[12] The need for interpreting was assessed on the basis of patient folder entries that indicated an interpreter was necessary and the views of the nursing staff consulted.
[13] These figures are comparable to those specified in Chapter 4 under the rubric of "Hospital folder review".

Of the 57% of interviews in which it is not clear whether an interpreter was used, most would appear not to have involved interpreting, but this could not be ascertained with certainty. This figure constitutes a significant gap in the data regarding the circumstances around using or not using an interpreter. The unfortunately small proportion of interviews for which clinicians completed questionnaires should therefore be approached with caution as they under-represent the actual use of the community health interpreters. Without question the questionnaire data under-represents the need for and the utilisation of interpreting.

The proportion of patients requiring interpreting

The figures reflected in Table 6.2 were derived from my records of the total number of patients in each of the FAWs and the MAWs included in the study. The figures from the FU reflect the patients seen at a ward round during the study period.

Table 6.2: Proportion of patients who required interpreting.

	FAWs		FU		MAWs	
	No.[1]	%	No.	%	No.	%
Total patients	54.3		46		70.3	
Black patients	11.5	21.2%	14	30%	24.5	35%
Need language service	6.7	12.3%	7	15%	13.1	18.6%

[1] This figure is derived from the average number of patients per week for the nine weeks of the study.

In the FAWs 21% of patients were black and 12% required interpreting. About 7 patients a week required interpreting. The FU saw 14 black patients (22%) in their ward rounds, 10 of whom required interpreting. In the MAWs 35% of patients were black, approximately half of whom (18,6%) required interpreting. Numerically, about 13 of the resident patients in an average week required interpreting. On inspection it emerges that there was likely to be twice as many patients requiring interpreting in the male wards per week as compared with the female wards. Clearly, the male interpreter was carrying a much heavier load.

Interpreting contexts

As in the previous VBH study, interpreting was required most for psychiatric assessment interviews (68%). Fewer family interviews were conducted than in a two-month period in the previous study but there were significantly more group therapy sessions (Occupational

Therapy and Supportive Therapy) where Xhosa-speaking patients were included. Ward round interviews fell in accordance with the smaller number of patients in the sample. These figures are represented in Appendix 13.

Interpreting by category

In both the FAWs and the MAWs the proportion of interpreting performed by the interpreter is under-represented by comparing the number of interviews (I/Vs) done. This is because the average length of interview with an interpreter is more than that with either of the nursing categories. The interpreter in the MAWs interpreted during 24% of the documented interpreting contexts in those units, as reflected in the questionnaires (Table 6.3). Nurses interpreted for 48% of the interviews. However, the interpreter accounted for 31% of the time spent interpreting. It is significant that the interpreting in ward rounds and support groups was provided by people other than the interpreter.

Table 6.3: Male Admission Wards' interpreter utilisation.

	No. of I/Vs	% of I/Vs	Total time (mins)	% of time
Interpreter	18	24	490	31.3
Nursing	35[1]	48	765	48.9
Other	9[2]	12	310	19.8
None	12	16		
Total	74	100	1565 (26.1hrs)	

[1] Two questionnaires omitted to specify duration of interview.
[2] One interview was a consultant interviewing a refugee patient in French in a ward round. Two interviews were a visiting student interpreting in a ward round. Once a security guard interpreted in a support group. On two occasions a patient interpreted during a support group but there were no instances of patients interpreting for an interview.

The figures for the FAWs were more even, at 50% for the interpreter and 44% for the nursing staff.

Table 6.4: Female Admission Wards' interpreter utilisation.

	No. of I/Vs	% of I/Vs	Total time (mins)	% of time
Interpreter	9	50	315	61.2
Nursing	8	44	155	30.1
Other	1	6	45	8.7
None	0			
Total	18	100	515 (8.6hrs)	

The figures for the FU were misleading in that they indicated 17 interpreter-mediated interviews, but only four of those were for Xhosa. The other 13 were interviews in which Afrikaans was interpreted. The FU figures are not represented in tabular form because only two of the seven Xhosa-speakers requiring interpreting were represented in the questionnaires. Nine patients required interpreting for Afrikaans. The interpreter was documented to have done four interviews amounting to 130 minutes. Importantly, there were no instances of the interpreter being unavailable in this unit.

Availability of interpreting

In terms of the availability of interpreters in the baseline study in 1993, there was someone to interpret immediately in 68% of instances, while 22% of the time the interview was delayed due to the unavailability of interpreters. In 27 cases (9%) the interview was delayed by more than one day due to the services of an interpreter being unavailable. The present figures suggest that in 18% of instances the interpreter was unavailable. However, only 11% of interviews proceeded without an interpreter or were abandoned. This reflects an ambiguity in the phrasing of the questionnaire. The questionnaire required clinicians to code whether the interpreter was 'available', 'available at a later time' or 'unavailable'. As a consequence, some clinicians coded the interpreter 'unavailable' but proceeded to interview a Xhosa-speaking patient with a nurse as interpreter, for example. Others would have coded that according to the availability of the nurse. Six out of the 12 occasions that there was no interpreter available at all involved OT groups in the MAWs. In the previous study OT groups would not have been coded at all in the male wards as there was no expectation at that time that Xhosa-speaking males be included in the groups. Raised expectations of interpreter availability therefore contribute to the relatively high 'unavailable' figure in the male wards. The very low proportion of unavailability in the FAWs and the FU is also significant. In the

previous study there was a delay in 17% of cases and unavailability in 27%. The present figures constitute a massive fall-off in the unavailability of interpreting in these units.

Table 6.5: Availability of interpreters by unit.

	FAWs	FU	MAWs	Total (%)
Available	17	16	45	72%
Delay	0	1	10	10%
Unavailable	1	0	19	18%

It was apparent from the interviews with the staff that the presence of an interpreter on the units positively influenced the attitude of nursing staff towards having to interpret. In the FAWs and one of the MAW firms the frequency of requests to interpret had dropped off to such a degree that when nurses were asked by clinicians they were willing on the whole. This is because they knew that they were a back-up to the interpreter, rather than performing a front-line interpreter function. One Xhosa-speaking male nurse on the FU had not been asked to interpret at all in a one-month period, and would therefore not have objected to the occasional request for interpreting. The exception to this was in the other MAW firm where the interpreter seldom made an appearance and where the bulk of the responsibility still fell to the nursing staff.

Comparison of the Male Admission wards across three contingencies

During the needs analysis conducted in 1993 there was a month of study during which there were no interpreters employed by the hospital. In this month professional nurses and staff nurses accounted for 91% of the interpreting done in the Male Admission wards. In the following month of the study, when a person was employed for four hours per day for the purpose of interpreting, the interpreter accounted for 31% of the interpreting done. The data gathered during the evaluation constituted a third data set[14]. The interpreter again accounted for 31% of the interpreting in the MAWs at this time. It would appear that the overall nursing interpreting load remained constant at a little under 50% during both periods that there was an

[14] The evaluation period was two months, while the other two periods were one month each. The figures are reported as percentages to deal with the difference in real terms arising from the differing length of data capture period.

interpreter in the ward. It should be noted however that the CHITEP interpreter was also responsible for the FU, while the interpreter during November 1993 was not[15].

Summary

- The amount of interpreting done by nurses was significantly less than before the employment of the interpreter. Nurses were asked to interpret less frequently and the interpreters were being used for the long initial interviews. An area that remained problematic was the MAWs.
- It would appear that inappropriate people were used as interpreters less often but that this had not stopped. It is important though that patients are not interpreting for fellow patients in interview contexts.
- The unavailability of any interpreter was significantly reduced. There was a marked increase in availability of group interventions to Xhosa-speakers.

There was also a spin-off in terms of the 'culture' of availability of interpreting. Even when the interpreters are not available themselves other staff seem more willing, and less imposed upon.

INTERPRETERS: ASSIMILATION AND MARGINALISATION

I will now describe in some detail the circumstances surrounding the placement of the interpreters in the institution. The difficulties of integrating them into the service are very clearly revealed by the ethnographic aspects of the study. These difficulties indicate 'contradiction' in the culture of the organisation regarding the provision of interpreter services and the extent to which the interpreters were assimilated while being simultaneously marginalised in the service.

The interpreter in the Male Admission wards

Mr G[16] was employed by VBH from February 1996, for four hours per day at R5.30/hour or R400 per month[17]. He was made responsible primarily for MAWs and the FU. However,

[15] See Appendix 13 Figures 6.2, 6.3, 6.4 for a comparison between the studies.
[16] I am employing abbreviations for names to protect the identity of the interpreters. Mr. G was in his early 20's, single and not previously employed.
[17] At the time of writing this is the US dollar equivalent of $64 per month. This is a very meagre sum even by South African standards.

nursing staff told me that he was in principle available to interpret anywhere in the hospital. Mr. G was the fourth person in three years to occupy this position. The previous interpreters left to earn more money and one was eventually given a permanent post in the grounds maintenance department of the hospital. Prior to the CHITEP initiative to take Mr. G into their programme he had received no training from the hospital, no supervision of his work, and no professional support[18]. He was based in one particular ward, where he was given an office to share with the part-time Occupational Therapist. There was no telephone in the office.

The positions have never been advertised and were filled by word of mouth or by people awaiting positions as general assistants. Before being employed by the hospital Mr. G was interviewed by someone in nursing administration. For the first time since the hospital began to employ interpreters, a social worker was approached to observe the candidate interpreting in an interview. A Xhosa-speaking nurse was also present. He was found to be adequate and personable.

Mr. G was taken into the CHITEP training programme one year after starting work at VBH. He participated in the two-month training programme and appeared to have met the requirements of the course. However, the hospital staff interviewed raised questions about the standard of Mr. G's English. Mr. G also appeared to misunderstand the concept of advocacy. Concern was expressed about his interview style, being "*abrupt*" and "*harsh*".

One of the main sources of concern regarding Mr. G's role in the units was his relative absence from one of the firms in the MAWs. It appeared that there had been a historical absence of the part-time interpreters from this firm and that this continued when Mr. G took the position. When he came under the CHITEP umbrella this was not addressed. There was also no structured programme of activities that Mr. G was committed to. Consequently, it was not clear to Mr. G which meetings he should attend and what his priorities should be when there was a clash of expectations. For example, if Mr. G was scheduled to attend a meeting in one ward and was requested to do an interview in another, it was not clear to him how he should prioritise these demands. There were a number of hospital staff members who

[18] He did have a senior nurse to report to but this person's role was largely administrative.

were dissatisfied with Mr. G's availability to interpret. A lack of clarity about lines of authority and monitoring procedures appears to have led to an ineffectual response from all parties.

In addition to the above difficulties, Mr. G also experienced problems in accessing 'team' contexts in the wards. He apparently went to team meetings with one firm at the start of his stay there. However, he was possibly made to feel that his comments were not welcome and may therefore have been covertly discouraged from attending these meetings. There was also an incident in which he was interpreting in a ward round and was contradicted by a nurse who then took over the role with obviously more beneficial effects. Mr. G appeared to stop going to ward meetings. This is the situation that prevailed at the time when the CHITEP took him on and for a range of reasons these problems were not addressed. There were clearly a number of organisational difficulties in securing a meaningful interpreter presence in the MAWs. The upshot of these significant difficulties appears to have been the marginalisation of Mr. G within the service[19].

The interpreter in the Female Admission wards

Ms. M's[20] position in relation to the hospital authorities was clearer than Mr. G's as a result of not having worked for the hospital previously. However, the physical accommodation of Ms. M at the hospital was a source of concern. She spent most of her day in a locked lounge area in the ward for the most psychotic female patients. She sat there all day unless she went to have lunch or tea, or was called to interpret or attend a meeting. She had no office and most significantly no key to come and go from this area[21].

Added to the problem of the lack of appropriate accommodation was the problem of being under-utilised in the FAWs. Days would go by without being requested to do an interview. Ms. M had also not been assisted by VBH staff to draw up a programme of activities that could use her services. This was partly because they were not clear about her function there

[19] It should be noted that the discrepancy between Mr. G's and the other interpreters' conditions of employment was a major source of disillusionment for him. Mr. G was paid by VBH for half a day at the original rate, and by the CHITEP for half a day at their rate. However, the CHITEP rate is considerably more than VBH's and so the other interpreters in full-time employ earned up to R600 per month more than he did.
[20] Ms. M was single, also in her early 20's, and had worked previously in child care.
[21] VBH told her she would have to pay R40 for a key. She could occasionally get a key from nurses, but this depended on at least one of the nurses not coming to work on that day.

and they did not see themselves as responsible for this. This put her in a difficult position in relation to the rest of the staff. Some nurses perceived her to be under-employed and complained to her that she did nothing all day. Ms. M, however, saw it as part of her work to sit with the patients because this afforded her an opportunity to counsel them[22]. The notion that the interpreter would counsel patients was not one that the hospital staff were aware of, nor was it integrated into the treatment plan the hospital had for patients. There were occasions when Ms. M informed the nursing staff that she was going take her lunch break and the nurses commented that she looked as if she had been on a break already. Ms. M had attempted to get assistance with learning psychiatric terminology but this had proved unsuccessful. Hospital staff were largely unresponsive to her requests, perhaps because they did not see a place for it in their busy schedules.

There was a strong sense from my discussions with the nursing staff that they felt a need to police the activities of the interpreters. The word "*abscond*"[23] was used a number of times in relation to the interpreters. The CHITEP supervisor was frustrated at the way in which the interpreter was being made use of in the FAWs. On the days that the interpreter was given a ward key, her position in the closed area of the ward meant that she was available to open doors for staff and patients who wished to move between the patient area and the staff area. The supervisor thus perceived the interpreter's primary function to have been reduced to this "*prison warden*" role.

Interpreting the place of interpreters

> *"[The interpreter's] presence says a lot. Not necessarily [the interpreter] as a person but him..., the role that he plays."* (Interviewee 15)

What is one to make of the beginnings of an interpreter service at VBH? As the evaluation was focused on providing the CHITEP with information regarding the effect they were having on the hospital, it is necessary to observe that the intervention was compromised in a number of ways. The provision of an interpreter with a 'generic' interpreter training clearly had an effect when working in the situation of an extremely complex clinical context. Not only was the discourse of patients that required interpreting confusing and inaccessible, but the

[22] One of the requirements specified in the NLP job description was the counselling of patients where necessary.
[23] This term is used when patients leave the hospital without permission.

structure of service delivery, and the place of the interpreter in this, was also difficult to clarify. Over and above these obstacles, it appeared that the CHITEP was compromised in what they were offering by inadequate access to the hospital management and organisational structures and insufficient knowledge of 'how the hospital worked'. By not having access to management they were not able to create a more accommodating situation for the interpreters. The importance of access to management for an interpreter project to be successful has been described in Chapter 2. However, the question must also be asked as to why the hospital structures were not more responsive to what was being made available by the CHITEP.

Until 1991 VBH was an institution with racial segregation inscribed in the structure of its service delivery. This structure was revised towards integration with the abolition of separate facilities for different race groups. However, as at LGH, the language issues generally, and the interpreter issue in particular, throw up additional unresolved aspects of services. The positioning of black patients in the revised structures continues to manifest elements of the old order, but in a form less crude than the apartheid model. Foster & S. Swartz (1997) have suggested that South African society has not completely shifted into the forms of power exercised in what they call Western liberal democracies and it is possible to see this illustrated through the language issue. While the 'veterinary' elements of the services available at LGH maintain 'sovereign' forms of control and surveillance, the more sophisticated approach at VBH employs more 'disciplinary' modes of control and surveillance.

Interpreters occupy a transitional space in the work they do (Swartz, 1998). It is not surprising then that tensions and contradictions within the process of change would be reflected in the way in which the interpreters have been taken up by the organisation. The lack of a coherent vision for the role of interpreters and the superficial integration of this resource into hospital structures reflects the lack of clarity around how a mental health service for black patients is to be developed. Dominant themes in psychiatry, and in South African society as a whole, regarding Africans have long revolved around surveillance and control, particularly control of access to particular spaces (McCulloch, 1993; S. Swartz, 1996a). The employment of interpreters appears to embody the wish for improved access to black patients. But there is also an anxiety about a corresponding improvement in patient access to institutional spaces, and the threat this may pose to maintaining control. Interpreters who have free access to both sides of the divide – staff/patient, white/black, oppressor/oppressed – can be sources of insecurity. They have the potential to be powerful on both sides of these

institutional divisions. One way of dealing with this anxiety is to appropriate the source in the service of maintaining the status quo in some respects, while in others bringing about institutional change that is consonant with the expectations of a hospital in the 'new' South Africa. It is through interpreters as transitional objects, and the structures or 'compromise formations' that arise around them, that a range of institutional discourses can be observed to operate. These discursive features may also be explored through examining the metaphors that describe what interpreters do, or are expected to do.

A CONCEPT OVER-BURDENED: INSTITUTIONAL ROLES FOR THE INTERPRETER

In Chapter 2 I discussed the many roles that interpreters have been expected to fulfil and the wide range of competencies that this presumed of people functioning as interpreters. As part of the evaluation of the CHITEP interpreters at VBH, I was interested in how hospital staff understood the interpreters' roles and what their expectations were. This was explored in the interviews by asking about the perceptions staff had of the interpreters' place in the multi-disciplinary team (MDT) and how they viewed the question of advocacy. The CHITEP specified that they should be performing both these functions. Proponents of the advocacy model of interpreting (Sanders, 1991; Shackman, 1985) are vocal about the importance of autonomy for the interpreters from the service provider structures in order to be free from the constraints of employee status. It is thought that this would allow for constructive criticism of service providers where necessary. The CHITEP, while explicitly supporting this view, were also under pressure to prove their usefulness to health authorities in order to secure future employment with the Health Department. They therefore needed to align the interpreters with the functioning of the organisation in order to be seen to be helpful. I wanted to explore the tensions between these agendas and how they were impacted upon by the expectations of hospital staff.

What emerged from interviews with hospital staff were a number of contradictory expectations. Some of these were stereotypical of inexperience with organised interpreting and can be seen to arise out of insufficient training and thought about language issues, and this is important in itself. However, aspects of the traditional expectations of interpreters were nuanced in particular ways by the complexity of the historical context of the hospital, situated as it is in a period of transition. Inevitably, there was conflict and disagreement, overt and covert, about where interpreters fit into the new order of things.

Language as a new sub-speciality in psychiatry: interpreter as 'language specialist' and 'the new member of the multi-disciplinary team'

One of the characteristic features of modern medicine is to divide health care into areas of specialisation. The concept of multi-disciplinary teams (MDT) arises out of an attempt to divide caring for patients into a jigsaw of specialised labour. In this model, the idea of a 'language expert' or 'language specialist' in a psychiatric team may have great appeal (c.f. Abbott, 1988). It is important to note that the idea of the MDT has been taken up in a particular way in psychiatry as practised in the Western Cape. Originally, the development and recognition of different types of expertise in mental health care delivery gave rise to a system whereby professionals would deliver the service for which they were specifically trained. This meant that a patient in hospital for example, would see a psychiatrist for diagnosis and medication; a psychologist to have the appropriate form of therapy; and a social worker for a range of social interventions. This could involve a number of professionals being involved with a patient simultaneously and is therefore labour intensive. It is this labour intensiveness and the shortage of hospital staff that has brought about a local adaptation to the model. When used here MDT refers to a patient being allocated to a case manager, who may be either a psychiatric registrar, a psychologist, a social worker, an occupational therapist or an intern medical student. The case manager is responsible for delivering whatever services are appropriate for the patient. These interventions are co-ordinated in team meetings, where the case manager (if not medically qualified) would report on his or her patient's response to medication, symptomatic improvements and side-effects. When a limitation in what the case manager can offer is recognised the professional who is expert in the area in question could be asked to assist. This occurs most frequently for medical complaints that the psychiatric registrar is asked to intervene with. Asking another team member to assist with management is not done lightly because everyone has his or her own caseload and it is considered to be extra work. It is into this context that interpreters were expected to insert themselves as members of teams.

As could be expected there was a range of views on the place of the interpreter in a psychiatric MDT. Some did not see the interpreter as part of the team at all and questioned the use of the term "*professional*" to describe their work. Many staff made the obvious point that the lack of psychiatric training would confine an interpreter to their specific function within the team. In this sense they were seen to occupy a place in the "*ward team*" but not in

the "*professional team*". Some staff felt that the interpreter could make a useful contribution through attending team meetings in which there would be no interpreting, simply because of the contribution they could make regarding "*cultural issues*". Others felt very strongly that an interpreter had an essential role to play in psychiatric work and that in order to meet the demands they would have to be an integral part of the teamwork. From the experience already gained with having an interpreter present on the wards but spread between units, there were views as to what would work in the "*intensity*" and "*pressure*" of admission wards. It was felt that the interpreter would have to be available immediately or else a nurse on the scene would be used. Interviewees felt that the interpreter could become a valued "*professional team*" member, however, he or she would have to demonstrate their worth by making a contribution to the complex clinical issues that are grappled with in such contexts.

> *"The only way it's going to work properly and effectively is if the interpreter in some sort of way is more closely involved in the clinical team, becomes an active, participating member of the clinical team. That poses difficulties, because you know, they need to be seen as being vital, that is to the, to team work, being indispensable, which no doubt they are, but there has to be that perception within the clinical team."* (Interviewee 4)

There was also a more sinister aspect to the place of interpreters in the team that simultaneously reflects the transitional space that interpreters are expected to occupy, but also the appropriation of their access to Xhosa-speaking patients. One suggestion by staff interviewed was for the interpreter to increase the contribution they make by reporting to the nursing staff each afternoon before going off duty. This follows the format of a 'handover', when nurses ending a shift bring the nurses coming on duty up to date with patient developments. The idea was that information gleaned by the interpreter in the course of a day spent with patients would be passed on to the nursing staff. This would include observations of psychiatric illness; signs of improvement; and aspects of a patient's situation learned while "*counselling*" the patient. It is reasonable to assume that a team member who learns of something important regarding the patient would report this to the team. However, there was a less laudable aspect to this "*handover*". Some staff spoke of the patients confiding in the interpreter because she is Xhosa-speaking, but also because she may not be seen as part of the hospital staff. This would allow the interpreter access to patient confidences they would not otherwise get. Examples are when a patient may conceal from staff on-going auditory hallucinations or when a patient, who uses cannabis, does not intend to stop using the substance. Clearly, ideas around the interpreter as a member of the MDT can be more about assisting hospital staff than being a patient advocate. Once again, the implications of this for

the extension of the means of surveillance and the penetration of the medical gaze are striking.

As interpreters develop in training and professionalisation, a code of ethics applicable to psychiatry would have to be developed. Clarity as to what boundaries interpreters should maintain and how they should negotiate these with staff and patients alike would emerge. However, clarity of professional boundaries may make engagement with the work of a team more difficult, as the Winnipeg group (Chapter 2) have demonstrated. The question of loyalty will be taken up again in Chapter 8.

The image of an interpreter as a new member of the MDT as a 'language expert', recalls a criticism levelled at the very idea of an MDT. Critics of the model have highlighted the mechanisation and fragmentation of care that can take place. A person may be subjected to a process of medical compartmentalisation that reifies aspects of experience and consciousness (Taussig, 1980). Medical interventions may proceed without regard for other aspects of the patient's life-world (see for example Miller & Swartz, 1991). Language does not lend itself to such compartmentalisation. It is the substrate of all communication and interaction. Furthermore, the numbers of patients involved and the multiple sites at which they interact with hospital staff of all levels creates a 'language matrix' that does not lend itself to the easy commodification of language as a skill missing from a group of monolingual health professionals.

Interpreter as 'culture specialist'

The implicit expectations of interpreters as 'language experts' are repeated in the ideas about interpreters as 'culture experts'. This reproduces the reification of these complex notions too. There were very high expectations regarding the interpreter as a "culture broker". Some of these required interpreters to know "*the culture*" of the patients. This expectation can be seen to arise in the context of assumptions of a monolithic culture that can be summarised and commodified for easy psychiatric consumption. Much of this may have to do with the way in which psychiatric writing on the question of culture and mental health has outlined the relationship between the two (Swartz & Foster, 1984). Swartz (1989) has shown how notions of culture in psychiatric trainees serve to produce an 'African culture' that is a digestible product to allow psychiatric work to continue. This reified 'African culture' neglects

enormous variation in the range of beliefs held by Xhosa-speakers alone (never mind the other South African ethnic groups) and the fluidity of beliefs and religious practices. The extent to which culture is a process that is difficult to articulate, rather than a product that can be easily compared with other belief systems, is also absent from this view (Lewis-Fernàndez & Kleinman, 1995). It is important to note that there was also an expectation amongst Xhosa-speaking CHITEP staff that the interpreters should explain cultural concepts and ideas to the psychiatric staff. Kaufert & Koolage (1984) describe the culture brokerage concept to involve explaining indigenous cultural beliefs to medical practitioners but also the mediation of medical culture to patients. The reification of an 'African culture' as something exotic and unusual can be seen in the way in which in this context it was thought that explaining medical beliefs and practices to patients was patient advocacy, as opposed to the brokering of medical beliefs to patients.

In addition to this more obvious use of the notion of culture broker, there was an additional aspect. Clinicians and non-Xhosa-speaking nursing staff alike expressed a hope that an interpreter would clarify the distinction between a "*cultural illness*" and a "*real*" or "*psychiatric illness*".

> *"...because if we talk culture-wise now, the amafufunyana*[24] *and all those things that we are not up to date with, you know he is supposed to have a good knowledge and understanding of that...But then he himself needs to understand the boundaries or... when this guy is actually sick or if he's not mentally ill."* (Interviewee 20)

> *"...things like whether this is spirit possession phenomena or whether its voices. You know if the ancestors are talking to them as part of amafufunyana or whether it is a direct hallucination of schizophrenia."* (Interviewee 8)

> *"I think very often these debates do develop about the cultural context and to what extent we might be misinterpreting, and it might not have anything sort of overtly directly to do with linguistic issues but to do with transcultural issues. ...to be a member of the team and to be making a contribution and providing a perspective. And providing a perspective not from our clinical background of our own pre-conceptions and categories."* (Interviewee 4)

These statements embody a number of assumptions. Firstly, that being black and being an interpreter gives one automatic access to a huge range of cultural information. Secondly, that

[24] *Amafufunyane* is a local illness term and refers to a possession state.

interpreters would be highly skilled in identifying subtle clinical phenomena. Thirdly, that interpreters' combination of linguistic capabilities, cultural and clinical knowledge would allow them to cut through the Gordian knot of when a clinical presentation is 'cultural' or 'psychiatric'. In a way, what they require of the interpreter is to be a psychiatrically trained *sangoma*[25].

The differences between medical and psychiatric interpreting are germane here. Medical diagnosis may more easily lend itself to being construed as having categories that are defined in biological clinical terms and criteria. Cultural aspects of medical presentations may have to do with identifying unusual aetiologies, compliance patterns, beliefs about the significance of illness and how acceptable the treatment prescribed will be. In psychiatry this goes much further, to the point where there would appear to be a wish that the interpreter would be able to say whether the person is ill or not, 'mad' or 'genuinely possessed'. Interpreters may thus be expected to function not only as junior clinicians but as superior clinicians as well.

An irony of this difficulty is that it arose out of a wish not to impose categories of psychiatric illness. The clinicians interviewed wish to practise in a culturally sensitive manner and feel ill-equipped to do this. There was an awareness of labelling theory and the idea that local possession states may exhibit features of psychiatric illness but which are not best seen in this light (Mills, 1985; O'Connell, 1980; Schweitzer & Bührman, 1978; Swartz, 1986a). There was also a tendency to think that cultural aspects to illness and psychiatric presentations were dichotomous and mutually exclusive. This may produce the same result as not considering cultural sensitivity at all, as when there is justification for a mental illness according to DSM IV (1994), then the cultural aspects of an illness presentation may be over-ridden. This is also consistent with the argument advanced by Swartz (1989, 1993) regarding how universalist discourses subsume relativist discourses in South African psychiatry.

All of these expectations regarding the "culture broker" role should be seen in the light of the actual interpreters' views on the subject of culture. One interpreter disavowed traditional cultural beliefs and appeared embarrassed by the implication that as a black person these were the views he would hold. The other was more ambivalent but not at all confident to represent

[25] A *sangoma* is an indigenous or traditional healer.

the 'African world view' or explain cultural symbolism. There was very little correspondence between the expectations and what the interpreters could offer.

Interpreter as 'patient advocate'

There was all round support for the notion of patient advocacy. Most staff acknowledged how disadvantaged Xhosa-speakers were in the hospital and that there was a need to make more of an effort to accommodate them. The need for advocacy was identified in a number of areas. Patient rights, awareness of grievance procedures, the meaning of sections of the Mental Health Act and even orientation to hospital procedures and routines on admission were all seen as important to be conveyed to patients[26]. It was suggested for instance that groups could be convened for Xhosa-speakers to address these issues, and that interpreters run these groups in the absence of nursing staff. It is laudable that the hospital staff wished to see these sorts of services offered to Xhosa-speaking patients. However, the question has to be asked as to why it should fall to an NGO, based outside the hospital, to provide these services. It appears as though there was an awareness that Xhosa-speaking patients in a psychiatric hospital may constitute a group with special needs in accessing services and being put at ease in this context. The hospital staff did not see their way clear to doing this themselves. A sense of restriction in job descriptions and feeling over-worked are reasons given for not intervening in this way themselves. Of note, is the concern that nurses would perhaps be forbidding or alien to patients, even when Xhosa-speaking themselves. This recalls the issues raised in Chapter 5 regarding alienation in psychiatric settings.

The issues raised here all refer to Xhosa-speakers' needs as a group and as such suggest group level interventions. The notion of advocacy in medical settings is primarily used when referring to the needs of individual patients. This requires an interpreter to intervene with an individual doctor/patient relationship and was an aspect of what the CHITEP training anticipated for the interpreters. However, the context of psychiatric work requires a somewhat different perspective. The concentration of expertise in a psychiatric MDT and the explicit commitment to a biopsychosocial model (Engel, 1977) demands a great deal of the interpreter if they are to add to team discussions regarding particular patients. Not only does

[26] A recently established working group in the hospital, dedicated to looking at ethical issues in the hospital, had begun to identify problem areas and how they could be addressed.

contributing towards team discussions, and challenging the outcomes of these discussions where necessary, require enormous self-confidence, but it also requires a very wide range of competencies. Challenges to members of a psychiatric team that may be self-consciously aware that they must be as non-discriminating and socially aware as they are able, requires of the person who seeks to contribute an acknowledged basis of authority to speak. An interviewee expressed this in the following way:

> *"My feeling is that an outsider could come in - a person who is not in the team, could come in if they were well-qualified and of relatively high status. They could come in and play that kind of advocacy role and that they would be taken more seriously, but if you are going to be not a professor of something, then you need to be part of the team. [You can] advocate from inside and be a conscience rather than [from] outside [and be a] judge."* (Interviewee 3)

While interpreters are expected to deliver services in a number of wards and units, the high level advocacy functions that are also rather blithely expected require a close-knit relationship with a particular unit and the necessary authority. An interviewee expressed this aptly by saying that psychiatric teams are very "*team-like*". Thus, gaining enough credibility, trust, respect and confidence to make challenges to a psychiatric team requires one to be an insider. This sort of involvement in a team impacts upon the autonomy of the interpreter and creates the risk that they may reproduce the very institutional effects they seek to avoid (see Drennan, 1996b; Muller, 1994; Swartz, 1991b), thus compromising advocacy functions.

The situation outlined above creates a paradox. It is very difficult, on the one hand, to intervene on behalf of an individual patient in the face of the authority and clinical competence of a range of professionals. And yet, there are such glaring deficiencies in the services offered to Xhosa-speakers as a group. This would suggest that the lack of a global strategy at a management level and the appropriate allocation of resources serves to hobble the good intentions of individual staff members. There is no reason why interpreters should escape this fate unless the approach is complemented with structural changes in the organisation. These changes would need to be aimed at modifying the culture of the organisation with respect to non-dominant language groups to reduce levels of alienation and marginalisation. The depth of the need to revise the organisation's relationship to Xhosa-speakers as a language community is highlighted in the following section.

Interpreter as 'institutional therapist'

It was clear from the previous study at VBH (Chapter 4) that the Male Admission wards were sites at which there was the perception of the greatest need for interpreting. When the single interpreter was employed he was placed there. However, when hospital managers were asked about the allocation of Xhosa-speaking nursing staff to these units there were contradictory responses. One manager denied that there was any particular effort made to place Xhosa-speaking staff in the male wards and claimed that if they were well represented there it was fortuitous. Another manager was more direct. This person said that there was a conscious effort to mix white, coloured and black staff in all the wards, and that a primary consideration in staff allocations was to ensure a mix of language groups. This was intended to minimise the dominance of any particular language group. The interviewee thought that there were drawbacks to this strategy because staff who felt socially isolated in a ward, with no one to talk to, did not work as efficiently. However, she felt that there had to be some overt intervention to integrate staff ethnically or else they would not do so spontaneously.

> *"We try and give the impression that everything is OK and we do mix that well, [that] we get along very well at Valkenberg and it's not the case..."* (Interviewee 22)

The Xhosa-speaking staff interviewed who addressed this issue, felt in a sense, that the coloured or white staff who had not learnt a black African language were getting their just desserts if they felt excluded from conversations in Xhosa. They expressed disappointment and consternation at the lack of effort to learn even a few words of Xhosa. It was felt that this betrayed a negative attitude towards the language and its speakers. Further, that there was a possibility of expedience in not learning Xhosa because then a proportion of work could be automatically passed on to the Xhosa-speakers. As one person put it:

> *"It is good for them because ... if you know you have got 10 Xhosa-speaking patients, then I will deal with them. My colleagues won't deal with them, so it serves your purpose."* (Interviewee 14)

The confusion amongst Xhosa-speaking staff as how to take up the perceived refusal to learn at least some Xhosa expressed an uncertainty as to when linguicism becomes overtly racist.

> *"I'm not sure if I feel them because I am a Xhosa-speaker or because I'm black you see."* (Interviewee 14)

Some non-Xhosa-speaking staff did refer to the sense of alienation they experience when colleagues have conversations in a language they do not understand. They also expressed concern at tensions between non-Xhosa-speaking staff and Xhosa-speakers. A non-Xhosa-

speaker was looking to the interpreter to raise awareness amongst the Xhosa staff of how alienated the non-Xhosa staff feel when excluded from conversations by the Xhosa staff. There was a wish that the interpreter could act as a catalyst to increasing the Xhosa-speakers' sensitivity to the exclusion of others, through spontaneously interpreting conversations that excluded non-Xhosa-speakers.

Hospital administrators, far from being unaware of the language issues, were personally acquainted with the problems in their own work. It emerged from interviews that interpreting is required in a range of personnel management contexts. Disciplinary hearings, meetings to explain salary structures, general meetings of the non-clinical staff all required interpreting. What is more is that this was being dealt with in the same way as clinical requirements – by asking someone present in a meeting to interpret. In addition, Xhosa versions of communications from the head office were required. As one Xhosa-speaking staff member put it when referring to disputes with colleagues and management:

> *"You know, if I'm angry about the way that the matter has been handled, therefore I would like to express myself in my own language, mother's language, and then I would feel comfortable. I would say the right thing, the way I should do. I don't want to say something which is similar to that, but I would like to say the same thing, I would like to express myself. ...you should express yourself in your own language as the constitution says."* (Interviewee 18)

A non-Xhosa-speaker supported the idea of an interpreter in the role of facilitating the constitutional rights of staff and serving as a mediator in staff conflict.

> *"...what I can add on is that the interpreter, his duties are now broadened, because he is acting now as a mediator where conflicts go." (Interviewee 24)*

The full extent of the expectations that the notion of an interpreter carries was surprising. The interpersonal, institutional and socio-political dimensions to the need for interpreters, suggested by Swartz (1998), could be seen to apply beyond service delivery needs to those of the institution's staff as well. Again, it may be simple to dismiss these expectations as inappropriate and an indication of the need for education about interpreting. Certainly, this is true and education is required. However, the concerns expressed by hospital staff, draw attention to the way in which issues of language, which are issues of access to particular relationships, information and institutional spaces, cut across the staff/patient divide. They reflect the inter-penetration into mental health care teams of the social divisions that are part

of the larger society. While the "*team-like*" behaviour of staff all working together to achieve a particular occupational goal manages to overcome class, ethnic and professional differences (Goffman, 1959), these social identities are not left at the door. The power relationships that crystallise around the language issue re-introduce them to the occupational domain.

An evaluation of an interpreter project in this hospital setting has highlighted a number of deficiencies in impact. Some of these deficiencies can be seen to arise out of the need for massive revision in the structure of health care for black patients. However, a difficulty with this appears to be that no one was taking an overt position of overseeing the implementation and working through of the changes. In this climate, the idea of an interpreter, laden with all the connotative implications outlined above, has come to be seen as *the* solution to the problems created under an apartheid mental health care system. In an apartheid system the voices and identities of black patients and staff alike were stifled or excluded. However, the achievement of a democratically elected government and the promise of social change have brought with them expectations that the hegemonic power of English and Afrikaans would be challenged. This requires the transformation of institutional identities, and creating service delivery that is consistent with the identities of individuals who make up the system. I will now turn to a consideration of the manifestations of language in clinical work, with and without interpreters.

PART III:

LANGUAGE AND IDENTITY

Chapter 7

THE PARADOXICAL VISIBILITY AND INVISIBILITY OF LANGUAGE IN PSYCHIATRY

"It may be worth considering, then, a glib Freudian paradox: That some of the most efficient forms of censorship are those that render themselves invisible."

Phillips (1993, p.55)

Introduction

In examining the impact of the language service provided by an external organisation at Valkenberg Hospital, aspects of the institutional setting of the intervention were thrown into relief. Institutional structures, the attitudes and expectations of staff members, and the processes of institutional functioning all contributed towards the relative successes and failures of the project. In addition, the social dynamics of psychiatry in South African institutions could be seen to play a role. The examination of macro-level aspects of service delivery thus also illuminated institutional discourses that under-pin how the services are delivered and how patients are managed. These issues are explored further here through case records, ward round excerpts and the views and opinions expressed by interviewees. These micro-level elements are used selectively to continue the exploration of particular themes and discursive products identified at the macro-level. The notion of paradox arises out of a consideration of unexpected silences and contradictory institutional discourses.

THE INVISIBILITY OF LANGUAGE DIVERSITY IN PSYCHIATRIC WORK AND PSYCHIATRIC RECORDS

The following extract takes place during a ward round. Members of an admissions ward team and visiting students are assembled in a room that is part of a ward. The psychiatric registrar has completed the presentation of the patient's presenting problem, family and personal history, mental state examination, special investigations, differential diagnosis and current biological treatment. The patient is ushered into the room by the nurse who went to fetch him

and she motions in the direction of the consultant psychiatrist. The psychiatrist is standing with an arm extended and gestures towards a chair.

> Consultant psychiatrist: *Hello Mr. Mgengwana*[1]. *Please come and take a seat over here.*
> Consultant psychiatrist: *What language does he speak?* [Aside to the psychiatric registrar who presented the patient.]
> Psychiatric registrar: *He speaks Xhosa.*

This scenario is one fairly typical of how a ward round interview with a Xhosa-speaking patient could begin. Another very typical variant on this theme is for the psychiatrist who will interview the patient to ask the patient whether they speak English or Afrikaans[2]. It is possible to arrive at this point in the presentation of a patient at a ward round and not know which languages the patient speaks and at which degree of proficiency. This happens so routinely that it is completely unremarkable in the context. One aspect to this omission of information is the absence of reference to the language that the patient speaks as a part of the assessment. It may be noted in the patient's hospital folder as part of the identifying data or in the initial part of the mental state examination[3]. However, it is frequently not clear from the assessment notes in a hospital folder which languages the patient speaks. Another important dimension to this elision of language is the absence of an indication as to its impact on the process of taking a history and arriving at an assessment. When this occurs it is largely because the process of information gathering was perceived to be unimpeded by the absence of a common language between doctor and patient. The fact that someone may have been used to interpret, and who functioned as an interpreter, is frequently effaced from the public presentation of the work of psychiatric assessment.

[1] Names have been changed to protect the identities of patients.
[2] It is not only Xhosa-speakers who present this dilemma in a ward round interview. I have often heard how a coloured person will be asked if they speak English or Afrikaans at the start of an interview. It is interesting to note that Valkenberg is a predominantly "English hospital" in that it is located in the southern suburbs of Cape Town, and so is predominantly an English area and has predominantly English-speaking staff. Groups are run in English as a rule, even when the staff member facilitating the group has Afrikaans as a home language. Even Afrikaans speaking staff will speak mostly English at work. Lentegeur Hospital and the other psychiatric hospital in the Western Cape, Stikland, are situated in Afrikaans-dominated areas and are staffed mainly by Afrikaans-speakers. It was a requirement of the public service that all state employees be fluent in both languages but the home language of the therapists has an enormous impact on the degree of comfort with offering services and the culture of the organisation.
[3] The "identifying data" and MSE are parts of the structure used by staff at the hospital to collect historical information about the patient according to the format introduced by the Maudsley Hospital, London, hence referred to as a "Maudsley".

When is language irrelevant?

The irrelevance of linguistic diversity in clinical settings arises firstly from the theoretical paradigm within which the practice of psychiatry is situated. The universalist school of psychiatry represented by Leff (1981), to which the Department of Psychiatry at VBH has a strong traditional connection (Gillis, Elk, Ben-Arie & Teggin, 1982), takes an empiricist view of language (Good & Good, 1981). The meaning of any utterance in any language can through this model be reduced to ostensive reference. Crudely put, words refer to objects, whether material or psychological, and they occur universally. This facilitates the straight-forward use of DSM IV (1994) categories, as it standardises the meanings that are possible. Thus, the categories of the mental state used to differentiate human experience into types of symptomatology penetrate the superficial variations of presentation expressed in different languages. Biological interventions can be seen to perform a similar function (Swartz, 1991a).

However, there is a more practical institutional investment in obscuring linguistic diversity, and that is the obscuring of the role of the interpreter. The effacement of the interpreter as the source of authority in access to speech, and by inference the mind, as a source of psychiatric data, maintains the impression that the clinician has untrammeled access to this information. The extent of the psychiatric insight and grasp of psychiatric concepts places tremendous constraints on the quality of the access to a patient's mental state that a doctor is likely to achieve. The impact on the quality of the assessment that is possible when working in a hurried way with an unqualified interpreter and a psychotic patient is significant. As discussed previously, mental health professionals working in this way may have a wish to hide from scrutiny the crude access to patients they have and the compromising of the power of the "medical gaze" (Foucault, 1973)[4]. The obscuring of linguistic diversity and the use of interpreters could be seen as an important mechanism by which a whole set of erasures and elisions are accomplished in colonial psychiatry (S. Swartz, 1996b). This point will be returned to again in what follows.

[4] See Drennan, Swartz & Levett (1991) and Drennan (1992) for discussion of how the process of producing translated psychiatric research inventories is obscured for similar reasons. Pool (1994), in his ethnography of illness in a Cameroon village, reflects on how difficult it was to learn the language spoken by the people of the village and how profoundly dependent on his interpreters this made his work. Surprisingly, he suggests that even ethnographers tend to render their interpreters invisible in their texts.

Nevertheless, institutional rules for how to successfully represent clinical work that is potentially compromised through crude access to a patient's speech may be revealed through rule breaking (Garfinkel, 1967; Kaufert, Koolage, Kaufert & O'Neil, 1984). The following extract is from the folder of a male patient in his early 30's, who required an interpreter for more than rudimentary communication.

> *"Has settled quite a lot. Had a reasonably coherent conversation with him. Reports ? dystonic reaction to depot (painful neck). Says he stopped meds when sister moved to ?* [another city] *? She used to give him tablets. (Anyway, that is what I think he said)."*

It is most unusual to have an acknowledgement of uncertainty of what a patient meant in this way[5]. Utterances of uncertainty in medical records are extremely problematic for clinicians. Firstly, as folders are medico-legal documents (Garfinkel, 1967; S. Swartz, 1996b) uncertainty places the clinician in a vulnerable position. Secondly, folders serve as a record of clinical competence (Barrett, 1988). All of this can be called into question if there is an admission that a relevant issue has not been clarified adequately by the clinician. This particular folder entry is noteworthy because it states that basic information was gleaned from the patient, but then undercuts this with an announcement that it may also be incorrect or misleading information. This sabotages the apparently successful construction of a narrative in which non-compliance with medication arose out of a loss of social support. The folder entry made by the psychiatric registrar admitting the same patient to hospital indicated that the patient spoke very little English and thus emphasises observable features of behaviour and the absence of observable features of psychosis, such as "*not objectively hallucinating*". The admission assessment was clearly impoverished by the absence of an interpreter. This was the patient's fourth admission to hospital and it was not clear from the hospital folder that an interpreter had ever been used in all of the previous admissions. However, this does not preclude the previous use of an interpreter to interview the patient.

As was outlined in the previous chapter, a review of hospital folders for patients who clearly required interpreting was undertaken as part of the study. In 57% of folder entries that

[5] As this folder entry occurred during the time period of the questionnaire study it is possible that it was made as a result of the language issue being foregrounded by the research and the clinician's wish to bring uncertainty to the attention of the researcher.

indicated the patient had been interviewed, it was not clear whether an interpreter had been used. Many of the interviews documented through questionnaires to have been with an interpreter present, also had corresponding folder entries in which it was not clear that an interpreter was used. It was more often the case that when an interpreter was not used, and this was recognised to impede the quality of the assessment conducted, that an entry would be made to reflect this, as in the example above.

A further dimension to the irrelevance of language in the bureaucratic management of patients is the neglect of the role of an interpreter when one is present. Folder reviews of patients in the Female and Male Admission Wards revealed very few references to the function or role of the interpreter in the interview *per se*. The notes in the folders of patients seen in the Forensic Unit more frequently referred to the presence of an interpreter and these instances will be considered below.

Constructing symptoms in the absence of adequate communication

The elision of translation and interpretation in the psychiatric assessment of a patient performs important institutional functions. Mishler (1984) has shown how the narratives that articulate the lifeworld of a patient are transformed into the discourse of medicine by the 're-languaging' of experience into the two categories of clinically irrelevant or clinically relevant, i.e. symptoms. Writing in a psychiatric context, Barrett (1988) has described the complex interplay between the narrative provided by a patient, the moulding of the narrative to clarify and negotiate particular meanings, and the inscription of this narrative in language that is meaningful to other psychiatric readers. Thus, the record of a patient's account must 'abstract' the patient's narrative sufficiently to crystallise the 'essential' meanings and code these in a language that Barrett terms "intermediate typifications" (p. 272). Part of the clinical competence expected of psychiatrists is to construct records in such a way that they are not too theoretical, but also not 'naïve' in the sense of a lay person's account. There is a sense then in which the clinical record must appear to reflect the patient's story, but with a psychiatric overlay that corresponds to having understood the patient in terms of a psychiatric frame of reference[6]. Not all psychiatric accounts are adequate and disputes can arise as to the

[6] This can include multiple layers of 'insight' depending on the abilities and interests of the clinician, ranging from psychiatric to psychological or psychoanalytic levels.

accuracy of a clinician's interpretation. However, not only must the patient's story be preserved, as data, but the patient's mental state must also be documented. This serves as a parallel interpretative process that intensifies the "medical gaze" by focusing on features of the person in the totality of their presentation to the clinician. The task of a psychiatric assessment can be seen then to have two cardinal dimensions: the patient's story (transformed), and the clinician's observations of the patient rendered in psychiatric terms.

This can begin very simply through 'making' observations. These observations may, if necessary, also be read as symptoms. There are a number of psychiatric illnesses that have muteness as a feature of the patient's condition. It is important for adequate intervention that this feature is noted and that the other aspects of an examination are completed[7]. However, making an assessment of a monolingual patient, who could communicate if they had access to an interpreter is not a comparable situation. And yet the impaired communication between clinician and patient may be subsumed into the assessment in such a way as to create the impression that this is a feature of the patient's presentation. The inscription of the by-products of communication difficulties in "intermediate typifications" creates the appearance of objectivity and legitimate psychiatric observation.

Symptoms that are typically passed off as the patient's are impaired intellectual ability and types of thought disorder. The folder entries of a young male patient during his first admission serve to exemplify this. A clinician 'managed' the patient for a period of one and a half months without using an interpreter and made the following entries.

> *"Patient gives a simple account of self. Seems to struggle to answer questions at times. Describes a range of psychotic symptoms".*[8]

Three weeks later the following entry appears:

> *"Still very impoverished account given. Poverty ++. Very simple man".*

While the patient was being seen by the clinician he was also taking part in support therapy groups. It was noted that an interpreter was required on each occasion for the patient to

[7] Muteness may be a feature of certain organic conditions, such as subdural hematoma. This is a treatable but potentially fatal condition. Other clinical signs, such as ataxia and impaired levels of consciousness may serve as indicators of this type of pathology. It is important to note here that registrars interviewed expressed concern about identifying conditions as biological as these in the absence of an interpreter.

[8] Abbreviations in folder notes have in some instances been replaced with the full word that they are used to represent. For example: pt for patient, a/c for account, v for very.

participate. Members of the nursing staff in the ward in which the patient was treated were also of the opinion that the patient required interpreting to be interviewed[9]. The clinician is able to proceed, however, because the patient can communicate to a certain extent in either English or Afrikaans. Ironically, it is the patients who are able to use a few words or phrases of English or Afrikaans that may be the most compromised in local settings. The clinician's apparent success at eliciting *"a range of psychotic symptoms"* lends credibility to the other observations, and may in fact subsume them as part of the psychotic illness. The assessment of the patient's intellectual abilities and the "*poverty*" of his thought are questionable in the absence of allowing the patient to communicate in his first language. These comments are profoundly stigmatising in this context. Barrett (1988) has drawn attention to the influence that clinical notes have on clinicians in subsequent interactions with patients. Observations made by one clinician have a way of becoming self-fulfilling prophecies[10]. The folder entries discussed above create an impression of a patient who has an impoverished style of relating. In subsequent interviews with clinicians, who will routinely interview the patient without an interpreter present, a restricted account from the patient would serve to confirm the impressions noted by the previous clinician, rather than serve as an indication that the patient requires an interpreter to facilitate communication.

It is remarkable that the terms used to describe patients when an interpreter is not involved can be so similar to the types of descriptions identified by S. Swartz (1996a) in her analysis of clinical records from the turn of the century. These constructions of black patients' identities surely persist partly because of the resilience of racist discourses in colonial psychiatry. However, the very few white clinicians who can speak black African languages today and the on-going institutionalised failure to recognise the communication needs of such patients, can also be seen to be implicated in the continuation of these stereotypes and failures in comprehension on the part of the clinician. In fact, the persistence of racist discourses in

[9] The question of discrepancies in the perceived need for interpreting will be returned to later.
[10] Similar observations have been made of the psychiatric careers of what are termed "difficult" or "problem" patients (Papper, 1986; Wright & Morgan, 1990). Patients who acquire this epithet may be given diagnoses of personality disorders. However, it may also be the case that they are the patients who are aware of their rights, and assertive and challenging of the system as a consequence. Thus, they are more likely to complain about bureaucratic inefficiency and inappropriate treatment. Clinicians, who may themselves feel frustrated at bureaucracy, may attribute the source of the difficulties to the awkward patient. It is instructive that a monolingual Xhosa-speaker may also experience "victim blaming" in this way, but be even less likely to defend their position.

institutional psychiatry can be seen produced and maintained in part by the inadequacy of communication in such settings.

Constructing cases in the absence of adequate communication

A feature of psychiatry in institutional contexts is the creation of stories that are passed off as the patient's (Swartz, 1991a; S. Swartz, 1996b). The absence of interpreter utilisation has significant effects on the minutiae of clinical assessments, as was illustrated above. Even when using an interpreter, a superficial and over-simplified assessment may be made when the clinician and the interpreter are working under restrictions on the amount of time that can be allocated to each patient. It could be argued that the effects on the details of an assessment do not significantly impact upon the overall assessment and management of a patient. While the effects of impaired communication may be more diffuse and less easy to specify at this level, the effects may be seen to be even more profound. There are two aspects that I wish to draw attention to. Firstly, diagnoses can and often do rest on subtle features or particular details of a patient's presentation. The diagnostic decisions that follow may have significant implications for the rest of a patient's psychiatric career. Secondly, the diagnostic conclusions arrived at in the course of an assessment are intended to form only part of a comprehensive biopsychosocial assessment (Engel, 1977). In the case of patients with whom there is impaired communication, a reductive assessment that does not extend much beyond a diagnosis is a possible outcome. Psychological, familial and other social problems may be obscured in the process.

The first point can be illustrated through a case seen at a ward round during the ethnographic period of the study. The patient presented in a ward round was a man in his mid-twenties, being seen at the hospital for the first time. The psychiatric registrar presenting the case material noted that the patient used cannabis, and was talkative, but incoherent. The interpreter who assisted with the interviews preparatory for the ward round appearance had struggled to follow what the patient was saying. This created uncertainty as to whether the patient exhibited the symptoms of flight of ideas or loose associations. The patient claimed that people on television talked about him and the content of his thoughts were noted to be religiose and paranoid. It was clear from the registrar's assessment that diagnostic uncertainty hinged on the patient's mood state and the nature of the thought disturbance the patient exhibited.

The extract from the ward round interview are from my hand written notes and memory. This extract follows an interview with a member of the patient's family, during which the patient was present but did not speak except once, briefly, in Xhosa. My notes at the time of this next interchange describe the patient as "demonstrative, over-familiar, pointing, smiling, perspiring, walking around at times". The interpreter was a visiting black student, with no psychiatric training and who did not speak Xhosa as a first language. The student did have extensive experience with interpreting.

Interviewer: [in English to patient] *How are you feeling?*
Patient: [English] *Great!* [proceeds in Xhosa, then says in Afrikaans] *Vrystaat!*[11]
Interpreter: [English] *I can't understand what he is saying.*
Interviewer: [English] *How well are you? 10%, 90%, 100% 110%.*
Patient: [English] *10%.* [Laugh]
Interviewer: [English] *I would have thought feeling great was better than that.*
Patient: *50%.*
Interviewer: [English] *Why are you feeling better?*
Interpreter: [Xhosa]
Patient: [Interrupting the interpreter, speaks rapidly in Xhosa]
Interpreter: [English] *He is not answering the question. He is telling me something else.*
Interviewer: [English] *Is anything worrying him?*
Interpreter: [Xhosa]
Patient: [English] *No.*
Interviewer: *Your family seem to think so?*
Interpreter: [Xhosa]
Patient: [Xhosa]
Interpreter: [English] *He has a problem with his heart, after that...* [gesticulates, laughs, appears embarrassed]
Interviewer: [English] *Does he have any special powers?*
Interpreter: [Xhosa]
Patient: [Speaks Xhosa briefly, then in English] *Mr. Rock. I am not a rock, I am a man.*
Interviewer: [English] *Who or what are we?*
Interpreter: [Xhosa]
Patient: [Xhosa]
Interpreter: [English] *He knows you are his mother amongst these...* [gestures towards the female nurses present]
Interviewer: [English] *What is this?* [Indicating the building]
Patient: [replies in Xhosa before the interpreter can speak]

[11] "*Vrystaat*" in English is "Free State". It is a rallying cry for a provincial rugby team with a strong Afrikaans history. The word is used by others outside of rugby contexts to comment on male aggression and dominance, and Afrikaner identity.

> Interpreter: [English] *He said it is a hospital.*
> Another clinician: [English] *Does anyone want to harm him?*
> Patient: [replies in Xhosa before the interpreter can speak]
> Interpreter: *He says not now but before they did. A man gave him special powers to see this.*

The patient did not speak in English again but answered a few more questions in Xhosa to do with whether or not the patient thought he was a witch, to which he answered "*No*". When the interview had ended and the patient was ushered out, discussion ensued as to the diagnostic possibilities that should be considered. The significance of the patient's elevated affect and mood was noted, as was his impaired concentration. The psychiatrist leading the discussion commented that the patient was thought disordered and that his impression had been that the patient was not making sense. He made the point for the students' benefit that thought disorder occurs in mania, but that even though the speech may be rapid "*one can follow*" what the patient is saying when manic. However, from his observation of the expression on the interpreter's face the patient was not making sense and was babbling. Various other points were made that revolved around the question of differentiating between a manic episode and a schizophrenic episode. The conclusion arrived at was that the patient was suffering from schizophrenia. A medical student present in the ward round asked why this conclusion was reached. The consultant replied that the "*nature of the thought disturbance*" was the deciding factor. While many factors contributed to the diagnostic reasoning applied to this patient, a single symptom can be seen to be pivotal in making important choices. Clearly, the actual rendering of the patient's speech was not ideal. And yet it is concluded that there was sufficient evidence for "*formal thought disorder*". The assumption that fragmentary speech is indicative of fragmented thought processes has been the subject of some debate (S. Swartz, 1987). However, when a patient speaks haltingly in what may be a third or fourth language the assumption is all the more tendentious. Interviewed clinicians expressed the value of psychiatric nurses who interpreted because of how they used clinical training and insight to assist the clinician.

> *"They'll [psychiatric nurses] probably be able to say he's psychotic whereas the interpreter may say I can't follow him."* (Interviewee 6)

While the nurse's rendition described here appears to assist in clinical diagnosis because it attaches a psychiatric label to thoughts, the patient can no more be known through this interpretation (S. Swartz & Swartz, 1987).

It is significant that during the preceding interview with the patient's family member, the family member had taken the opportunity offered to ask a question. The family member had said (in Xhosa) that the patient was 25 years old and yet had never had a girlfriend. The family member expressed an anxiety that the patient was being made mentally ill by the sperm that he was not using. In the context of the ward round there were embarrassed smiles all around and the interviewer responded by pursuing an inquiry about homosexual contacts. The question of masculine roles, behaviour and identity was not returned to. A close reading of the patient's utterances in English could be seen to be an extension of the family member's concerns. The part of the interview detailed here reveals a pre-occupation with gender identity and a meta-commentary on South African male stereotypes. The patient exclaims the word "*Vrystaat*" in the way that it is often used to symbolise male virility and competitiveness. Later he addresses the male interviewer as "*Mr. Rock*" and proceeds to say he is not a rock, he is a man. He then challenges the interviewer indirectly by saying he is a mother amongst women, commenting perhaps on the 'feminine' qualities of caring and sympathy in the work of the caring professions. The possible 'sense' in the content of what the patient says in the ward round appears to have been either lost or unrecognised in the discussion about diagnosis. While there certainly was explicit reference to the possible role of a manic defence in the patient's presentation, the actual content of what the patient said did not contribute to the consideration of what may be wrong with him. A focus on form of thought rather than the actual content of the patient's thoughts contributes to a reductive psychiatric understanding in the place of a psychological understanding[12].

There is a sense in which the significance of diagnosing schizophrenia as opposed to mania (or Bipolar Affective Disorder) in the patient described here is far-reaching. Typically, this is expressed by clinicians as having a major impact on the medication chosen and hence the efficacy of the treatment. While the choice of medication is significant, the very emphasis that is placed on this factor under-scores the absence of alternative treatments. In the case described above, the diagnosis of schizophrenia will immediately limit the range of interventions that will be considered for the patient. The extent of the psychotherapeutic

[12] The issue of the interpreter's silence is important. It is instructive that the person who interpreted was a post-graduate social science student. And yet he was silent about the interpretations made about the patient on the basis of the interpreting he performed. Later in the ward round the student had asked if the question regarding sperm as a cause of mental illness could be true. This provides some indication of even how a relatively qualified and experienced interpreter can lack confidence and authority in such settings.

investment and the place of a social work intervention will be informed by the extremely limited resources available for black males with this diagnosis. The patient could be seen as suffering from a manic episode in the context of depression linked to identity development, limited social skills and unemployment. If this were the case a different set of interventions would be indicated and the failure of the mental health care system to provide for them would be foregrounded. The following case example also highlights the role of impoverished communication in maintaining a focus on the disease aspects of psychiatric illness and the concomitant emphasis on almost exclusively biological interventions.

The second main issue that I wanted to draw attention to with respect to the construction of a case without sufficient communication has to do with the narrowness of focus that can arise. Swartz (1992a) has highlighted previously how biological interventions are prioritised in the face of minimal communication with speakers of black African languages. A male patient in his thirties was admitted in a post-ictal state. He was brought to the hospital by his mother. The following mental state examination (MSE) notes were made in connection with this patient on admission.

> *"Sits appropriately, but looks around in a distracted manner.*
> *Looks a little unsteady on his feet.*
> *Mood: Euthymic*[13]*. Affect: Restricted, dulled.*
> *Speech: ↓flow. Monotonous. Monosyllabic answers.*
> *Thought: ↓flow. One word answers. ? TD* [Thought disorder]
> *Denies hall's/delusions.*
> *Cognition: Disoriented – T, P* [Time, Person or Place]
> *Poor concentration, poor memory, ↓insight.*
> *A* [Assessment]: *Post-ictal psychosis (? Schizophreniform) Epilepsy"*

The teaching in the Department of Psychiatry at the hospital was that the MSE should reflect the clinician's observations. This is maintained in spite of the aspects of the MSE that are derived from the patient's self report. The MSE is made up of a number of categories: Appearance and behaviour, speech, mood & affect, thought (with sub-divisions of flow, form, possession, content), perception, obsessive-compulsive phenomena, and cognitive functions (sub-divided into attention, concentration, memory, abstract thinking, intelligence) and insight & judgement. The emphasis on observation as the cornerstone of the MSE can be seen in the

[13] The convention in the hospital is for the patient's mood to be specified in the term used by the patient to describe how he or she is feeling. The use of the term "*euthymic*" is thus an error here. This too can be seen to be a logical consequence of not communicating sufficiently well with the patient to be able to specify a feeling-state in the patient's own terms.

fact that it can be completed on a completely mute patient, as discussed above. There is an onus on the clinician to complete as much of the mental state as is possible under the circumstances pertaining to the patient's presentation. This is precisely the rub. The examples above create the impression that the impoverished detail in certain categories arises from the features of the patient's presentation, rather than the inadequacy of the communication.

If the patient is accompanied by a referral note indicating a reason for admission, or was assessed elsewhere, a cursory MSE as described above, would be enough to allow the bureaucratic function of admitting a patient to hospital to proceed (c.f. S. Swartz, 1996b). The absence of the interpreter under these circumstances is not routinely recorded. The obscuring of the need for an interpreter to make more than a superficial assessment of a patient is rendered irrelevant by the continued bureaucratic processing of the patient. This irrelevance is confirmed by the absence of any reference in the documentation of the process of the absence of an interpreter.

The patient referred to here stayed in hospital for 10 days. There are folder notes indicating a further three interviews but that no interpreter is used during these interviews. The note in the folder prior to discharge states "*Well since Thursday* [five days]. *Discharge*". The patient was returned to hospital the following day by his mother. He was assessed again but without an interpreter, thought to be not psychotic and discharged five days later. He was readmitted four months following this having had seizures on three consecutive days. Again, there is no evidence of the patient being interviewed through an interpreter. One interview was recorded in the folder that documents appropriate answers to simple questions, the patient's inability to perform a basic calculation as a test of concentration, and a query as to whether the patient was hallucinating because he looked around after each question. He was discharged five days later.

Six days following this discharge the patient was readmitted following an attempted rape of his mother. He appears to have been interviewed without an interpreter and the admitting doctor notes "*Difficult to assess because says 'I don't know' to all questions including what is*

your name"[14]. The admitting doctor interviewed the patient's mother who provided the following details: "*not right*" since the last discharge; refusing to eat; staring vacantly; speaking incoherently; very quiet and withdrawn; inappropriate behaviour; tried to have sex with her that night; and the mother was very frightened. The next note in the folder is from an occupational therapy art group.

> *"Patient was very quiet in group. Language was a big problem as he speaks only Xhosa. Said a few words in Afrikaans but wasn't much. Communicated with fellow patients in Xhosa but I could not get the trend of the conversation".*

One week after admission the patient was discharged with the following entry:

> *"Improved quickly, apsychotic, well behaved".*

The description above is selective for the purposes of clarifying the relationship between poor communication between the patient and various clinicians and the truncated construction of the patient's situation. Throughout this series of contacts with the hospital the entries create the impression of an organic disorder (Epilepsy) that is poorly controlled. Certainly there is a serious biological disorder, but the range of difficulties that any such patient presents are complex and multi-factorial. It seems from the entries that the few words that the patient can speak of Afrikaans were used to check the mental state features associated with epileptic seizures. These served as an indication of recovery from an organically induced state and once this had been ascertained there appeared to be no further need for intervention. The pressure that clinicians may feel to discharge patients in the shortest possible time is no less an issue here than elsewhere (Mizrahi, 1986; Rhodes, 1991). Nevertheless, the superficiality of assessment conducted in the absence of any interpreting results in the patient's social context being completely effaced from the intervention. The patient himself may have contributed to this difficulty in assessment through non-co-operation at times. This is highly plausible under the circumstances of having made sexual advances towards his mother prior to the last admission described here. However, complexities of this sort require an even more careful assessment, of risk and other contributory psychopathology, which minimise the obfuscation of monosyllabic communication.

[14] The issue of the patient's refusal to speak is important and questions of passive resistance and the role of the patient in poor communication between doctors and patients will be addressed in Chapter 8.

The shadow of the interpreter

In contrast to the obscuring of the absence of the interpreter, the obscuring of the presence of an interpreter is also a feature of the patient folders reviewed. The vast majority of entries detailing patient utterances are represented in folders as quotes, but without acknowledgement that these may be translations. The combination of not specifying that an interpreter was used when they were and providing quotes in English go towards creating the impression that there was no need for interpreting for individual patients.

In my review of 67 folders from FAWs and MAWs I found four examples of the use of Xhosa words. A Xhosa speaking patient admitted to hospital through an interview without an interpreter is quoted as saying "*Haai, andiase*"[15] to all questions. One other clinician noted a Xhosa word for sad (*ludala*) in an MSE. This reference to the emotional state of a patient with the Xhosa word is extremely rare. The words "*amafufunyane*"[16] and "*ukuthwasa*"[17] were both used once as they refer to what are considered to be 'cultural illnesses'.[18]

WHEN IS LANGUAGE RELEVANT?

The examples presented above illustrate how 'functional' communication with patients can be. This functionality serves the interests of the institution by creating patients who are constructed in particular terms and therefore able to be processed through the bureaucracy. We have seen that these constructions of patient symptoms and narratives may lack an awareness of broader social and psychological considerations. Further, we have seen how the gaps and silences in the clinical records because of impoverished communication are elided. The absence of interpreter use is obscured and when interpreters are used the precise nature of the contribution they make is obscured. There is a sense in which the bureaucratic accomplishments of these effects can be seen to be demonstrations of situational clinical competence. However, the context of forensic psychiatry is somewhat different. In a forensic setting there is a greater degree of public accountability and closer scrutiny by colleagues in

[15] The correct Xhosa is "*Hayi, andiyazi.*" This means "No, I do not know."
[16] *Amafufunyane* is a local illness term for a particular possession state that is extremely negatively valued.
[17] *Ukuthwasa* is the term for an illness that serves as a calling to enter into training to be a traditional healer (*sangoma*). The cure for this is to undergo the initiation process, often of two years duration.
[18] Cultural Formulations, as recommended in the DSM-IV (1994) are not used in local hospitals. This aspect of the additions to the DSM since the revised third edition have not filtered into clinical practice as yet.

the legal and health professions (see also the discussion in Chapter 4). Here there is a different range of clinical competencies that must be articulated. This results in a number of overt references to the role of the interpreter in the assessment that are quite unusual in the mainstream settings.

A man in his late 20's was admitted with a charge of having raped a child. While the notes on a patient being admitted to other wards are notoriously perfunctory, this entry was more detailed. It was noted that the patient spoke Xhosa, that he took a long time to understand questions *"(via Xhosa interpreter)"*. In addition, it was noted that *"(According to the translator no evidence of FTD[19])"*. This entry alone is unprecedented in the notes found in the male and female admission wards. However, notes from an assessment two weeks later repeat the precedent:

> *"Thought flow normal, form* [of thought] *normal (Interpreter says, also his speech in Afrikaans = Normal form)"*.

Another male patient in his late 20's, admitted on a charge of murder, has similar entries in the folder notes, atypical for other wards. The admitting doctor notes that the patient had *"reasonable contact with interpreter"*. This is the first acknowledgement I could find that the patient's rapport or quality of emotional contact is primarily with the interpreter and not the clinician. It is ubiquitous to find in clinical interviews I observed in ward rounds for the clinician interviewing the patient to direct all questions towards the interpreter and to speak of the patient in the third person[20]. It is also most usual for the interpreter to reply in a similar fashion. The acknowledgement that the patient's rapport is with the interpreter, and only secondarily with the clinician, is counter to the customary elision of this in clinical notes.

The same admission interview notes indicate the following:

> *"Does feel that he may have been 'bewitched' at that moment (translator felt his explanations culturally appropriate)"*.

[19] Formal thought disorder.

[20] Many articles that provide guidelines as to how a clinician should work with an interpreter indicate that the clinician should speak in the first person to the patient. This is done to maintain contact with the patient and to assist the interpreter with direct translation. In my experience this has not always been appropriate. Patients often find it confusing and the level of skill of the interpreter may also need to be considered.

Again, this is the first overt reference to the interpreter's role in making a 'cultural' evaluation of the patient's experience. Further interviews by another clinician yielded the following comment in the folder notes under the rubric of the MSE:

> *"Speech: Used interpreter – coherent but interview drawn out – not talkative. Account not consistent. Interpreter felt that* [the patient] *understands English and also understood the interpreter but was acting stupid. Interpreter does not believe patient to be stupid but feels he was obstructing the interview".*

One of the many complex tasks of training in forensic psychiatry is to demonstrate clinical competence by differentiating the sources of information. So an account of the events that led to the arrest and referral of the accused to hospital must be constructed into a narrative that is credible and coherent within a psychiatric frame of reference. Often this requires making careful distinctions between what the patient claims took place, what other third parties claim occurred and what the clinician surmises took place. Clearly this is an extremely complex and sensitive task that requires not only clinical competence but a great deal of experience in the setting. When a patient communicates through an interpreter an enormous responsibility is placed upon the interpreter to make important judgements, many of which require just the astute combination of clinical insight and experience that comes with forensic work. In the example quoted above, a mental health professional appears to rely on an untrained interpreter to differentiate intellectual impairment from deceptiveness. It could be argued that many other features are taken into consideration in a forensic context before such an opinion is inscribed as a firmly held conviction in the clinical team. However, the overt way in which this impression is inscribed in the folder indicates that the clinician was not comfortable with glibly endorsing the assessment and clearly attributes it to the interpreter. By the same token, the clinician would be at a loss to arrive at this interpretation of the communications of the patient without the assistance of the interpreter's judgement. The use of the word "*stupid*" foregrounds the above instance as the opinion of a lay person overtly by not rendering the opinion in "intermediate typifications". It is highlighted as an opinion, and not an assessment, through the use of lay terminology.

However, there were other instances where the transformation of the interpreter's utterances into psychiatric discourse was hidden or effaced. The statement *"(According to the translator no evidence of FTD)"* illustrates this. An untrained interpreter would not be able to say "*no evidence of FTD*" because the interpreter would not have acquired this term. Thought disorder, and even formal thought disorder as a sub-class of thought disorder, is often

characterised as a subtle and difficult clinical assessment to make. It has many features such as flight of ideas, loose associations, knight's move thinking and derailment. These features are defined and can therefore be quite clearly taught and illustrated. Others are more amorphous and rely a great deal on an overall impression of the patient's speech. Descriptors such as circumstantiality and over-inclusiveness are entirely up to the clinician's discretion and not all clinicians would necessarily agree on any particular instance. In a forensic context clear evidence of thought disorder is of great value as clinicians believe that it can not be 'faked'. In the face of this clinically complex task with the use of an untrained interpreter, the issue is often resolved by asking of the interpreter "*Did the patient make sense?*". If the answer to this question is "*yes*", then the clinician can write "*no evidence of FTD*". This is sufficient for the purposes of the bureaucratic production of a text that displays the necessary jargon and competencies on the part of the clinician (c.f. Spencer, 1988). In other ward contexts the role of the interpreter in arriving at this assessment is elided, but in a forensic context the clinician hedges this opinion by clarifying that it is the interpreter who is responsible for creating this view.

The above examples have demonstrated the production of psychiatric texts either with or with out the assistance of an interpreter. There were instances where it appeared that an interpreter was required for the patient to be interviewed and yet an interpreter was not used. We also saw examples of the range of uses to which an interpreter's work can be put. South Africa has no policy in health care regarding when to use an interpreter and when not. There are, as yet, no legal or bureaucratic guidelines for when an interpreter should be used to interview service users or how this should be recorded for medico-legal purposes. The discrepancy between when an interpreter is used and when not with the same patient, gave rise to the question for me as to how clinicians decide when to use an interpreter with any given patient.

THE INSTITUTIONAL CONSTRUCTION OF 'THE PATIENT WHO REQUIRES INTERPRETING'

The recently adopted constitution of this country specifies certain language rights to the citizen in dealings with state agencies[21]. However, there are no clear guidelines as to how this right should be exercised or how service providers in institutional contexts should facilitate it.

[21] See Appendix 3.

These will no doubt emerge with time. In the interim, the notion of 'the patient who requires interpreting' would at first blush appear to have an objective existence. Such a patient is surely someone who is monolingual and with whom there can be no meaningful communication without an interpreter. This view neglects the processual nature of communication and the multiple factors that determine the decision to use an interpreter in institutional contexts. In Britain, where practice guidelines have been established, there are certain statutory requirements of services providers such as social workers when dealing with service users whose home language is not English (Baker et al., 1991). However, even these statutory requirements take second place to the wishes of the client. The first step in dealing with someone whose home language is not English is thus to request whether the service user would like an interpreter. This is not equivalent to the question "Do you speak English?".

In the present context, with no training in how to use an interpreter, no access to psychiatrically trained interpreters, and no ethical guidelines as to when it is inappropriate to proceed without an interpreter, there is considerable incentive for the clinician to take the route that 'gets the job done'. It could even be argued that this is in the best interests of the patient. This means that patients may well be interviewed through the medium of the little English or Afrikaans they can speak and understand. It is normative for any person communicating in a second language to have better comprehension of the second language than expressive capabilities (Cook, 1993). Consequently, patients may comprehend (or appear to comprehend) a question but struggle to respond in more than a monosyllable[22]. Such monosyllabic responses create the impression for the clinician interviewing the patient that the communication is functionally adequate. I use the word functional advisedly here as it is precisely in this respect that one can see the institutional mechanism by which communication difficulties are minimised. Doctors typically employ a number of conversational strategies to manage (control) medical interviews (Ong, de Haes, Hoos & Lammes, 1995; ten Have, 1991). These involve closed-ended questions, interruptions, etc. Psychiatric and psychology textbooks promote a more facilitative style of interviewing but in a situation in which the medical practitioner is doubly more articulate than the patient (English and medical jargon), more restrictive biomedical interview strategies can re-assert themselves. Interviews that resort to the language in which the doctor is comfortable become

[22] Oquendo (1996) makes the additional important point that functional competence in a second language varies with the patient's clinical status, or as the level of psychosis varies.

more medicalised. Monosyllabic responses to closed-ended questions seeking to confirm or disconfirm the absence of particular symptoms become the norm. There is little opportunity for an answer of the "yes, but..." variety, and certainly very little likelihood of an actual illness narrative.

It must be said that in my experience of observing fellow clinicians interview patients in ward round settings, both as a researcher and prior to that as a fellow clinician, that interviews of the nature described above are uncomfortable for clinicians. The discomfort may arise out of the frustration of how poorly one understands the patient's situation but also because even the biomedical aspects of the task are impaired. Occasionally this is because subtle clinical distinctions in the phenomenology of the illness presentation can not be distinguished. At other times it is simply because 'gross' distinctions between psychotic illness or a neurotic illness can not be made with any confidence. The lack of a certain degree of confidence in a clinical setting is always disquieting for a clinician. As in the situation described at LGH, clinicians themselves can feel trapped, along with patients, in a tangle of institutional limitations. Survival in such a system often requires an attitude of 'do the best you can' (Mizrahi, 1986). Through this, institutional mechanisms to continue to be productive arise and become routinised (Fisher & Todd, 1983; West, 1984). The problems of working around the difficulties in communication become subsumed into a range of material and institutional impediments to the ideals of clinical practice. These abilities to manage the communication problems eventually become a skill in themselves and can even be valued as 'clinical skills', much in the way interview strategies to elicit paranoia becomes esteemed as skill (even art) in interviewing (c.f. Arluke, 1980; Garfinkel, 1967; Light, 1980; Mizrahi, 1987). It is not insignificant that interpreters are subject to the same pressures and constraints on how they function in institutional contexts (Muller, 1994).

In the context of psychiatric work that requires a diverse range of competencies informed by institutional limitations, the question of who needs an interpreter is subsumed by the question 'for what purpose?' In taking the decision to use an interpreter, clinicians draw on a wide range of criteria, including clinical contingencies and situational factors.

THE ROLE OF LANGUAGE IN THE PROCESS OF A HOSPITAL ADMISSION

The question of when to use an interpreter with any given patient is informed by the point in the process of an admission. I have summarised the key points in terms of stages that occur over the course of an admission to hospital: admission, management, full work-up, ward round, and discharge. This outline is schematic to allow a brief examination of the five stages in terms of language requirements in context.

There is a sense in which communication, and hence the use of interpreters, is a raw material of the work of institutional psychiatry. Institutional tasks must be accomplished and one of the building blocks of this task is the construction of the patient as an entity that can be assessed, diagnosed and ultimately discharged. There are many other components that have a role to play: special investigations, various forms of therapy, medication, community resources, family support etc. From a language point of view the most fundamental premise in communicating with monolingual patients is that there are no interpreters. Under these circumstances interpreting is a rare commodity and it is not routinely made available to patients. If all patients were offered interpreters many more patients than is desirable in a system that has no interpreters may request one. Thus, the decision as to whether an interpreter is necessary is left largely in the hands of the clinician[23]. So the decision to include interpreting in the mix of resources used to accomplish the tasks at hand depends upon the question 'does the clinician need one?', a variation on the theme of 'for what purpose?'. The answer to this question depends on the success of the initial attempts to communicate with the patient in English or Afrikaans. If communication is so impaired that the clinician 'really' needs one, then there can be some justification for improvisation. In this case an interpreter must be manufactured at short notice and often with some ingenuity. Interpreters are manufactured firstly from black people. As one interviewee put it, in a tight spot *"we kind of just look for any black face we can"*[24]. The second criterion for someone to be an interpreter

[23] One clinician interviewed said that patients often ask for an interpreter.

[24] It is remarkable that a "black face" is such a successful building block in the manufacture of an interpreter. There are languages indigenous to South Africa that stem from the same group, such as Zulu and Xhosa classed as Nguni, and therefore allowing varying degrees of comprehensibility of one from the other. Many languages are not similar however and so it is remarkable that this assumption on the part of those who do not speak African languages is not disconfirmed more often. One Xhosa-speaking nurse expressed the following opinion on the question of multi-lingualism amongst Africans.
"Whereas if you ask me how many languages I speak, if I say I am multi-lingual, you can bet I don't speak French, or German but I speak most of the languages that are spoken in South Africa. It's a matter of being

is that they have some degree of communicative competence in the language of the patient and either English or Afrikaans. This linguistic competence is not questioned or tested in any way, it is largely assumed. Even when the CHITEP employed interpreters they did not test the language competencies of the candidate in any formal or systematic way. A third criterion is psychiatric training or insight. This was highly valued by clinicians for interpreting, but under the circumstances of institutional practice, it is an optional extra.

The question of the extent of the clinician's need for an interpreter is implicitly present many times in the course of an admission. Where in the sequence of an admission the patient is situated, and what other institutional factors have a bearing on the issue, informs this. This could be characterised as a 'language decision-making tree'.

Admission

The patient arrives in the ward and must be seen by a doctor in order to be admitted. Option one: The patient is seen by a doctor who is doing a rotation in the unit[25]. This means that the admitting doctor may be the case manager for the patient. In this case the admission history-taking is a very important opportunity to 'break the back' of the issues that will require attention in the process of managing the case. The clinician may be required to present the patient at a ward round. The admission interview, if done well, can serve both the purposes of the admission routine but go a step further in doing the full work-up for ward round (c.f. Barrett, 1988). If the admitting doctor discovers that an interpreter would be required to take a detailed history, whether or not they proceed with this will depend upon the availability of an interpreter and the time constraints on the registrar. If either of the two latter components presents an obstacle, then the admission procedure can be performed more cursorily.

Option two: The admission 'clerk' is done by a registrar who is on call[26]. In this option the admission is a routine and bureaucratic procedure for all patients, but a number of linguistic issues pertain. There are no provisions made by the hospital for interpreting after normal

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interested in other people. You get Sotho-speakers, you don't have a problem because I speak Sotho and [another nurse] *speaks Sotho. You get Tswana, I speak Tswana. So it is not a problem, and it is not a matter of having been provided by the institution of those things, just a matter of being interested in knowing 'how do people in this particular area speak?'".*

[25] Not all members of the team can admit a patient. It is hospital policy that a medical doctor admit patients as a physical examination (even if cursory) is required on admission.

[26] After 5.00pm in the afternoon or over weekends.

working hours at all. No one I interviewed, even the strongest advocates of the need for interpreters to be employed by the state, raised the necessity for interpreters to be available after hours and on weekends. This is I believe a measure of resignation. If there are no interpreters during normal working hours, what chance can there be of getting an interpreter after hours?

An example was given above of the routine admission of a patient who is monosyllabic in English. The need for communication directly with a patient who presents a language problem is even further reduced if the patient is accompanied by a relative who will explain the circumstances of seeking admission, or if the patient has come to hospital with a referral note[27]. Another situational factor that assists the clinician in sidestepping communication difficulties is if the patient 'appears' to be psychiatrically unwell. This can be observed when the patient is obviously psychotic or behaviourally disturbed or depressed. A cursory assessment and the initiation of treatment can proceed without an interpreter under these circumstances. Thus, the admission of a monolingual patient would almost never require an interpreter unless the clinician involved chose to go beyond basic institutional requirements for their own purposes. Individual clinicians vary in their degree of discomfort with their own compliance under these circumstances and take whatever steps they can to address the situation in each individual case.

Management

Each patient is allocated to a clinician as the case manager, usually at a feedback meeting where the whole team will be assembled to discuss each case. Once again the question of 'does the clinician need an interpreter?' asserts itself here, but with a different set of contingencies. Unless the clinician knows in advance that the patient speaks and understands no English or Afrikaans, the initial attempt to communicate would be without an interpreter present. The answer to the question of the need for an interpreter depends on the success of the initial attempts to communicate with the patient in English or Afrikaans. There are many ways in which this is a desirable option. The presence of a third party in a clinical interview is never ideal and to be avoided where possible. However, a trained staff member, whose

[27] Similar such admission procedures in the face of communication difficulties were described at LGH in Chapter 5.

function it is to interpret, and training of the clinician in working with such a person could ameliorate this reluctance to have a third party present. However, the preference of a one-to-one interview will never be completely removed. Given the limited goals of the stay in an admission ward, these can at times be accomplished through a minimal degree of communication with the patient.

The first task is to monitor the patient's progress. This clearly involves many facets, such as response to medication, the appropriate ordering of special investigations, placement on the appropriate ward, and contact with the patient's family where possible. Many of these are accomplished with the assistance of other team members but the case manager is responsible for bringing information on the patient's physical and mental state to the attention of other team members. Nursing observations also contribute to the team discussions, but nurses do not routinely interview patients individually.

As with the admission interview, overt psychiatric pathology will influence the clinician's perception of the need for an interpreter-mediated interview. One clinician summarised these considerations thus:

> *"...another thing is if a patient's objectively hallucinating and it's his first week, I kind of know he's psychotic and objectively hallucinating. I don't rush to get an interpreter..., I kind of know and then I'll get the interpreter after a few days whereas.... I think its nice to know what he's hallucinating but if he's uncooperative and hallucinating and aggressive I don't rush it."* (Interviewee 5)

Bureaucratic considerations are significant in choosing to interview with or without an interpreter. The clinician's workload has an impact.

> "[A long interview with an interpreter is] *the kind of thing I like to do on a quiet morning when I've got time to sit with an interpreter and go on and on. Its a very difficult thing to do when one is rushed and has got a million and one things to do and then I feel I'm doing a disservice."* (Interviewee 5)

This statement conveys many aspects of the situational considerations that inform using an interpreter. There is a sense of the interpreter-mediated interview as being a luxury, even for the clinician. Constraints on the amount of time available to be spent on any particular patient are a serious factor. There must be functional 'clinical' indications for spending more time than is indicated for routine interviews. But while weighing up these considerations, there is a sense of discomfort at the way in which a patient may miss an opportunity for more

meaningful contact with the clinician because of the pressures on the clinician. The same clinician did not see a need for an interpreter when there was a sense that the extent of the patient's needs from the clinician were being met:

> *"I should use an interpreter every day when I speak to him but I know all he would say is 'discharge' and I understand him. And I say you're not going home and he says then 'visit' and I know he wants his mother to visit him ... and I kind of feel that I'm not doing a disservice to him."* (Interviewee 5)

The clinical details of this patient are not known but the extent of the power of the clinician in relation to language resources and the contribution this makes to infantilising the patient is clearly enormous. This further illustrates the normalising of institutional racism, and the complicity of inadequate language resources in maintaining this. The extent of social distance from the patient and the collusion of the patient also serve to maintain these attitudes. Another clinician suggested that race is one aspect of a cluster of factors:

> *"I am not so sure that it is the skin colour per se as the language, the education, the feeling of familiarity."* (Interviewee 3)

Clinicians expressed serious concern about the quality of the care they offer without language assistance, and the inherent consequences for patients. Although staff shortages and limited resources compromise all patients, clinicians acknowledged that what little resources are available are least likely to trickle down to Xhosa-speakers. Two clinicians expressed it in this way:

> *"Those who are not, those who say are English or Afrikaans-speaking, you can at least try and understand what's going on or can suggest ways to them for coping with their voices. But with a Xhosa patient it is not possible. We land up saying: 'Well, this person is still psychotic. Not much more we can do, home and into a clinic'."* (Interviewee 1)

> *"They really do get the '10 minute' interview. Are you hearing voices? Are you seeing things? Are you going to smoke dagga[28] anymore? No. Alright. You're OK. Goodbye. I am exaggerating but I think there is a certain element of truth in it."* (Interviewee 3)

In order to transfer a patient from a closed ward to an open ward an assessment of stability or improvement has to be made. The clinician's not being able to assess the patient satisfactorily will militate against the patient's access to less restrictive ward contexts and where the patient group is less behaviourally disturbed. Confinement with a group of psychotic and potentially

[28] South African term for cannabis.

dangerous fellow patients may be an extremely distressing experience in itself[29]. This introduces the restricted access to the full range of services for speakers of African languages. It was shown through the first questionnaire study at VBH (Chapter 4) that patients, who do not speak English or Afrikaans, very rarely access psychotherapeutic wards and services. This extends to the limited range of community resources that are available as well (see also Swartz, 1991a, 1992a).

It should be noted here that not all patients are passive in relation to the use of an interpreter in interviews. Interviewees reported that patients may choose not to have the interpreter because of being insulted at the implication by the clinician that their English is not good enough. Here, the patient's pride at speaking the language of power may play a role. It is also to be expected in a psychiatric context that the nature of a patient's disturbance would express itself in relation to the use of interpreters. Thus, interviewees referred to paranoid patients being afraid that an interpreter may be in cahoots with a persecuting family. Instances of this were also identified in the review of patient folders and such patients refused an interpreter. A third reason for patients to refuse the assistance of an interpreter was to avoid the interference of a third party in the relationship to the clinician. One interviewee had had numerous experiences of patients requesting an interpreter. The questionnaire studies discussed here and the interviews with other clinicians did not confirm this impression as a frequent occurrence.

Full work up

Most new cases are seen at a ward round, as described previously. This important aspect of an admission to hospital fulfils a number of functions. In the situation of a patient presenting for the first time, it may be the only time that a comprehensive history is taken, detailed collateral information obtained where possible, with the ultimate intention of arriving at a definitive diagnosis and treatment plan. Ward round presentations also serve an important teaching function, for undergraduate students of many disciplines, psychology interns and psychiatric registrars. It also serves as an opportunity for the MDT to exercise its function and for the consultant psychiatrist and other members of the team to scrutinise one another's

[29] As staff numbers fall, particularly nursing staff, in the current economic climate, there have been increasingly vocal calls of alarm from concerned hospital staff at the risks to patients in closed admission wards. There is a disturbingly high incidence of rape and physical violence.

work. As such there is considerable pressure on students and team members to make the best assessment of a patient they can under the circumstances. However, assessment of a Xhosa-speaker has a role to play here. It is common for patients who were not previously interviewed through an interpreter to be interviewed for the purposes of the ward round with an interpreter's assistance. Patients who may speak some English and Afrikaans may be seen without an interpreter until basic information has been gleaned. For more subtle clarifications the help of an interpreter may be enlisted. Two of the responses to the question in interviews of when clinicians decide to use an interpreter addressed this issue.

> *"I'd base it on the quantity of the information that one needs ... to do an assessment. ... its a gut feel that I'm missing something."* (Interviewee 5)

> *"[When] there is an uncertainty of the psychopathology."* (Interviewee 8)

The same reasoning applied to questions of subtle evidence of psychopathology (e.g. thought disorder) is applied to questions regarding the role of cultural beliefs and practices in the origin and development of psychiatric disturbance. An interpreter may not be seen to be necessary in basic communication, but is when an interpretation of the role of culture is required:

> *"...debates do develop about the cultural context and to what extent we might be misinterpreting. And it might not have anything overtly to do with linguistic issues but to do with trans-cultural issues."* (Interviewee 4)

Thus, an interpreter may be needed in a ward round to untangle the assessment of thought disturbance and cultural issues in order to make a diagnosis but not for other more superficial engagements. Even so, an interviewee expressed concern about the nature of the assessment preceding the ward round and the ward round assessment itself.

> *"I think there is some kind of, we are employing some kind of reductionistic model to black patients. We rely on the phenomenology[30] and we are able to extract the signs, the clinical signs, but we are not able to see the patient as a whole and in the end the patient's context I think."* (Interviewee 2)

[30] The term "*phenomenology*" is used here to refer to the clinical signs of psychiatric disturbance. This is a modification of the original meaning of the term as coined by Jaspers, which was to document the patient's experiences in their own words. The contemporary use of the term is to denote a classification and objectification of experience (Barrett, 1996). The degree of slippage between the patient's experience and the objectification of this in psychiatric discourse may be increased for a Xhosa-speaker in the absence of access to the patient's own descriptions.

These limitations extend beyond academic settings to the management following the ward round. Often the monitoring of the response to medication and symptom reduction can be conducted through observation and cursory access to the patient's internal experience. Re-admissions are seldom re-presented at ward rounds, unless a complication develops or a re-evaluation is indicated. Recognition of the need for re-evaluation depends on the individual clinician or the concerns of the consultant psychiatrist. Again, cursory assessments of Xhosa-speakers make the likelihood of the recognition of the need for a re-evaluation smaller. The review of hospital folders turned up a number of cases where interpreters were used sporadically throughout the patient's contact with the service when the management of the case proved problematic. Routine management did not as frequently require the assistance of an interpreter. This is consistent with the argument earlier that as a scarce resource, interpreting would be used sparingly, and a strong indication would be when the clinician is 'worried'.

Clearly, ward round interviews are first and foremost about the biomedical tasks at hand – diagnosis and teaching. Ward round interviews are not intended to serve as therapeutic encounters, nor can they. The effort made, not always successfully, to have an interpreter present at a ward round interview, is driven by the bureaucratic tasks of psychiatric hospital production. This is no less the case for the information gathering exercise of clerking. The difference lies in the greater power wielded by the consultant psychiatrist and the increased probability of an interpreter being present. This is not to belittle the enthusiasm and cohesiveness of a team that seeks to offer the best psychiatric assessment they can muster. It is also not to detract from the benefit to patients of this. But it is to draw attention to the fact that no matter how well this task is accomplished, it can not serve as a substitute for language resources that are unavailable for a wider range of interventions and patient needs.

Formal teaching settings for registrars have much in common with ward rounds except the emphasis is even more squarely on clinician self-presentation and the maintenance of ideal psychiatric practices. These teaching settings require a psychiatric registrar to present a case to their entire registrar cohort under the guidance of a senior member of the teaching staff. However, the fragmented and superficial access to the patient's internal world and social context would be a source of embarrassment and potential criticism in a teaching case presentation. Clinicians can respond to these pressures by suppressing this aspect of their work:

> *"...so when you going to look for the ideal you just feel that you cannot present an African patient because the information is lacking."* (Interviewee 2)

This type of self-censorship not only censors the clinician's work but censors particular patients' social and personal narratives. These narratives are reproduced as lying on the periphery of a universalist academic psychiatry.

Discharge

In this final phase of an admission a new set of practical contingencies present themselves to clinical staff. It is necessary to move beyond the monitoring of treatment to the negotiation of a discharge. There were instances identified through the data gathering that the help of an interpreter was enlisted when placement of the patient outside of the hospital became a problem. On occasion this was because the family required interpreting in order to be enlisted in on-going management. Again, the superficiality of the work that could be done in the absence of an integrated language resource was lamented by clinicians. One expressed the concern in this way:

> *"But I think it means speaking to the families in a meaningful way, when we don't. Its really pointless me saying to the family... 'Mama, make sure this person takes his pills....' I mean it's really a waste of time unless the person can be spoken to and they can be given a number to contact."* (Interviewee 1)

The point at which a patient leaves the hospital is another opportunity for clinical work, divorced from social reality, to be confronted with this evasion. Superficial communication, oriented towards biomedical management, once again serves to collude in the avoidance of desperate social circumstances for many patients, discharged back into a community without adequate food and shelter. In the same stroke, institutionalised superficial communication frustrates the intentions of those clinicians who do wish to assist patients in dealing with the social reality they confront on leaving, what is sometimes, the relative sanctuary of the hospital.

THE CONTESTED STATUS OF 'THE PATIENT WHO REQUIRES INTERPRETING'

> *"Power is not simply expressed and reproduced through discourse; rather, there is a complex and dynamic process of ideological struggle in which different and competing groups attempt to shape and influence the way in which social reality is constructed"* (Mumby & Clair, 1997, p 187).

I have argued that the situational and practical requirements of a functional clinical competence are decisive in the use of an interpreter with any given patient. As such the status of 'the patient who requires interpreting' is that of an institutional construct. However, the preceding discussion has focused on the role of the individual clinician in the manufacture of this institutionally constructed entity. Other members of the psychiatric team are of course involved in this process as well.

Occupational therapists for instance may not perceive the need for interpreting in a group that focuses on practical skills or handwork. The 'language status' of the patient becomes relevant when the required degree of engagement with patients is increased in the context of a support group or role-play group. Psychologists may avoid the thorny problem of language in psychometric testing procedures by using only 'non-verbal' tests[31].

An additional aspect of the uncertainty over who amongst patients requires interpreting and who does not, was thrown into relief by keeping statistics on a weekly basis of which patients in the wards studied required interpreting. I was surprised at how often nurses were not able to provide this information. It soon became clear that the English and Afrikaans-speaking nurses were the least confident about indicating interpreting needs. I was often referred to the Xhosa-speaking nurse on the ward for this information. It emerged that because English and Afrikaans-speakers were not approached by clinicians to provide interpreting, they did not always know which patients required this. While some Xhosa-speaking patients may have been able to communicate effectively enough with a non-Xhosa-speaking nurse at the level that was required by the nursing duties, this was not an accurate reflection of who required interpreting to be interviewed. It appeared that the issues raised in Chapter 5 and Chapter 6 regarding the 'division of labour' between psychiatric nurses along language lines was highlighted once again by asking this question. As was discussed in Chapter 6, Xhosa-speaking nurses felt that non-Xhosa-speaking colleagues were all too quick to decide that a patient required interpreting, as it relieved them of responsibility to meet the patient's needs. Xhosa-speaking nurses were generally more accurate about who required interpreting, but even this was not foolproof. New patients and patients who were interviewed exclusively

[31] The Raven's Progressive Matrices Test is an example of a widely used test for black patients. English and Afrikaans-speaking patients would be tested through more up-to-date tests that assess a wider range of competencies.

through the CHITEP interpreters were not necessarily known to the Xhosa-speaking nursing staff as patients who required interpreting. As all their own communication with the patient was conducted in Xhosa, the nurses need not necessarily know who could not speak enough English and Afrikaans for communication with other staff.

Through an examination of situated institutional practice in this chapter, discrepancies between the views of nurses and doctors as to who requires interpreting, and amongst different clinicians, were made visible. As has been observed elsewhere (Barrett, 1988) criticism of colleagues in clinical notes is invariably implicit. One way in which a clinician can criticise a colleague for not using an interpreter with a particular patient is by making overt reference to the use of an interpreter in one's own notes. In the folder notes there were numerous examples of where occupational therapists made entries that drew attention to the need for interpreting (see example given above). Occasionally doctors would make entries that drew attention to the need for interpreting in a way that also served as an implicit commentary on the previous absence of the use of an interpreter. The failure of a clinician to use an interpreter in some cases could be seen as expedient by another clinician at a later point and exposed as such by setting an overt and documented example. The use or not of an interpreter can therefore become an arena in which inter and intra-professional disputes are played out.

In Chapter 5 I discussed the way in which the issue of interpreting had become currency in disputes between hospital management and other employees. This aspect could also be discerned at VBH but will be touched on only briefly here. In the debate around whether the hospital required interpreters, a cash-strapped administration expressed the view that clinical staff were exaggerating the need for interpreters. An administrator was of the opinion that the clinical staff had coped for so many years without interpreters that he was suspicious of the more recent chorus of appeals for interpreters (see Chapter 8 for a more detailed discussion.).

The notion that 'the patient who requires interpreting' is an institutional construct, is attested to by illustrations of the way in which it is contested in institutional spaces, between professions, native language speakers, and political discourses. The question of 'for what purpose?' functions at a number of institutional levels, extending far beyond the confines of the clinical interview. Mumby & Clair (1997) have argued that "even the most apparently natural human characteristic – one's race – is subject to social construction through discourse.

Racial identity is not fixed, but is constructed through the complex set of signifying practices that position each of us discursively" (p. 187). Any attempt to engage with the need for interpreting in clinical settings, must grapple with the complex and shifting construction of this entity in the situated and practical realities of institutional practice.

CONCLUSION

This chapter has attempted to show that the issue of language in clinical work can be rendered as either relevant or irrelevant by a complex set of institutional conditions and imperatives. This expands and exemplifies in a more detailed analysis of clinical records the institutional paradoxes in the recognition of the language issue raised in the previous chapters. The challenge of providing mental health services for a multi-lingual population can be recognised or not depending on the institutional contingencies that prevail.

The factors that impact upon the practice of public psychiatry in the context of multi-lingualism have been shown to be paradoxically visible and invisible. A monolingual Xhosa-speaking patient may at some times be seen to require interpreting, and at other times not. The use of an interpreter may be made clear or obscured under different institutional circumstances. The opinions and perceptions held by interpreters about patients are at times clear, at others not. The fact that a patient may have spoken in a language other than English or Afrikaans in a clinical context may be obscured or emphasised. Thus, the fact of a clinical record representing both a translation and interpretation of patient discourse may be hidden or foregrounded.

The institutional contingencies that operate in this particular psychiatric context have been examined here starting at the micro-level, in terms of the minutiae of clinical entries in patient folders and the daily requirements of clinical practice in this institution. There is a tradition in the sociology of psychiatry that seeks to examine the minutiae of clinical work for accuracy and competence, and to critique psychiatric practice through this (Hak, 1992). This approach inevitably uses the notion of a pristine psychiatric praxis as a benchmark for comparison. Such an approach neglects the practical realities of psychiatric practice in public institutions, "the swamp of action" (Gordon, 1988 in Rhodes, 1993a, p. 129). In this more mundane clinical reality, clinical competence is measured and demonstrated through a range of 'skills', not all of which are found in textbooks, that situate the clinician in a particular context.

Comparisons with a reified clinical ideal may in fact contribute to the self-censorship on the part of clinicians that was illustrated in relation to teaching contexts within this institution. Critiques as to the accuracy of clinical work may thus run the risk of being 'irrelevant' to a localised praxis. But more than this, they may serve to maintain the silences regarding the implication of psychiatry in the reproduction of societal discourses and ideologies. A simple focus on the clinical competence of practice may reproduce the evasion of the social competence of this practice.

It is for this reason that I have attempted to introduce to the analysis the societal discourses that are reproduced in the clinical management of the language issue. I have argued that the minutiae of clinical work in the absence of meaningful communication with patients, the folder notes, the diagnoses, the management strategies, construct the identities of African patients in terms that reproduce discourses of race that are reductionistic and dehumanising. These psychiatric practices can be seen to have enormous social relevance, both inside and outside the hospital itself. A clinician gave voice to these concerns about his own work:

> *"Because we have continued violating patients rights, because they are marginalised people. I think if you are treating a psychiatric patient with whom you cannot communicate you are violating them in a way. You* [just] *contain them, people don't know what's going on."* (Interviewee 1)

The use of an interpreter has the possibility of ameliorating the violation described so succinctly above. And yet the analysis presented here suggests that the use of an interpreter may serve to obscure or render invisible the distorted patient subjectivities and social conditions that are constructed with the assistance of interpreters. Considered in Foucauldian terms, the containment referred to above is a euphemism for the confinement of the body and a limiting of what can be said and heard in institutional spaces. The use of interpreters may thus facilitate more subtle forms of surveillance and discipline, enhancing the power of psychiatric discourse in materialising particular relations of power in society[32].

However, an analysis of the relations of power in psychiatric institutions in Foucauldian terms requires a more subtle treatment. This chapter began with a quote from Adam Phillips that draws attention to a paradox of visibility and invisibility in censorship. The emphasis in this

[32] See Butchart (1996) for an analysis of the medical examination of miners in South Africa producing similar effects.

analysis of clinical records and research interviews has been on the types of biomedical discourses that are prioritised in institutional settings, but I have also sought to illuminate the silences and elisions in these discourses. My emphasis was thus on the power of biomedicine in inciting particular discourses while silencing others. It was shown that even within the professions that constitute psychiatric teams, there are muted conflicts and struggles that manifest themselves around the issue of language. What has been largely inferred because of the efficiency of the censorship through language has been the subaltern voices of patients. This risks the construction of an account of the role of language that reproduces a simplistic notion of power as mono-directional (Foucault, 1980; Krips, 1990; Rhodes, 1993b). It neglects the possibility that patients too can censor the constructions of identity that are possible within institutional spaces. It neglects to consider the capillaries of power exercised through resistance that allow patients a degree of control over the narratives that can come into being and that this self-censorship can also be rendered invisible. Language is an important site at which this power is exercised. It is to the question of the institutional construction of identities that I turn in the follow chapter.

Chapter 8

NEGOTIATING IDENTITY IN INSTITUTIONAL SETTINGS: THE ROLE OF LANGUAGE

"Language can be used to reveal certain identities, and to mask others."

Makoni (1998, p. 247)

Introduction

In the preceding chapter I examined the impact of language diversity on clinical work in a particular hospital setting. Much of the impact was seen to be mediated by institutional or situational factors operating within the service provision context. A complex set of professional competencies influence the nature of the work conducted in such settings. In this chapter I will consider the question of identity - that of the institution - but also the multiple and negotiated identities of the staff who work in institutions and the patients who are treated in them. First, I will consider the position of the Xhosa-speaking psychiatric nurse as aspects of the negotiation of identity are made visible through the role of interpreter and culture broker. I will then turn to a consideration of the position of the Xhosa-speaking patient in a South African institution. The position of the nurse vis-à-vis the Xhosa-speaking patient, and the patient vis-à-vis the psychiatric service, will be shown to have been mirrored in the research process. Tensions in relation to the researcher on the part of Xhosa-speaking interviewees and the institutions themselves reflect on the dynamics of identity in the new South Africa. Issues of how clinicians negotiate identity were also mirrored in the research process. This is explored in relation to the tensions inherent in writing about racism in South Africa today and the production of a text that makes use of both discourse analysis and elements of ethnography.

CULTURE BROKERAGE, LOYALTY AND BETRAYAL

Before embarking on the interviews at LGH I conducted a pilot interview with a Xhosa-speaking nurse and explored experiences in her role as an interpreter over a number of years. A fascinating portrait of the tensions and pressures involved in interpreting in psychiatric contexts emerged. Aspects of these tensions constellated around the culture broker idea. It was made clear that culture brokerage for nurses involved managing issues to do with race and identity on behalf of patients, but also for themselves. This also involved playing a role in the control patients sought to exercise over their self-presentation to doctors. The transparency of these strategies by patients to the nurse-interpreter, often because they were made explicit, presented dilemmas regarding betrayal. This betrayal was not only a question of loyalty to a particular patient, but loyalty to traditions held in common with the patient.

> *"I must admit I do not always feel comfortable about talking to people when they ask me about such things. As a Xhosa-speaking person who has been reared in this background of people having ukuthwasa, having to undergo certain training to become a sangoma, I have been orientated to understand that the white people or the western culture is not supposed to be involved in this. So I always feel, if I have to interpret for patients or interpret for these doctors or these white people, must interpret for them exactly what that person was saying. You know, somehow I always feel that I'm betraying that person because I know exactly she is saying this because I'm asking her..."*

And again:

> *"The patients will often say: 'Sister you know. I don't need to tell you about this because this is our...', whatever words he's going to use. But before you move from that, you need to reassure the person that it's not a matter of you saying her over to these people for any reason. You only want to help her"* (emphasis added).

This is a profoundly eloquent expression of the complexities of interpreting in South African institutional contexts. Interpreting is not simply about conveying words and meanings, but also about moral choices. This is captured in the phrase "*saying her over*" summarising, in a poetic condensation, the betrayal that may be implicit in what is interpreted of the patient's talk.

Issues to do with advocacy and loyalties to patients have been highlighted in the local and international literature on interpreting (Kaufert & Koolage, 1984; Putsh, 1985) and I anticipated exploring these through interviews with nurse-interpreters. However, the issue of cultural betrayal as a corollary to the question of loyalty gave an additional depth and nuance

in local contexts. My subsequent interviews at LGH and VBH attempted in a limited way to open up these issues for discussion. These LGH interviews met with mixed success in clarifying questions of loyalty, betrayal and the complex choices that must be made by nurses acting as interpreters. The following extract from a research interview illustrates this.

> Researcher: *Do the patients ever expect you not to explain that [ukuthwasa, amafufunyane]? Do the patients ever ask you 'why are you telling them?'.*
> Nurse: *No, I have never met such a situation.*
> Researcher: *So you have never felt divided in your loyalties?*
> Nurse: *No. Some other time there was a patient who had those ropes on her neck, feet and hands*[1]*. So I just explained to the social worker, the social worker was the one who was interviewing, about her cultural aspects. And about how committed she is to that particular profession [sangoma]. So the patient couldn't explain that, because she was afraid to present all the secrets and whatever to another person who belongs to another culture. So I had to present it quite fairly.*
> Researcher: *But you said it was a secret for the patient?*
> Nurse: *There are some that are secret. Like going to this winter school. The blacks are the ones who go there for circumcision and all sorts of things.*
> Researcher: *But you were giving that secret away to the social worker.*
> Nurse: *No, that is not the type of a situation that I was presenting. I was presenting this profession, the sangomas, schooling, and all sorts of things. Ja, I just explained to her what is happening down there. But this school of, the blacks' winter school, I didn't present because I don't even know, and the secret, they* [the participants of the school] *can't tell you when they are from that school.*
> Researcher: *But what if you knew that it had something to do with the patient's mental state?*
> Nurse: *I'll have*...[pause], *sorry*? [Request for clarification]
> Researcher: *If you knew it had something to do with their illness?*
> Nurse: *With her illness. And I, I will oblige to divulge the information? No, I won't, because I must respect the secrecy of the patient, and at the same time meet her needs so that she can become mentally healthy.*
> [Silence]
> Researcher: *Are there any other cultural issues that you think are complicated or problematic for psychiatry?*
> Nurse: [Long silence.]
> Researcher: *No? OK* [next question] (emphasis added)

In the initial part of the extract the nurse-interpreter describes how she was aware of the patient's hesitancy to divulge certain information to do with her initiation as a *sangoma*. However, the nurse felt comfortable with using her own judgement to explain certain cultural implications to the social worker. The concept of *ukuthwasa* and some of the ritual aspects of

[1] Thin ropes worn around the wrist, ankles and neck are indications of undergoing or having undergone *ukuthwasa*.

this illness and its meaning are now well within the domain of psychiatry and psychology as taught at local universities. So there are in a sense, precedents for explaining *ukuthwasa* to an outsider. She did not feel the same degree of freedom to over-ride injunctions regarding the secrecy of other cultural practices and this reticence manifested itself in the research interview. Even within the context of a research interview with a colleague, the issue of access to certain types of cultural information must be negotiated (c.f. Herselman, 1995). In this instance there was a limit to the access that I was allowed. This negotiation mirrors the tensions in a clinical interview, in spite of the absence a patient. What is being protected here is a group identity and who may have access to the elements of that identity. Arguably even more important than any information about "*winter schools*" is the illustration in the dialogue of the strategies that can be employed to assist in defending a position without losing face, offending the interviewer and creating a potentially embarrassing incident. The power of the claim "*I don't even know*" and the accompanying evasion of silence, is instructive. It is often said that silence 'speaks volumes'. However, in clinical contexts silence can more often be inscrutable, and a powerful shield against the pressure to speak, while not wanting to earn the disapproval of a powerful interlocutor[2]. In so far as the strategies succeed in navigating these tensions, silence and claims not to know function as forms of censorship that make themselves invisible.

Interviews at VBH proved to be less overtly problematic in the area of exploring hidden cultural influences in clinical interviews. This may have had something to do with the nurses' familiarity with me prior to the study and in the course of the focused ethnographic study. The interviews at VBH hospital also reflected a shift in my concern to go beyond merely documenting sources of conflict for nursing staff acting as interpreters. Following the experience of the study at LGH, I wished to extend the inquiry into explicitly identifying sources of alienation for black patients in a western psychiatric institution. This may have made it easier for nurses to describe aspects of Xhosa belief that they were aware of having an influence on the experience of hospital admission for Xhosa-speakers, through distancing it from their own personal sense of conflict.

[2] See Huby (1997) for an exploration of this issue in patient satisfaction studies with AIDS and HIV positive patients.

Inquiring about sources of cultural alienation bore some fruit. One example given referred to the lack of regard within the hospital for markers of social stratification (the problem of circumcised men having to mix, and especially wash, with uncircumcised men, their social juniors). There was also reference made to dress codes for men and women that are violated by the norms of dress in the hospital. Nurses expressed a dual concern about the implications of these customs in psychiatric settings. One, that the behaviour that arises from these social norms within Xhosa culture could be interpreted negatively in a psychiatric context, and thereby prejudice the patient in the evaluation by the staff. Two, that through not being able to observe certain social requirements, the patients may be retarded in their improvement or even further distressed. It is not my intention to develop a list of cultural factors in psychiatric settings that alienate Xhosa-speakers in the Western Cape. This is too large a project, worthy of a study in itself, and would take me away from my primary concern here. However, there are two aspects of this that I wish to expand upon. The first touches on the dynamics of asking such questions, and the second on identity and alienation in such institutions.

The importance of eliciting explanatory models and the strategies suggested by Kleinman (1980) for doing this are apposite here. While the explanatory model concept in psychiatric interviews is certainly under-utilised, this should not be taken to mean that no effort is made by clinicians to understand what cultural factors may contribute to what troubles patients. Patients are also not always passive about bringing complaints to the attention of their case manager or the consultant psychiatrist. Explanatory models that differ from what a patient believes the doctor may be interested in, may not necessarily be volunteered (Helman, 1994). The research interview illustrates an instance of asking a question regarding cultural alienation in hospitals and receiving a limited answer. The limits to the depth of ethnography, the brief period of time spent in one-off interviews, and trust regarding the use to which the information will be put may all have constrained access to further information. All of these limits apply here and most certainly indicate that there is much more to be learnt. However, the resistance evidenced here to the smooth and easy discussion of such issues is illuminating of the conflicts, tensions, and how carefully negotiated the access to these questions need to be.

The second point has to do with alienation in a western psychiatric hospital and how this affects Xhosa-speaking patients. Possible explanations were advanced by one of the Xhosa-speaking nurses interviewed.

> Nurse: *It's affecting a lot of us and there are lots of things involved. That also needs to be given to other people who are working here who don't know our culture. Like an old woman outside in the community is not expected to be seen without something on her head. But coloureds, they don't believe in that. And those are the very difficult issues that put the patients down because to be seen by other people from outside with their head without the hat would make her more worried and more sick.*
> Researcher: *And they don't allow people to wear head dresses here.*
> Nurse: *No they* [the nursing staff] *are concerned about the grooming part of it. They don't care about that as long as the head is covered.*
> Researcher: *But the Muslim women*[3]*, are they not able to wear their doek* [head scarf]?
> Nurse: *They do, they do. Because we were not taught right from the beginning to speak up for ourselves. Because the nurses say I must pull my head like that, comb it. She cannot say, no, I'm not allowed to do that. They believe that because I'm in a hospital, I must obey.*

At first the nurse attributes the absence of headgear on patients in the hospital to the restrictions imposed by the hospital regulations, and contrasts this belief with "*the coloureds*". When I point out to her that the Muslim women are also expected to cover their heads in public, but perhaps for different reasons, and that this is not prohibited by the hospital, an additional issue emerges. The nurse draws on the attitude of conformity and compliance, perhaps to the authority of other nurses, but also to the norms of what is perceived to be a foreign institution, or a 'white' hospital. The nurse refers to "*the coloureds*" suggesting that they do not have the same obstacles. Perhaps there is a sense of being the most marginalised in the institution.

Critical studies investigating the construction of psychiatric knowledge and institutional practice in South Africa have, until recently, focused on discourses regarding alienation and racism in psychiatric settings. The many factors that contribute to domination and oppression, either through the exercise of sovereign power or through forms of discipline that maintain a hegemonic control (Foucault, 1980) have been viewed in terms of an apartheid or colonial social order. As S. Swartz (1996a) has demonstrated, in a racist system of mental health care and with the neglect of the role of communication in providing that care, there was a sense in

[3] Muslims in the Western Cape are by and large coloured and Afrikaans or English-speaking.

which black patients were profoundly unknown to their caregivers. The most commonly recorded aetiology for a black patient during the period of S. Swartz's (1996a) study was "unknown" (p. 157). Social contexts and personal histories were often omitted from patient records and invariably even the mental state of the patient was omitted from the certification forms. However, what may require examination now that a new social order is possible, are the forms of resistance to hegemonic dominance that endure and take new shapes in institutional settings.

IDENTITY AND INSTITUTIONAL SURVEILLANCE

One of the criticisms of much South African cross-cultural psychiatric research, and indeed much of the international literature, is that it is pre-occupied with 'exotic' cultural phenomena (Littlewood & Lipsedge, 1985). The exploration of identity issues in this context is at risk of reproducing reified notions of black identity defined in terms of 'otherness' and cultural difference. The discussion above indicates that there are aspects of Xhosa identity that are informed by a sense of separateness from the dominant culture of psychiatric institutions. As was discussed in Chapter 5, this is partly because the 'culture' of psychiatric hospitals is so dominated by western norms. However, ethnic alienation in a South African psychiatric institution can be argued to be a subset of patienthood in all psychiatric institutions in any society (Barrett, 1996; Goffman, 1968). There are a number of areas of life that the clinical gaze in psychiatry seeks to penetrate, but this act of penetration provokes the resistance of the subjects of this gaze. Psychiatric institutions represent the dominant norms of a society and at times are implicated in enforcing them, even when individual practitioners may not themselves support such norms. Thus, aspects of patients' lives that they believe, accurately or inaccurately, will result in sanction, whether moral or legal, are obscured and hidden in what is brought to a clinical encounter. This is no less the case for African patients and is not merely confined to stereotypical ideas about the reified essence of 'African culture'. The nurse quoted above in relation to her feeling of betrayal when talking of religious beliefs gave a further example of mediating the patient's anxiety regarding exposure to scrutiny in a hospital context:

> *"...most of the patients will actually tell you that they do smoke dagga although some of them will still be very scared of this white man, thinking that maybe he's going to send the police...The thing is, some patients who talk to you and tell you: 'No, I do smoke but don't tell him'. I mean sometimes you are so aware of what the patient said, and if now you have to explain to the*

doctor, to the interviewer, what that patient said, you felt okay that you were guilty because the patient trusted you that you were not going to tell[4]*."*

Not all speaking is unambiguously good for patients in a psychiatric hospital. The more the patient says the more they risk exposing themselves to scrutiny and sanction. If a patient talks about hearing voices, a clinician is very likely to extend the patient's stay in hospital. If a patient disagrees with the decision that they should stay in hospital for longer, and they say this to their case manager, they may betray themselves further. Under these circumstances a case manager may evaluate the patient as lacking insight, thereby creating a stronger case for an extended admission. Being 'known' is not necessarily of unambiguous benefit to the subjects of psychiatric practice. Patients wish to access the assistance of the clinician, but this access must be negotiated with the minimal betrayal of oneself on multiple levels. Similarly, African patients (and their families) may wish to benefit from aspects of psychiatric treatment, whether through medication or social intervention. However, there may be other aspects of psychiatry, to do with various forms of regulation, surveillance and compliance, which are less appealing. The subject may thus seek to benefit from the power of psychiatry, but to evade its colonising influence. In this negotiation by a Xhosa-speaking patient the nurse is both an ally and potential foe. The stakes of the exchange across ethnic, class and social identities are substantial. The particular shape and form of these tensions for African patients of psychiatry are what interpreters, and particularly Xhosa-speaking nurses, must hold within them. I will differentiate between a socio-cultural aspect to this tension and a socio-political aspect, although both are inter-related. I will turn first to the socio-political aspect, and of particular note in this regard is the reference made in the above quote to a fear of the police and the reassurance that the nurse must provide. It is important to situate this in the context of South Africa's history.

BEING BLACK AND 'KNOWN' TO A SOUTH AFRICAN PSYCHIATRIC INSTITUTION

"Part of the task is to get the patient to reveal himself" (Rhodes, 1993a, p. 134). The starting point of the potentially profound experience of being known in a therapeutic encounter begins in institutional settings with the mundane and bureaucratic procedure of having one's name and address noted down. This apparently simple starting point can prove to be a source of

[4] It is illegal to possess or use cannabis in South Africa. There has been a vocal lobby within a section of the mental health community to have cannabis decriminalised. There are rural areas of the country that produce cannabis and depend on it as a type of 'cash crop'.

some vexation in the face of a lack of basic familiarity with the African language of the patient. English and Afrikaans-speaking clinicians will be familiar with the experience of being given a patient folder and not knowing which of the names on the cover is the first name or surname. When I reviewed VBH patient folders for the purposes of the research in 1994 and 1997, there were a number of folders that could not be traced on the basis of the name provided by the clinician on the questionnaire documenting an interpreted interview. A lack of basic familiarity with Xhosa, for instance, results in not being able to distinguish click sounds and various other sounds that make up the phonology and which do not lend themselves to easy Anglicisation. It is a common South African experience to have some confusion between speakers and non-speakers of African languages when it comes to remembering and repeating African names. Typically, the English or Afrikaans-speaker stumbles over the pronunciation of the African name, making a number of stabs at it and saying something quite different at each attempt[5]. This was something that occurred in ward round interviews as interviewers attempted to pronounce patient names correctly in the course of an interview. The effort made to say the person's name correctly is in itself an indication of changes in the broader society around at the use of, in the local context, Xhosa names. However, it was striking how seldom the patients involved or the other Xhosa staff present would correct a mispronounced name.

The difficulty of working in what is a foreign language to English and Afrikaans-speakers presented problems in the registry department[6] of VBH. A detailed examination of the registry system was not undertaken, but a member of that department described a strategy of "naming" patients, when it was not possible to find out the name of the patient, according to the packet of cigarettes the patient had with them on admission. So there would be files with "Gunston" and "Chesterfield"[7] to identify patients. Clinicians at LGH and VBH spoke of not knowing at times the exact home address of a patient. This was quoted by the clinicians to illustrate how impaired their work can be at the most fundamental level by communication barriers. It would be a mistake to assume that the clinicians, or for that matter the ward clerks and nursing staff who attempt to record the name of the patients, had made no effort to find

[5] Originating from the time of the missionaries it has been a common practice in South Africa for Africans to take (or be given) a Christian name. This avoided the difficulties for non-African language speakers of repeating and remembering names that were foreign to them.
[6] Where patient records are kept.
[7] Brand names of cigarettes.

out the patient's address. In addition, there may be a number of psychiatric reasons for not being able to elicit a name and address from a patient on admission. The level of consciousness of the patient, paranoia, cognitive impairment through intoxication or other reasons, would all be possible explanations. However, a socio-political dimension to this issue was raised through a patient who was attempting to be the opposite of invisible in the system.

During the period of data collection at VBH there was a patient who had been sent to the hospital by the Truth and Reconciliation Commission[8] (TRC). His family had been killed when his shack burnt down in the mid-1980's and he believed that they had been murdered for political reasons. He wanted the people he believed to be responsible brought before the Commission. Within the hospital unit team there had been some difficulty at arriving at a diagnosis and so the patient was interviewed at a team meeting. In an interview in which a nurse served as interpreter, the patient was insistent that he should be given "*his documents*" (in the words of the nurse interpreting). It emerged that the patient had understood the process of providing his personal history to the clinician to be equivalent to the process of taking a statement in a legal matter. He argued that the hospital records contained his life story and that this would verify his case for the arrest of the perpetrators[9]. When his request was declined, the patient argued that the TRC could give the authority for the hospital to release his papers. This tragic story and the patient's desperate plea could stand as a microcosm of what is changing in South Africa, and what may be perceived to be the same.

There is a sense amongst the poor, disempowered and formerly disenfranchised of South Africa that the government and the state, through bodies like the TRC, now care about what happened to people during the dark years of apartheid. There is a perception that the stories of suffering that did not matter then, do matter now and are being attended to by sympathetic and just authorities. This is nothing short of miraculous. However, implicit in the expression of optimism by this particular patient is the notion that the state hospital is an arm of this new

[8] The Truth and Reconciliation Commission was established under the Promotion of National Unity and Reconciliation Act, No. 34 of 1995. It functions primarily through three committees: the Amnesty Committee; the Human Rights Violations Committee; the Reparation and Rehabilitation Committee. The first two committees have held hearings throughout the country focusing on particular events during the apartheid era.
[9] Part of the TRC process for applicants involved the submission of a statement regarding the perpetration or experience of gross human rights violations. These applications may have been taken down by TRC investigators and a proportion were further investigated.

justice. What this suggests to me is the perception of the hospital as a state organ, and, I would surmise, that this is not a new idea. I would argue that this notion is a remnant of the old South Africa, and that whatever its potential virtues now, there are also many sinister implications for patients.

South Africa has recently emerged from being a virtual police state. Freedom of movement was restricted for black people through the requirement that they carry a 'passbook', which indicated where they could legitimately be and, by implication, where in the country they had no right to be[10]. Migration to cities and other regions in search of work or family was dealt with through imprisonment and forced removal to a 'homeland'. These and many other restrictions on civil liberties rendered being known to the state a threat to life and limb. Being identified and identifiable to the state was dangerous and gave the apartheid bureaucracy the means by which to exercise control. It should not be surprising then that patients would be anxious about being 'known' to a state hospital. During the apartheid years this would have been the case for all black patients. However, the shifts in recent years may have modified this for multi-lingual service users. For various reasons to do with education, access to the media and the effects of poverty, monolingual Xhosa-speakers and limited English speakers would perhaps be the most at risk for carrying the historical identity of mental health care institutions, as perceived by the community of service users, in the present time.

There were (and are) many indications in the process of psychiatric admission that would suggest that a state hospital did not differ a great deal from other oppressive state institutions. Many black patients are brought to hospital by the South African Police Services (SAPS)[11] and thus risk scrutiny immediately. They are often admitted to wards that are locked and which have barred windows. Most of the windows of what are now the racially integrated admission wards at VBH look out across the river to the maximum security ward, with the regular appearance of SAPS vans transporting those accused of crimes and admitted for

[10] The Pass laws were repealed in April 1986, only to be replaced with stricter anti-squatting regulations.
[11] Aggressive and violent behaviour is a key indicator for admission to hospital of black patients. Access to telephones, ambulance services, private transport and the cost of any other form of transport are also factors that influence the mode of gaining access to hospital care.

psychiatric observation. The impact of this would have been even more dramatic when the 'black side' of VBH was on the same side of the river as the forensic wards[12].

In interviews with hospital staff regarding interpreters and the placement of CHITEP interpreters at VBH, much emphasis was placed on the issue of confidentiality. This is an enormous area of neglect in the protection of Xhosa-speaking patients' rights. The use of a general assistant or another patient as an interpreter presents a range of clinical issues around the integrity of the information that will be garnered. This should present to the clinician the spectre of a whole host of ethical and medico-legal sanctions. It is hardly surprising that evading these hazards could come to be seen as a significant aspect of clinical skill. The fact that clinicians face no overt risk of ethical sanction and there is no documented instance to my knowledge of a clinician ever being sued in South Africa for malpractice under these circumstances, is an indication of the extent to which monolingual African language speakers are disempowered in the health care system.

However, any risks that face a clinician when using an unqualified and unauthorised interpreter pale in the face of the hazards a patient must negotiate. If such a patient wishes to be helped by the clinician, they risk the many levels of exposure that are possible when confiding in an interpreter who has no professional obligation to respect the trust placed in them. Not only is there the risk of inter-personal shame and derision, but exposure to ridicule within one's community of origin is risked. To this must be added the not insignificant weight of socio-political threat in a violent and divided society. Thus, in the apparently simple, mundane and routine activity of enlisting the help of a general assistant or patient to interpret, the clinician produces a merger of moral and legal discourses of observation and discipline in a single stroke. This discursive merger can be no more complete than when the person enlisted to interpret is a security guard[13].

[12] A great deal of time and energy is expended by psychiatrists in attempting to resist being constructed by the SAPS, magistrates' courts, communities and families as agents of control over disruptive individuals. However, the fact that this is the case merely underscores my point regarding a general perception regarding the role of psychiatry in society. See Mossman (1997) for a superb attempt to address this in relation to the debate regarding homeless people in the USA.

[13] Tribe (in press) has drawn attention to the issue of confidentiality when working with refugees and survivors of torture with interpreters in Britain. The evidence heard at the TRC has graphically confirmed the role of the SAPS in perpetrating human rights violations during the apartheid era. The implication of psychiatric institutions in this has not yet been explored (du Toit, 1998).

PSYCHIATRY AND COLONISING THE AFRICAN MIND

In a monograph provocatively entitled Capture by description Thornton (1988) traces the history of anthropology in southern Africa. While eschewing a facile form of the notion that anthropology participated directly in the colonial enterprise by providing the 'intelligence' (in the sense of information) necessary to rule more effectively, he does acknowledge that ethnographies of southern African people were profound in their influence over the shaping of linguistic, cultural, ethnic and geographical boundaries. Of interest in the context of this discussion is Thornton's proposition that a shift towards emulating the natural sciences in anthropology resulted in incomparable cultural phenomena being compared with universalised descriptive categories. However, he argues that far from making African cultural forms transparent to interpretation, it rendered them profoundly opaque, even mystified. This suggests a number of parallels with the psychiatric enterprise.

Arguably the dominant impulse in global psychiatry is towards a single, all-encompassing diagnostic system (DSM IV, 1994). Massive research projects seek to validate diagnostic categories in a large range of cultures and regions (Jablensky et al., 1992; Leff, Sartorius, Jablensky, Korten & Ernberg, 1992; WHO, 1973, 1979). A passing interest in 'exotic' cultural phenomena is subsumed within this larger universalising project. One of the ways in which this is accomplished is to make a distinction between form and content in mental phenomena, thus accommodating deviant cultural content in a typology of universal forms. Swartz (1993) has described how this has functioned in a particular way in South African psychiatry. A relativistic position on cultural aspects of emotional distress mystifies the phenomena and renders them incomprehensible, while simultaneously subsuming these phenomena into universalistic biological discourses. In this way uncertainty over the meaning of cultural phenomena is over-ridden with the confident assertion of universal biological implications, and in this way biological intervention is validated. Individual meanings in the mind are reified in the process of their transposition into symptoms of the mind.

At the individual level, the description of states of mind is closely linked to these states of mind being subsumed into psychiatric discourses of psychopathology. The implications of this process are not ideologically neutral. Various forms of control and surveillance are mobilised as concomitants of the power of description. Certain descriptions are prioritised

over others (McCulloch, 1993, 1995; S. Swartz, 1996a). "Moral trajectories" (Barrett, 1996) in behaviour and compliance with medication (Trostle, 1988) are often part of treatment. The failure of a patient to modify his or her identity in relation to a diagnosis is often negatively construed and maybe accounted for in terms of the illness (Estroff, 1993). In what was discussed above in relation to being 'known' for blacks in South African institutions, it was shown that there might be social perils in being described accurately. Reticence regarding the role of specific cultural beliefs and practices may also be fraught for similar reasons. The reluctance to disclose culturally informed beliefs might arise for individual and group reasons.

One of the critiques of the "ethnic sensitivity" approach to multi-cultural health care has been the way in which lifestyle choices are labelled actively or by implication as socially and morally unacceptable. In Britain this has been expressed in relation to birth-control, child-rearing practices, etc. (Stubbs, 1993). In this way the surveillance implicit in the psychiatric enterprise is translated into pressure on the members of particular groups to conform to normative social forms. Local examples can be seen in the biomedical approach to traditional healing practices. These are simultaneously lauded for being "holistic" without evidence (Swartz, 1996), and vilified for poisoning patients (Joubert, 1989). While research into traditional healing is framed in terms of a value-added approach, implicit in this gaze at traditional healing is the possibility of control and regulation under biomedical auspices (Cavender, 1991; Freeman & Motsei, 1992; Kottler, 1988; Varga & Veale, 1997).

The dynamics of managing language diversity in institutional settings are the dynamics of negotiating identity. For the patients who are treated in institutions, certain identities may be mobilised when engaging with the institution, while others may be suppressed or obscured. This may take place for a range of personal, social, political or cultural reasons. Thornton (1996) has described the bewildering fluidity of identities in a South Africa that is more post-modern than post-colonial. The arbitrarily assigned categories of apartheid have dissolved and signifiers that previously served to create an illusory coherence fail to do so. A powerful way in which the fluidity and 'negotiable' quality of identities is sustained is the sanctuary of impaired or restricted communication. When considering the role of nurses as interpreters, or community health interpreters for that matter, it is important to recognise that they must contain and mediate this negotiation of identities. Language issues also foreground issues of identity for individual clinicians and for institutions, and it is to this that I now turn.

LANGUAGE, RACE AND INSTITUTIONAL IDENTITY

Lentegeur Hospital:

At the outset of this research I had hoped to assist in putting the role of interpreters and language issues generally higher on the agendas of local policy makers and service providers. As a clinician working within the state health care system I was well aware of the frustrations of staff and patients and felt personally identified with this struggle. It was therefore distressing to find that an initial draft of a paper for publication based on the study conducted at LGH met with a negative response from hospital authorities (Drennan, in press-a). While I was aware that the paper quoted interviewees' most strongly worded statements and that it drew challenging conclusions regarding race, I naïvely assumed that it could be of benefit to a hospital that desperately required more substantial state support. Some issues with the draft referred to inaccurate historical detail but the main thrust was the view that the hospital had been misrepresented with respect to the question of race and racism. It was felt that the identity of the hospital was informed by its policy to be a 'non-racial' institution, an identity adopted years before integration became macro-health policy. The respondents to the initial draft felt that this aspect of the hospital's identity was lost through my not adequately situating the problems in the context of the wider health care system. These comments were most certainly valid. The practices in any particular institution are strategies developed to deal with the pressure of reflecting larger social forces and paradoxes in their work. The position of the researcher commenting on the practices of a particular institution as an exemplar of the effects of certain types of social pathology is, however, a complex one (Rhodes, 1986). Conflicting loyalties and identifications on the part of the researcher may result in over-simplification and even misinterpretation.

Part of the objection to the inference that practices at LGH may be interpreted as racist could be seen to arise from the coloured experience of discrimination under the National Party, along with black groups. However, in a post-apartheid South Africa political issues are less dichotomised than prior to 1994. There is emphasis now, through the powerful metaphor of the 'rainbow nation', on richness in diversity. The new ethos aspires to recognising the many disparate voices and interest groups that make up the new order. I wish to explore this issue through examining the appointment of an interpreter at LGH in some detail. This will illustrate the complexity and range of issues that are embedded in such developments.

The appointment of an interpreter at LGH was discussed in Chapter 5 and reference was made to the fact that the person appointed was a coloured man, formerly in the position of a security guard at the hospital, who spoke many African languages[14]. A range of factors must be considered when examining this appointment as simplistic conclusions may fall short of adequately contextualising the decision. The first issue that warrants consideration is the ethnic identity of the incumbent. I am not privy to the criteria that informed the appointment of a coloured interpreter, and I do not wish to question the competence of the person appointed. But the question of competence may be precisely the rub. It is possible to question the use of a decontextualised notion of competence, as is characteristic of biomedicine, in the absence of a consideration of identity issues. The appointment of a coloured interpreter could be seen to entrench the perception of the hospital as a coloured one. A Xhosa-speaking coloured interpreter does little to address issues of alienation and marginalisation of black patients that manifest through language service provision, but are not reducible to it. However, it further seems to illustrate the shortcomings of reifying language skills as a technical feature of service provision, while evading larger issues. The argument advanced in Chapter 5 that an interpreter can be used to expedite the objectives of the institutional management of patients is reinforced through this.

The issue of jobs and competition for scarce resources must also be considered as Erasmus & Pieterse (1997) have linked the rise of coloured ethnic nationalism to this. There is evidence that the coloured community was given preferential treatment, in areas such as social welfare support, compared to black people under the Nationalist government. It was also explicit policy for coloured people to be given labour preference in the Western Cape. LGH was an employer in the area, with historical loyalties to the surrounding coloured community. This could have had a bearing on the small number of Xhosa-speaking nurses employed over the five years since the hospital began to admit large numbers of Xhosa-speakers. In my discussion with union representatives at VBH, they argued that a new category of interpreter should be created in the public service post structure, but that no new people should be employed to fill this post. It was felt that general assistants should be given a career path and

[14] Competence in these languages was not to my knowledge assessed.

promotion option through training to work as interpreters. This sentiment may also have had a bearing on the decision at LGH to make an 'in-house' appointment[15].

The Western Cape is the only one of nine provinces that has a National Party[16] majority in local government following the democratic elections of 1994. This is attributed in a large measure to the coloured vote. The choice of this electorate is seen as an expression of anxiety amongst the coloured population about the consequences of a predominantly black ANC government, and the rise of a coloured ethnic nationalism (Erasmus & Pieterse, 1997). Arguably, employing someone with the power of multi-lingualism but the loyalties of the dominant group at the hospital could be seen as relevant in this context. Again, this had echoes among VBH staff, where coloured staff expressed anxieties about a change in the character of the institution towards being more Africanised. There was indirect opposition to the special arrangement of having an interpreter for Xhosa-speaking patients from Afrikaans-speaking staff at Valkenberg. Some had begun to refuse to interpret Afrikaans for the clinicians who were not proficient in this language, as they felt that the interpreter should provide this. As one nurse put it:

> *"... but I feel that there was a bit of unhappiness amongst the other nurses, you know, where there was, um. Why must you [the interpreter] just talk in Xhosa, why can't you talk in Afrikaans? That's your job, it's in your job description to interpret so you have to talk in Afrikaans."*

An issue omitted from the original draft of the paper submitted to LGH hospital was the question of blame. This was an important theme in the talk of interviewees and each had a theory as to who was responsible for the service to black patients. By my omitting to address this specifically in a draft of a paper for wider consumption, it is possible that the hospital administration would seem the most likely to be implicated by readers, without regard for the multiplicity of contextual factors that impact upon service provision for particular groups in local hospitals. These include economic factors, labour relations, macro and micro socio-political factors. However, the response from the institution can also be seen in the light of what can be said and not said in public spaces with regard to service provision for ethnically diverse populations.

[15] Security guards are employed on the grade of a general assistant.
[16] The ruling party during the apartheid era.

Local academic writing during the apartheid era was subject to particular internal and external pressures regarding what could be written about in relation to racism (Lambley, 1980; Swartz, 1985). Howitt & Owusu-Bempah (1994) and Ahmad (1993) have written in recent times of similar such struggles in Britain. While there has always been tension between researchers and practitioners with regard to exposing the work of clinical practitioners (Rodman & Kolodny, 1977), the pressures regarding questions of race and racism are always particularly intense (McGary, 1992). In South Africa during this period of transition the gradual permeation of change into institutional contexts, a type of working through with its attendant anxieties, may create types of self-censorship which are not easily overcome. The enormous social and emotional consequences of exploring questions of race and racism at the present time create a climate in which this is an uncomfortable experience for all involved.

CHALLENGING RACISM AT HOME

Of speaking and writing

"'Fieldwork' is coming closer to 'homework' than we usually think" (van Dijk & Pels, 1996, p. 247). For a number of reasons I have been explicit thus far about the identity of the institutions where the research was conducted. One is that, before becoming fully aware of the implications of what I was embarking upon, I published a paper in a local journal where I specified the location of the research (Drennan, 1996a). This was done because the features of the hospital studied are unique in South Africa and would have been transparent to a South African audience. It was also useful to be able to name the hospital because of the standing it has in the mental health community as a teaching hospital. A later paper that addressed the language issues at another hospital, and that did touch on the sensitive issues raised in the previous chapter, also specified the institution (Drennan, in press-a). Again, this was partly because, if adequately contextualised, it would be immediately identifiable because it is the only institution of its kind in the country. It was therefore pointless to try to conceal the identity of the institutions with the usual conventions of anonymity.

The question of anonymity is a moral and ethical dilemma that anthropologists have struggled with in relation to studying professional elites (Harrell-Bond, 1976), but most particularly when conducting research with people who will read the texts that are produced. Added to

this can be the difficulty of having on-going relationships with and direct accountability to the subjects of research, and for whom there may be negative effects (Cheater, 1987). Even if anonymity to a wider audience for the researched group were possible, this cannot protect the more important intimate relationships from these implications (Facio, 1993). Cheater (1987) refers to these dilemmas as those of a "citizen anthropologist". Ngubane (1991) writes of the difficulty of being a "native anthropologist". I am attempting to be explicit about these issues here precisely because I believe them to be fundamental components to understanding the complexity of language issues, and the integration process, in local institutional contexts.

Under the apartheid government, academic work critical of policy across a range of settings including institutions was morally laudable. To do this was anti-apartheid and anti-racism. In a sense, the politics of criticism were straightforward and there was a certain degree of protection afforded the academic by liberal institutions. The new South Africa is politically more complex, and the politics of critique are more complicated accordingly. Bekker (1996) has written of how difficult it is to criticise the new order in the face of a number of pressures. These include the economic concerns of the government; possible accusations of a lack of patriotism; counters that such criticism is premature in the development of new democracy; and that premature criticism actually undermines or damages the process of transformation through damaging confidence in the political leadership of the day. All of this leads to a sense that the would-be critic should give the new order more time before embarking on criticism.

An attempt to critique institutional practice now, and the suggestion that institutional racism continues to undermine, if not characterise institutions, involves being construed in one of two ways. Either one is saying that the institution is not progressive, lives in the old South Africa and is thus racist. Or it involves saying that the new order continues to be racist in spite of superficial changes in policy. The former has the potential to be very damaging to the institution that permitted scrutiny of its work. This raises a whole host of ethical dilemmas as to how rights are to be prioritised and the imponderable consequences that are possible outcomes of such a critique. However, the latter is also very difficult. In fact, such a charge runs the risk of being seen as racist itself. Here the question of who has the authority to speak on such matters, in terms of how such statements will be read by others, is pertinent (c.f. Kottler, 1990; Swartz, 1989).

However, it is not only the process of writing that manifests these difficulties. Kavanagh (1991) has drawn attention, through an ethnographic study in the USA, to how the "sensitivity" of race and gender issues results in avoidance in formal organisation communications. When commented upon, these issues were usually confined to comments amongst peers and subordinates. If not, the person who was outspoken was unlikely to be a permanent member of staff, thought of as unprofessional, and pejoratively labelled as "an agitator" (p. 264). Roth & Swartz (1992) have noted that the racial integration process at another Western Cape hospital was remarkable for its silence on issues of race. They hypothesised that talk of race can slip very easily into racist talk and that anxiety about how talk about race will be perceived results in this being avoided.

There was a great deal of talk about the language issue at LGH. However, this talk, it seems, had not ventured into the territory of public talk about race. Swartz (1986b) has drawn on Foucault's notion of "incitement to discourse" (p. 140) to sound a note of caution about the intrinsic value of talk in the area of societal struggles with the issue of racism. Some forms of talk can detract from silences and gaps in the discourse of engagement with particular problems or struggles. It is possible that an "incitement to discourse" at LGH on the question of language was serving to obscure institutional engagement with issues of race and racial integration. The apparent paradox of how extensive the interpreting need was perceived to be and how difficult it was to clarify the details of this need could be understood in terms of ambivalence in the institution. It appeared that what was unacceptable to LGH, by virtue of its challenge to its identity, was the inference that the problems it experienced with respect to language could be interpreted as giving rise to institutional racism.

DISCOURSE ANALYSIS, ETHNOGRAPHY AND AUTHENTICITY

In Chapter 3 I outlined the theoretical articulation of a discourse analysis approach to the study of institutional practice and contrasted this with a subjectivist or hermeneutic project. The method of discourse analysis, in this instance in relation to institutions, requires that institutional 'texts' be analysed for the purposes of identifying or abstracting out recurring themes. However, such an analysis must acknowledge that the 'discourse analyst' comes to the process with his or her own set of interpretive repertoires. Discourses in texts are not so much discovered anew as synthesised from a combination of the particular context and the pre-existing "maps" (Wetherell & Potter, 1992) available to the researcher. In the course of

this research my own process of identifying relevant information was informed by a dialectical engagement with the information made available through the ordering process of the research method and the directions this suggested in my reading of previous writings. For example, the very striking differences in the services available to Xhosa-speakers in hospitals on the basis of communication difficulties with service providers led me to explore the issue of institutional racism in the available literature. This strengthened a focus on this problem and provided a language with which to articulate the issues more coherently. This would seem to accord well with Foucault's concept of sovereign power which is precisely not the power of a particular individual but the power that an individual acquires through particular discourses and discursive practices (Clegg, 1994)[17]. However, there is an implicit hierarchy of perception in this process of acquiring rhetorical power through familiarity with the discourses of discourse analysis, that results in the privileging of the researcher's interpretation over that of research subjects. I have come to problematise the question of authority in relation to discourse analytical studies of biomedical settings, through the juxtaposition of ethnographic methods in such research.

Littlewood & Lipsedge (1997), in an overview of racism in psychiatry in Britain, describe a range of examples of institutional racism. Like in many American studies, institutional racism is demonstrated through aggregating particular instances of difference in treatment (Chung, Mahler & Kakuma, 1995; Flaherty & Meagher, 1980; Sabshin, Diesenhaus & Wilkerson, 1970; Segal, Bola & Watson, 1996). Thus, in the case of prescribing patterns for different ethnic groups, the average dose of a particular medication may be higher for particular groups, but this would not necessarily make a particular dosage of medication a 'racist' dosage. This attempts to disconnect particular examples from the implication of necessarily being racist, but demonstrates trends in how black patients are treated as a group. A discourse analytic approach seeks to clarify the complex relationship between particular interactions and "aggregated" trends. Kuipers (1989) cautions researchers wishing to synthesise micro-analyses of institutional texts with discourse approaches that "'macro' discourses are not merely 'micro' formulations writ large" (p. 110). There is a process of "gradual objectification and decontextualising of discourse" (p. 110) and redefining it in a

[17] While the overall thrust of the Foucauldian description of a new economy of power relations notes a shift from sovereign power from above to that of a disciplinary power operating within relations, Clegg (1994) is describing how some individuals reproduce discourses more powerfully than others.

new context. While this process may add meaning to particular institutional texts, the stripping away of particular contextual details may result in a degree of reductionism. Such a process may be antithetical in some respects to the ethnographic enterprise, where recreation of the context in which 'texts' should be understood is imperative. Consequently, discourse analytic approaches have been cautioned as to what may be lost in the "salt-flats of abstraction" (Cox, 1989, quoted in Terre Blanche, 1997, p. 155).

Ethnographic research is inevitably an intensely challenging and emotional process. The extent to which this is represented in the academic texts that reflect on the ethnographic experience may variously reveal or obscure this facet of the enterprise (Marcus & Cushman, 1982). It is necessary to consider my position in relation to the textual representation of the research process, as it highlights the difficulty of representing multiple perspectives. In the course of this study I have experienced myself in a number of roles in relation to the institutions involved. When setting out I construed myself, and was construed by others, to be a member of the institutions, a researcher and perhaps a helper. These roles were fundamental in granting me largely unquestioned access to certain types of information and institutional spaces. However, as the significance of the language issues and its connection to fundamental questions of human rights gained in moment for me, I was caught up in attributing responsibility to particular parties. This led to a more journalistic or activist approach in relation to the complexities, and obscured most of all my identity as member of the institutions. As was discussed above, the draft of a paper for publication regarding Lentegeur Hospital implicitly placed the responsibility for the service provision difficulties at the door of that hospital's administration. A set of assumptions informed by my sympathies towards clinicians, my sense of vulnerability as a clinician myself, and my expectations of bureaucratic authority, led me to avoid approaching administrators directly. When I did interview administrators their familiarity with some of the language issues and their willingness to engage with a critical interpretation challenged some of these assumptions. It became clear that hospital administrators in both settings had their own perspective on language services. They too felt trapped by organisational limitations, only they were caught between local government and the competing demands of clinical and administrative hospital staff.

As part of the ethnographic process I asked clinicians at Valkenberg Hospital to read and comment on a part of the text presented here. The response this provoked was strong and yet

ambivalent. For clinicians who worked in the units involved in the study, engaging with the language of discourse analysis in representing their clinical work was an intensely difficult experience. Feelings of anger, shock and distaste made the text difficult to read. There was a concern that clinicians were represented as ignorant, complacent or at worst actively colluding with the racist oppression of black patients. The ambivalence arose as a result of the wish to see the issues of racism and inequity of services made explicit nevertheless. There was a wish not to deny institutional racism nor to require an apologist interpretation of the context of clinical work. But there was also a feeling that the care and concern for black patients expressed in clinical work was not adequately represented. A discourse analytic approach might justify such responses in terms of denial (van Dijk, 1992) or discount them as irrelevant at this rarefied level of analysis.

However, Fisher & Todd (1986) in their consideration of institutional discourse refer to Garfinkel's (1967) cautionary words, that people are not "judgmental dopes" (p. x). My representation here of clinical work that takes place, often in the absence of meaningful interpreter assistance, focuses on meanings that do not come into being. This may obscure or even 'obliterate' the meanings that do come into being with patients, in spite of the obstacles, that are both empowering and humanising. In fact, clinical communication and clinician identities can seem truncated through appearing to be reduced to the textual representations of institutional documents, in something akin to the reification scandal in discourse analysis referred to by Terre Blanche (1997). S. Swartz (1996b) describes this additional layer of institutional reality as "lived actuality" (p. 154). Thus, "clinicians may produce documents which conform to institutional patterns but simultaneously engage with their patients in ways which facilitate the expression of complex and contradictory experience in both themselves and their patients" (p. 154).

Part of the difficulty for clinicians in reading the draft section of the text was with the language of discourse analysis, which tends to emphasise negative aspects of discourse. Terms and phrases such as 'collude', 'conceal from scrutiny' and 'reproduce racist discourses' may be argued to be comprehensible within the discourse of discourse analysis as less pejorative than they seem. However, a similar argument in relation to psychiatric terminology regarding personality disorders, for instance, would not perhaps stop a discourse analysis from inferring nevertheless the presence of moralistic discourses implicit in the psychiatric text. The implicit reductionism in such an account and the obscuring of

contradictory discourses results in an analysis that fails as an ethnographic description. While the discourses of racism are important to identify for many reasons, the value of the interpretation is undermined if there is a perception that it "gets it wrong" (Ngubane, 1991). Such an analysis can attempt to influence practice through raising awareness, most particularly if the perspective can find its way into training courses (Fairclough & Wodak, 1997). But the ways in which discourses of institutional racism are modified or cut across by other contradictory and competing discursive practices would remain unclear, and perhaps less likely to be modified by self-initiated changes on the part of individual clinicians.

The struggle for a researcher who wishes to make a critical reading of institutional practices, without flinching from socially and politically sensitive issues, and who wishes to be helpful to providers and patients in the process, may lie in striking a balance. Too harsh a critique risks the loss of credibility within the community of hospital workers; but too superficial an analysis risks the failure to grasp the nettle that is choking change. Institutions may well want assistance with service provision problems in health care for black patients, for which they feel under-resourced and ill-equipped. Hospital staff themselves are frustrated by the lack of consideration being given to the needs of Xhosa-speakers in psychiatric settings. Appeals were made in the course of interviews conducted during this study for a coherent strategy that goes beyond the fragmented efforts of individuals.

> "[So that] *it's not just this improvised, arbitrary, superficial, interrupted process.*"

But in order to draw attention to the need for a broader, more all-encompassing process of change, there is a sense in which the institution must become known to the wider community in terms of deficiency. Exposing inadequacy is always difficult. To identify a need in an institution, even when giving voice to this need may be valued, can be much like the role of a therapist in relation to a struggling patient. The patient may appreciate that an untenable situation in their life has been named, but may be exasperated at being implicated in the maintenance of the problem (c.f. Rhodes, 1986)[18]. The parallel situation to this in a research context can be a persecutory experience for the institution, and felt most acutely through its

[18] It is important to note that this metaphor may also be seen as patronising, as it conveys another construction of the researcher as in a position of superiority over the researched. Implicit in the metaphor is a hierarchy of perception and a distancing of the researcher from complicity in the situation being described. This is particularly problematic in "practitioner ethnography", but also obscures the implications of the researcher's emotional involvement in the research process (see, for example, Hunt, 1989).

representatives. This challenges the identity of the institution in particular ways, highlighting vulnerability and risk. The dilemma of how to get help without being compromised, judged, or constructed in particular terms, and yet to have a need recognised, is a vexed one. Inevitably this leads to an attempt to manage self-presentation. It is far more acceptable to manage this presentation, whether by self or other, as being one of a lack of institutional resources such as interpreters or multi-lingual clinicians. This deficit can be addressed pragmatically without moral implications. It is much more difficult if the institution is to be represented as racist and in need of transformation. This implicates biomedical institutions in the particular racist structures of apartheid that they presented themselves as being above. The moral implications of this and the question of what to do about them is not as easy to resolve.

PART IV

CONCLUSIONS AND RECOMMENDATIONS

Chapter 9

CONCLUSIONS AND RECOMMENDATIONS

A striking aspect of this study of language in institutional settings is the way in which language issues are everywhere and yet appear to belong nowhere. There is no group or sector that overtly takes language issues to be an integral aspect of its purview within the institutional practice of psychiatry. I have shown that this neglect of language, and the issues that cluster around, it may fundamentally compromise the nature of clinical work that can take place in such settings. This implicates each individual clinician in the issues of language. But even more significant are the implications of neglecting the language issue for institutions as a whole. Before considering the implications of the different facets of the research presented here, I will briefly address aspects of the study that may impact upon the conclusions drawn.

CONSIDERATIONS IN INTERPRETING THE RESULTS OF THIS STUDY

My focus on interpreting in psychiatric settings places limitations on the extent to which the findings here are applicable in a range of other biomedical contexts. Psychiatry is far from being prototypical of biomedical settings, and there are many features of other biomedical settings that may make interpreting considerably less problematic. This is true both from the point of view of the institution providing the service and for interpreters working in these settings. However, many of the issues explored are as cogent and urgent in mainstream medical practice as they are in psychiatry.

Secondly, the focus on the Western Cape is on a region where the impact of the language demographics are of a nature that may be quite different to another province, such as Gauteng or the Free State. Some of what been addressed here would need to be adapted to these contexts.

There is also a question about the validity of assessing services for black service users without directly comparable data on other groups of service users, in essence the question of a control group. There are a number of ways in which this could be framed, for instance comparing

diagnoses, medication, outcomes, etc. The answers to such questions would be multi-factorial, and language issues would be inseparably entangled with other dimensions of treatment. I have not set out to prove the relevance of language to these sorts of measures. I take the central importance of meaningful communication in mental health care to be a given. Until equitability of the services offered at this basic level of communication is achieved, groups of service users who can communicate and those that cannot are fundamentally incomparable groups. For this reason a far more significant gap lies in the limitations of the ethnographic aspect of the study.

The developmental progression of the research I described previously could be seen to arise out of a sense that the initial studies were deficient in casting light on the institutional complexity of the role of language diversity, and by implication, the role of interpreting. However, the final study described here is no less subject to that observation. There are two main reasons for this. One involves the many limitations of employing a focused ethnography approach. While a focused approach does allow results to emerge quickly and addresses itself very directly to a practical problem, the depth of insight that is possible may be constrained. A short period of time in any setting in which one is attempting to arrive at a rich understanding of the context and the way in which it shapes the realities that can come into being is a compromising factor. This limitation arises partly out of the way in which I have sought to address multiple levels of identity in institutional settings. This goes beyond a focus on pragmatic solutions to language service problems, to exploring underlying discursive formations at both societal and institutional levels. Within the limitations of the present study, this exploration may be incomplete in many respects, but I have attempted to show that a narrow focus on language and linguistic diversity as a practical problem is also deficient in a number of respects. Practical solutions run the risk of being inappropriate without consideration of the wider historical and socio-political context, and may well reproduce aspects of an oppressive health care system unwittingly. At the most basic level, they may simply fail. At another level, make-shift strategies that are inevitably short-lived, reproduce the issue of access to services for various language groups as peripheral, and the place of the groups themselves as marginal in society.

The second limitation of this research as ethnographic, is the fact that I have only begun to learn to speak Xhosa. Barrett (1996) notes that in ethnography "fluency with language is mandatory" (p. 7). In ethnographies of psychiatric settings this language is usually the

professional language of psychiatry. However, as my focus here was on multi-lingualism in South Africa, it is a grave cause for concern that I do not speak a black African language. This most certainly compromised my access to certain types of information and my awareness of what was taking place during interpreter-mediated interviews. At the risk of making a virtue out of necessity, it is worth noting that one of the aspects of this research I have drawn attention to is the way in which there can be a mirroring of the patient/clinician dynamics within the researcher/researched relationship.

There is an important role in research on psychiatry in institutional settings for an account of how these settings mobilise and interact with the multiple identities of service users. This would need to be more than another account of a reified and 'traditional' African culture in a modern institution, but would need to accommodate identity as dynamic and constantly shifting. The contribution of this study, precisely because of my identity as a non-Xhosa-speaking white male clinician, is an amplification of issues of identity negotiation in psychiatric institutional settings as problematic. The obstacles to gaining access to particular aspects of identity in relation to Xhosa-speakers, whether staff or patients, are obstacles for clinicians seeking to understand and be of assistance to patients. But they are potentially more important obstacles to black patients gaining access to meaningful services and a contributing factor to an experience of alienation in these settings. Aspects of my identity as a researcher were also seen to impact upon the production of a written document regarding the research. Issues to do with access, freedom to speak/write, betrayal and the representation of the work of clinicians and interpreters all surfaced through the research process. This suggested echoes with the sorts of constraints that operate on members of institutions in the daily performance of their institutional roles. This can also be seen in relation to clinical work and its textual representation. It would make for a smoother scientific product were I to obscure or detract from the importance of not speaking the indigenous language that is so central to this research. However, this mirrors aspects of the clinical work and writing that was described in Chapter 7. Rather than discrediting the possibility of meaningful clinical or research work in the absence of speaking an indigenous language, acknowledging this limitation and exploring its implications is an important starting point in making the issues visible.

RECOMMENDATIONS

The recommendations from this study I will describe in two ways. One I see as being a national strategy (the 'high road'), the other is localised and specific (the 'low road'). By national I mean that the first overall approach to the issue involves addressing macro-level issues in the delivery of health care. The second is informed by keeping a wary eye on the size of the task in addressing macro-level issues and the many obstacles that will arise to make meaningful change an inevitably slow and cumbersome process. The urgency of the language issues perhaps demand a certain pragmatism. Strategies that offer immediate and localised solutions can be of enormous value as well. Not only do they address clinical needs now, but they can serve as models for other settings and contribute towards a potential data-base of experience when formulating policy. There are also, however, many potential dangers in a localised and hence fragmented approach. One is that these strategies may deflect attention away from the macro-issues by pacifying various interested parties. We have seen how important legislative and governmental support is to facilitating change in local practice through the experience in Britain and the USA. People working on the ground in health care settings are vulnerable to demoralisation and disillusionment where efforts to offer equitable services are not supported, or are even tacitly obstructed, by over-arching bureaucracies.

National strategies

A document is currently in preparation by a research group at the Department of Psychiatry, University of Cape Town, in consultation with a wide range of role players nationally, regarding national standards of care in psychiatric settings[1]. This document includes a particular focus on language and cultural issues and addresses the role of these aspects in transforming services. As important as this document will be in setting benchmarks, it is necessary to look at how to go about materialising the envisaged changes. There are a number of fronts on which this could be tackled at a national level.

- The governing bodies of the medical and paramedical professionals, such as the Interim National Medical and Dental Council of South Africa (INMDC), could be lobbied to explicitly address the ethics and risks of the professional activities of their members without interpreter assistance. There are a number of overseas models of how this could

be addressed, regarding social work in Britain (Baker et al., 1991), and the Medicaid guidelines in the USA (Putsch, 1985). If professional guidelines made it clear that certain practices are unethical, and therefore liable to prosecution or sanction unless under exceptional circumstances, there would be an immediate impetus for individual practitioners to take responsibility for their individual practices. Where the professionals practice in institutional settings, it would be possible for the existence of professional requirements to exert pressure on the institutions that make use of their services. An additional front on which national governing bodies could be pressed to re-examine policy would be in the area of language requirements. At present functional competence in English is the only requirement to be licensed to practice locally. This explicit adoption of a *lingua franca* of health care may facilitate the acquisition of foreign medical doctors, but it does little to foster a local medical community that is dedicated to meeting the needs of South Africans.

- The Nursing Council could be lobbied to take up the issue in relation to nurses' performance of the task of interpreting. This could seek to clarify the circumstances under which this work is informally institutionalised, address training issues, and question of recognition of this task (whether through remuneration or status).

- Medical aid and medical insurance schemes could be lobbied to recognise the services of an interpreter as fundamental to gaining access to services and the quality of the services delivered, through granting an allocation to the hiring of interpreter services for members (as is the case in Germany for hospitalised patients, Rüder & Opalić, 1997). Unfortunately, the economic and social inequalities of the past may make the number of subscribers to private medical aids who do not speak either English or Afrikaans small. For most users of interpreter services the provincial health departments would be the most relevant groups to lobby.

- Some steps have been taken to lobby provincial health departments regarding interpreter services. The very real pressures of shrinking budgets, staff lay-offs and hospital closures all contribute towards an environment where the notion of expanding services is

[1] This work is being conducted on contract from the National Mental Health Directorate.

anathema. However, one area in which there is a commitment to expanding services is primary health care. If the importance of interpreting at this level of service provision were to be recognised, other systemic changes could follow.

- Training institutions can also have a significant impact on modifying individual and institutional practices. There have been many calls overseas for the training of health professionals in language issues and the use of interpreters, but this issue bears repeating (See for example: Carr, 1997; Corsellis, 1997; Corsellis & Crichton, 1994). All of these identify the critical need for the training of public service personnel in a wide range of issues in providing services to a culturally diverse population. If this were to take place, change could slowly filter through to institutions. Writing locally, Swartz (1998) has gone further to suggest that all health professionals, and indeed all human service personnel, should have training in one or other indigenous language other than Afrikaans. This would not obviate the need for interpreters, but would greatly facilitate training in language and cultural sensitivity.

- Consumer groups could be lobbied to take up language issues as part of their interest in protecting the rights of consumers, particularly the most potentially vulnerable to marginalisation and abuse.

Local strategies

The most important starting point for addressing language issues in particular institutions would be a willingness on the part of the institution to examine its services and systems for equity, access and appropriateness to the communities who make use of them. This would of necessity involve a consideration of the remnants of discrimination and exclusion left over from the apartheid era, but would also need to consider the place of mental health services in a new South Africa. This process of self-reflection could take a number of forms and there are many models available. Some of these, particularly those developed in the USA (Adams, 1995; Cross et al., 1989; Roizner, 1996), involve structured approaches to reviewing service provision. These strategies could be adapted to local circumstances. In this way, a consideration of language service provision could be embedded in an overall strategy to create and deliver culturally competent services.

With specific reference to language services, the three-tiered system suggested by Carr (1997) and Fortier (1997) may need to be adapted for local conditions and with the addition of a fourth tier.

- In the Western Cape the first tier could be structured access to a 'bank' of volunteer or professional interpreters for patients who present infrequently with languages that are not indigenous to the region. Tswana, and Pedi are examples of South African languages, but French and Portuguese are also important to consider as refugees and migrants from the rest of Africa increase in number.

- A second tier could be professional interpreters who are employed by an agency outside of the institution itself who provide language services on a regular and structured basis. An example of this would be when an agency provides an interpreter for a particular out-patient clinic on a regular basis.

- A third aspect could be made up of professional interpreters, who are either employed by an outside agency or by the institution itself, and who are based at the institution on a full-time basis. These interpreters could be allocated to particular aspects of a service or used throughout an institution, depending on the volume of need and how the services are structured.

- The fourth aspect would be the organisation of the interpreting services provided by nurses. This would involve training for nurses who were willing to contribute in this way and the recognition of this aspect of the work, in terms of reward, the allocation of duties and the allocation of nurses to particular units within a service. The addition of this facet would be to address the need for easy access to language services in certain clinical settings, but also so that communication between staff and patients in indigenous languages does not get split off from other aspects of service provision.

All of the strategies listed here are of the "add-on" or "add-in" variety (Swartz et al., 1997). While they may contribute to a change in the 'culture' of a particular institution, there are other ways of thinking about the interface between language and services. Swartz et al. (1997) suggest that multi-lingual psychiatric nurses are an under-utilised resource. If the language skills and ethnic identities of psychiatric nurses were adequately recognised and

supported, the possibilities for offering a broader and more appropriate range of interventions may be enhanced.

The professionalisation of interpreting

The professionalisation of interpreting at a national level is a key issue here. It is important that the available national resources for the training and professionalisation of interpreting are developed and broadened to include health care work. This can not take place initially without clarity as to how trained interpreters will be employed in health care settings. Career paths and reasonably secure employment would have to be potentially available to justify investing in expensive training courses. It would in my view be a mistake to create an expectation that interpreting in health care should become the exclusive province of specifically trained interpreters. The enormity and diversity of the task should not be under-estimated. There are also hidden pitfalls. As was discussed in relation to interpreters in multi-disciplinary teams, the presence of a language professional can reify the simple and yet fundamental task of communication in health care in a way that splits it off from other clinical functions (c.f. Miller & Swartz, 1991, in relation to clinical psychology in medical settings).

The presence or potential presence of designated interpreters was seen to make a significant impact upon the all round availability of language services at Valkenberg Hospital. However, the interpreter service should be part of a co-ordinated overall strategy. I will take this up below but the potential availability of designated interpreters may make the interpreting situation worse for health services under particular circumstances. If it is not clear to other services providers, such as nurses, what their position is in relation to interpreting when there are designated interpreters, there is the possibility that nurses may refuse to interpret. This may compromise the services in a number of ways. The experience of this research has shown that services are vulnerable to this problem when there is unhappiness amongst the service providers. When team membership and co-operation is undermined, requests for interpreting are a soft but vital area in which to give voice to dissatisfaction. The tacit interpreting arrangements that are vulnerable to this sort of conflict are symptomatic of the failure to recognise that language is an important facet of any medical service. Nevertheless, rigorous training in the discipline of liaison interpreting and the strategic utilisation of a specific professional service could create the backbone of language services that could be augmented and supported in many ways.

NGO interventions in health care, with particular reference to psychiatry

As a language practitioner the interpreter would seem to be ideally placed to assume the mantel of the person responsible for the language needs of institutional mental health care. With the cautions noted above, there are two ways in which this service could be structured with a number of possible permutations. One strategy would be to attach an interpreter to a specific aspect of a service and have them focus their availability on meeting the needs of the service providers in that unit. Possible problems with this, as we saw above, have to do with under-employment and a compromising of independence in relation to the demands of the service. It would perhaps be more realistic, in terms of resources and optimum utilisation, to structure access to language services specifically aimed at the more time consuming and labour-intensive work. *Ad hoc* interpreting with trained nurses could still play a role in short and unscheduled interpreting.

Another strategy would be to view a language group as a special constituency requiring stewardship through a system. The interpreter could have a caseload in certain units and focus on the needs of specific individuals in relation to the services. This may require a wider range of skills and result in a function more akin to a link-worker in the British model (Raval, 1996). An interpreter who has contact with the patient independently of the clinician could build relationships and get to know patients better. This could go a long way towards addressing the alienation of an admission to hospital, but should not happen in isolation from or as a substitute for broader systemic changes. A number of factors would have to be in place for either of these models to work efficiently.

If the interpreters were employed by an agency outside of the institution, access to hospital management structures would be imperative. This would enhance the respect and consideration given to the language services. A clear grasp of organisational structures and routines on the part of the external organisation would also enhance appropriate service provision. But it also behoves the institution to take responsibility for maximising the benefits of such interpreter services.

The interpreters should be required to keep detailed records of their work that reflect patient contact, interviews that required interpreter services, and ward meetings attended. A clear, structured programme of responsibilities should be negotiated, and made available to all

involved wards and administration staff. Certain staff and patient meetings may require attendance and the interpreters should be given guidance on which these are and why. The hospital staff may require this to be clarified for them as well. The experience of the CHITEP in providing a service at a particular hospital indicated clarity about lines of authority and accountability to be imperative. Closer links with teams in which relationships of trust are built between interpreters and clinicians, to facilitate confidence in both parties, are important to develop.

Training for psychiatric work is particularly important. In this respect, the provision of an interpreter with a short training in generic medical work may be insufficient. Westermeyer (1990) lists the areas of expertise required of an effective psychiatric interpreter. These suggest that the best training for this may be that of psychiatric nursing. In addition, specific training regarding the South African Mental Health Act, patient rights in this context, and the role of cultural factors in mental illness are imperative. The latter capability should not be assumed. Preparation for working on the axis of mediating cultural factors is a murky area, but experience in addressing this issue would be of great value to the wider mental health community. In line with this, the interpreters require a great deal of professional support to improve their awareness of an appropriate advocacy role and more active empowerment to perform this. Training for interpreting in psychotherapy and psychometric testing would be important directions in which to develop a basic interpreter training.

Training for health care providers

The issue of training for the users of interpreter services, health care service providers, was raised above. There is obviously a significant practical component to the types of training that could be envisaged for health care providers. Raising awareness of the modifications to technique necessary in clinical contexts when working with an interpreter would surely improve services for those at risk of marginalisation and exclusion on the basis of language. This could be done quickly and cheaply, as in-service training or part of the curriculum at under-graduate level. However, where this training would fall short would be in promoting an understanding the role of language in access, on many levels, to services. Linked to this is the issue raised in Chapter 2 regarding the distinction between the language gap and the cultural gap. There is a marked limit to the amount of contextualising and cultural elaboration that an interpreter can provide in the routine course of interpreting an interview. Not only

may such elaborations intrude into an interview, but the interpreter may have no way of knowing what should be elaborated on and when. It is imperative that more and more clinicians begin to understand the social and cultural implications of a good translation of what a patient has said, rather than having to depend upon an explanation. It is necessary that the capacity to contextualise the illness presentations of black patients become implicit in medical and psychiatric work.

Possibly the single most important way to begin to broach all the training issues, technical and discursive, is through the practitioner's attempts to learn a black African language. While some medical schools have had one-year courses in a black African language for some time now, this strategy has not been particularly successful for a number of reasons. The low status of the languages, the lack of interest from professional role models, and the lack of real incentive from the point of view of course requirements have all contributed to a dismal outcome from these courses. Other professional trainings have similar difficulties, with the notable exception of the Clinical Psychology Masters level training at the University of Cape Town. The intake for 1998 was the first that had a demonstrated attempt to learn an indigenous language other than Afrikaans as an entrance requirement. This has taken a number of years to bring to fruition, but the effects permeate down into under-graduate education. If this policy were more widespread in medical and paramedical training, a knock-on effect to school education would result. Language abilities would do a great deal to address issues of social distance, the 'otherness' of black patients and discrimination in health care institutions.

Of course, if service providers were able to be at least functionally competent in a black African language this would not obviate the need of interpreters. Basic competence may reduce the need but not remove it. Further, there are many languages that could not be learnt and for which interpreting would be required.

A FINAL WORD ABOUT MEANING

It seems that much research in the social and health sciences is ultimately idealistic. Research can be idealistic in the sense of being loosely tethered to the reality of a chaotic and fragmented everyday world as it points hopefully towards a more ordered and coherent ideal. It can be idealistic in the sense of containing, explicitly or implicitly within it, exhortations for

practitioners of these sciences to do more, and to do better. This can be more of a burden than assistance to practitioners who are already stretched beyond reasonable limits. Finally, research can be idealistic through not attempting to solve any particular practical problem at all, but merely trying to describe something. This last type can seem to be the most offensive form of idealism from the vantage point of the over-worked, under-resourced and under-rewarded 'cogs' in the machinery of health care. At the start of this study I had set out to describe the place of interpreting in mental health care, but I was not then satisfied with a description. I had hoped that a description would contain within it potential solutions to a problem. However, this exploration of the dimensions of the language problem in local institutions has led to a thicket of institutional, social, political and historical problems that dwarf any aspirations to resolution. They are the problems that confront most South Africans in many areas of personal and public life in a country that Thornton (1996) describes as emerging from a state of being "perpetually just ahead of apocalypse" (p. 158). The scale of the tasks that are embedded in any attempt to address the deceptively simple issue of language in mental health care has led me to appreciate anew the value of 'mere description'. If by description there can be a beginning to the process of making meaning, first for ourselves, and then for our patients, this study will have served its purpose.

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APPENDIX 1

OFFICIAL LANGUAGES OF THE PROVINCES OF SOUTH AFRICA

OFFICIAL LANGUAGES OF THE PROVINCES OF SOUTH AFRICA

1. EASTERN CAPE: Xhosa, Afrikaans, English, Zulu, Southern Sotho.
2. FREE STATE: Afrikaans, Southern Sotho, English.
3. GAUTENG: Zulu, Afrikaans, Northern Sotho English.
4. KWAZULU-NATAL: Zulu, English, Afrikaans.
5. MPUMALANGA: English, Swati, Afrikaans, Ndebele.
6. NORTHERN CAPE: Afrikaans, Tswana, English, Xhosa.
7. NORTHERN PROVINCE: English, Northern Sotho, Afrikaans, Tsonga, Venda.
8. NORTH WEST: Tswana, English, Afrikaans.
9. WESTERN CAPE: Afrikaans, English, Xhosa.

Table 7: Official languages of the provinces of South Africa.

	English	Afrikaans	Zulu	Xhosa	Tswana	North Sotho	South Sotho	Tsonga	Venda	Swati	Ndebele	Total
EC	●	●	●	●			●					5
FS	●	●					●					3
GT	●	●	●			●						4
KZN	●	●	●									3
MPL	●	●								●	●	4
NC	●	●		●	●							4
NP	●	●				●		●	●			5
NW	●	●			●							3
WC	●	●		●								3
Tot	9	9	3	3	2	2	2	1	1	1	1	

Source: State Language Services, Pretoria.

APPENDIX 2

LANGUAGE COMPOSITION OF SOUTH AFRICA

LANGUAGE COMPOSITION OF SOUTH AFRICA

Table 8: Language composition of South Africa.

Language	Number of speakers[1]	Percentage
Zulu	8 343 590	22,1
Afrikaans	5 702 535	15,1
North Sotho	3 530 616	9,4
English	3 414 900	9,0
Xhosa	6 646 568	17,6
South Sotho	2 420 889	6,4
Tsonga	1 439 809	3,8
Tswana	3 482 657	9,2
Swati	952 478	2,5
Ndebele	477 895	1,3
Venda	673 540	1,8
European Imm.	109 825	0,3
Oriental	25 505	0,1
Other	495 597	1,3
TOTAL	37 716 404	100%

[1] Based on RSA Population Census 1991.

Adapted from: van der Merwe, I. J., & van Niekerk, L. O. (1994). Language in South Africa: Distribution and change. Stellenbosch: University of Stellenbosch.

APPENDIX 3

LANGUAGE-RELATED ASPECTS OF THE CONSTITUTION OF SOUTH AFRICA

Source: Language Plan Task Group Final Report (1996). Towards a national language plan for South Africa. Ministry of Arts, Culture, Science and Technology, Pretoria.

ANNEXURE 1

Constitution of Republic of South Africa, 1993

Languages

3. (1) Afrikaans, English, isiNdebele, Sesotho sa Leboa, Sesotho, siSwati, Xitsonga, Setswana, Tshivenda, isiXhosa and isiZulu shall be the official South African languages at national level, and conditions shall be created for their development and for the promotion of their equal use and enjoyment.

(2) Rights relating to language and the status of languages existing at the commencement of this Constitution shall not be diminished, and provision shall be made by an Act of Parliament for rights relating to language and the status of languages existing only at regional level, to be extended nationally in accordance with the principles set out in subsection (9).

(3) Wherever practicable, a person shall have the right to use and to be addressed in his or her dealings with any public administration at the national level of government in any official South African language of his or her choice.

(4) Regional differentiation in relation to language policy and practice shall be permissible.

(5) A provincial legislature may, by a resolution adopted by a majority of at least two-thirds of all its members, declare any language referred to in subsection (1) to be an official language for the whole or any part of the province and for any or all powers and functions within the competence of that legislature, save that neither the rights relating to language nor the status of an official language as existing in any area or in relation to any function at the time of the commencement of this Constitution, shall be diminished.

(6) Wherever practicable, a person shall have the right to use and to be addressed in his or her dealings with any public administration at the provincial level of government in any one of the official languages of his or her choice as contemplated in subsection (5).

(7) A member of Parliament may address Parliament in the official South African language of his or her choice.

(8) Parliament and any provincial legislature may, subject to this section, make provision by legislation for the use of official languages for the purposes of the functioning of government, taking into account questions of usage, practicality and expense.

(9) Legislation, as well as official policy and practice, in relation to the use of languages at any level of government shall be subject to and based on the provisions of this section and the following principles:

(a) The creation of conditions for the development and for the promotion of the equal use and enjoyment of all official South African languages;

(b) the extension of those rights relating to language and the status of languages which at the commencement of this Constitution are restricted to certain regions;

(c) the prevention of the use of any language for the purposes of exploitation, domination or division;

(d) the promotion of multilingualism and the provision of translation facilities;

(e) the fostering of respect for languages spoken in the Republic other than the official languages, and the encouragement of their use in appropriate circumstances; and

(f) the non-diminution of rights relating to language and the status of languages existing at the commencement of this Constitution.

(10) *(a)* Provision shall be made by an Act of Parliament for the establishment by the Senate of an independent Pan South African Language Board to promote respect for the principles referred to in subsection (9) and to further the development of the official South African languages.

(b) The Pan South African Language Board shall be consulted, and be given the opportunity to make recommendations, in relation to any proposed legislation contemplated in this section.

(c) The Pan South African Language Board shall be responsible for promoting respect for and the development of German, Greek, Gujerati, Hindi, Portuguese, Tamil, Telegu, Urdu and other languages used by communities in South Africa, as well as Arabic, Hebrew and Sanskrit and other languages used for religious purposes.

Constitution of the Republic of South Africa, 1996

Languages

6. (1) The official languages of the Republic are Sepedi, Sesotho, Setswana, siSwati, Tshivenda, Xitsonga, Afrikaans, English, isiNdebele, isiXhosa and isiZulu.

(2) Recognising the historically diminished use and status of the indigenous languages of our people, the state must take practical and positive measures to elevate the status and advance the use of these languages.

(3) National and provincial governments may use particular official languages for the purposes of government, taking into account usage, practicality, expense, regional circumstances, and the balance of the needs and preferences of the population as a whole or in respective provinces; provided that no national or provincial government may use only one official language. Municipalities must take into consideration the language usage and preferences of their residents.

(4) National and provincial governments, by legislative and other measures, must regulate and monitor the use by those governments of official languages. Without detracting from the provisions of subsection (2), all official languages must enjoy parity of esteem and must be treated equitably.

(5) The Pan South African Language Board must -
   (a) promote and create conditions for the development and use of
      (i) all official languages;
      (ii) the Khoi, Nama and San languages; and
      (iii) sign language.
   (b) promote and ensure respect for languages, including German, Greek, Gujarati, Hindi, Portuguese, Tamil, Telugu, Urdu, and others commonly used by communities in South Africa, and Arabic, Hebrew, Sanskrit and others used for religious purposes.

APPENDIX 4

QUESTIONNAIRE 1

INTERPRETER UTILIZATION QUESTIONNAIRE

We are attempting to find out more about the needs of hospital staff and patients with respect to the use and availability of interpreter and translator services. Please complete this brief questionnaire to assist us in improving these services.

STUDY OBJECTIVES

1. To count how many times people are used as interpreters.
2. To count how often interviews do not take place OR are impaired by the absence of an interpreter.

Date:.....

Patient's name:.....

File Number:.....

Female ☐ Male ☐ ☐

Home language of the patient with whom you wished to communicate?

Afrikaans..... ☐
Xhosa..... ☐ ☐
Other (specify):. ☐ .....

Language of interview (if different from above):..... ☐

Context in which interpreter service was required:

Psychometric Assessment..... ☐ Ward Round..... ☐
Psychiatric Assessment..... ☐ Group..... ☐ ☐
Family Interview..... ☐ Other..... ☐
(Specify).....

An interpreter was: available immediately..... ☐
: available at a later time.... ☐ ☐
: unavailable..... ☐

Duration of interview?..... ☐

The person who interpreted was a?

Registrar..... ☐
Psychologist..... ☐
General Assistant. ☐
O.T..... ☐
Visitor..... ☐
Student Nurse..... ☐

Professional Nurse... ☐
Social Worker..... ☐ ☐
Staff Nurse..... ☐
Patient..... ☐
Family Member..... ☐
Other..... ☐
(Specify).....

Female ☐ Male ☐ ☐

Other observations / comments that you would like to make about this interview:

.....
.....
.....
.....
.....THANK YOU

APPENDIX 5

XHOSA-SPEAKING STAFF: VALKENBERG HOSPITAL
OCTOBER – NOVEMBER 1993

XHOSA-SPEAKING STAFF: VALKENBERG HOSPITAL OCTOBER – NOVEMBER 1993

Table 4.3: Xhosa-speaking staff allocated to the units studied.

Unit	Professional Nurse	Staff Nurse	General Assistant	Total
Female Admission wards	2	2	1	5
Forensic Unit	5	5	4	14
Male Admission wards	7	3	3	13
Total	14	10	8	31

APPENDIX 6

VALKENBERG HOSPITAL: FIRST STUDY (1993)

VALKENBERG HOSPITAL: FIRST STUDY (1993)

Table 4.4: Contexts of interpreter utilisation.

Context	C23	FAWs	FU	MAWs	All units
Psychometric	0	0	1	1	2
Psychiatric assessment	72	60	16	99	247
Family interview	5	4	3	3	15
Ward round	0	0	8	6	14
Group	0	7	2	0	9
Other	3	0	1	8	12
TOTALS	80	71	31	117	299

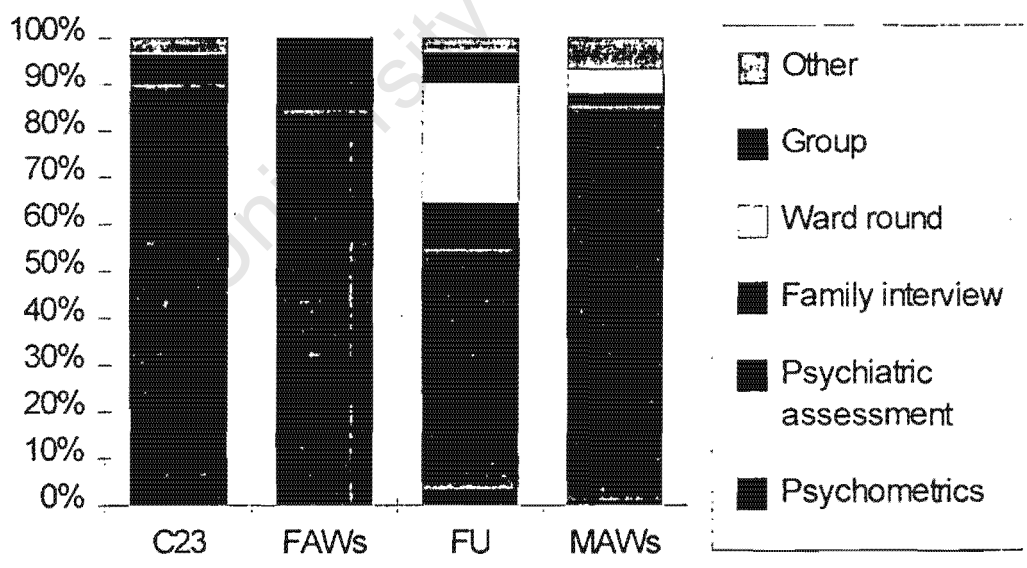
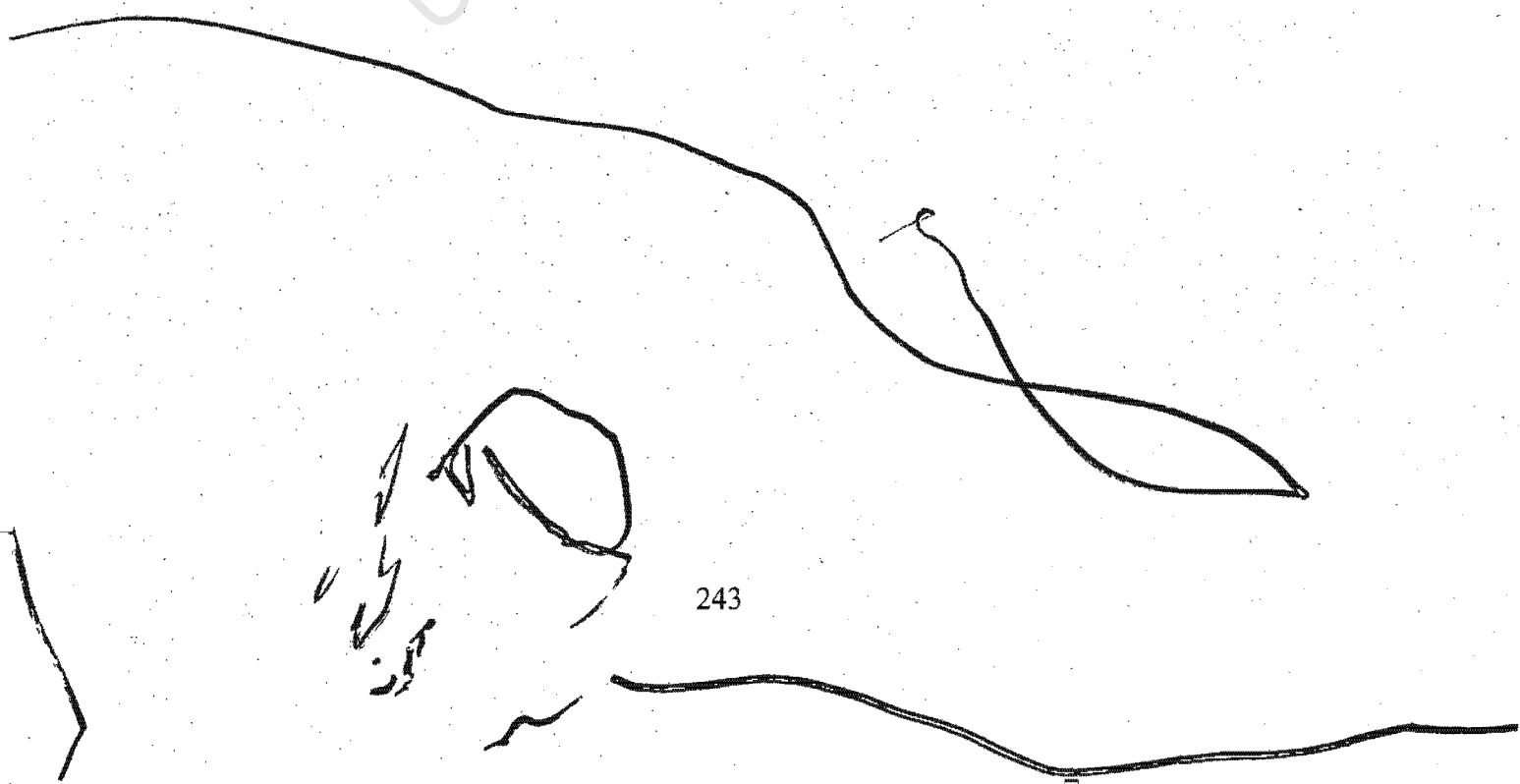


Figure 4.1: Contexts of interpreter utilisation by unit (in %)

APPENDIX 7

QUESTIONNAIRE 2



INTERPRETER UTILISATION QUESTIONNAIRE

Date: ----------

Patient's Name: ----------

File Number: ----------

Female ☐ Male ☐

Home language of the patient with whom you wished to communicate?

Xhosa ☐

Other ☐ Specify: ----------

Language of interview (if different from above)?: ----------

Context in which interpreter service was required:

Psychiatric assessment	☐	Group	☐
Family interview	☐	Psychometrics	☐
Ward Round	☐	Other	☐
		(Specify)	----------

An interpreter was:

Available immediately	☐
Available at a later time	☐
Unavailable	☐

Duration of interview ? ----------

Time of interview? ----------

The person who interpreted was a:

		Enrolled Nurse	☐
Registrar	☐	Professional Nurse	☐
Psychologist	☐	Social Worker	☐
S.A.	☐	Nursing Assistant	☐
O.T.	☐	Patient	☐
Visitor	☐	Family Member	☐
Student Nurse	☐	O.T. Assistant	☐
Psychologist Intern	☐	Medical Officer	☐
Other	☐ Specify:	----------	

Female ☐ Male ☐

Other observations / comments that you would like to make about this interview:

Thank You

APPENDIX 8

QUESTIONNAIRE 3

INTERPRETER UTILISATION QUESTIONNAIRE
Nursing Questionnaire

Ward: ----------

Date: ----------

Number of Xhosa-speaking patients requiring an interpreter: _____

Number of staff on duty today:

Category	Number	Xhosa speakers	
Prof. Nurse			
Enrolled Nurse			
Enrolled Nursing Assist.			
Student Nurse			
General Assistant			
Interpreter			Specify:
Other			

Other languages requiring an interpreter: ----------

No. of Ward Round interviews with interpreter available: _____

No. of Ward Round interviews with interpreter unavailable: _____

Name: ----------

Rank: ----------

Comments:

Thank you

APPENDIX 9

LENTEGEUR HOSPITAL:
SEMI-STRUCTURED INTERVIEW OUTLINES

LENTEGEUR HOSPITAL: SEMI-STRUCTURED INTERVIEW OUTLINES

INTERVIEWS WITH XHOSA-SPEAKING NURSES:

- Name, age, qualification.
- How did the person come to be working in psychiatry?
- How long have they been at LGH and which wards have they worked in?
- Do they have experiences of interpreting in another medical discipline, and how was this different to psychiatry?
- How does interpreting impact upon their work as a psychiatric nurse?
- What experiences have stood out in terms of interpreting, best, worst experiences?
- How does it affect relationships with other service providers and with patients?
- How do they handle cultural issues, what cultural issues come up when interpreting?
- Should interpreting be part of nurses' work?
- How should the problem be solved at LGH?

INTERVIEWS WITH CLINICIANS AND NURSES:

- Name, age, qualification.
- How did the person come to be working in psychiatry?
- How long have they been at LGH and which wards have they worked in?
- Do they have experiences of interpreting in another medical discipline, and how was this different to psychiatry?
- How much of a problem has the need for interpreting been in their work experience?
- What experiences have stood out in terms of interpreting, best, worst experiences?
- What sorts of cultural issues have come up when using an interpreter?
- Should interpreting be part of nurses' work?
- What has been tried in terms of solutions to the need for interpreting and how should the problem be solved at LGH?

APPENDIX 10

CHITEP: JOB DESCRIPTION FOR COMMUNITY INTERPRETERS.

CHITEP: JOB DESCRIPTION FOR COMMUNITY INTERPRETERS.

JOB SUMMARY:

To offer an interpreting service to Xhosa-speaking patients in their contact with health care providers. To facilitate communication between Xhosa-speaking patients and non-Xhosa-speaking health care providers by offering interpreting services. To ensure that the Xhosa-speaking obtain appropriate health care.

PRINCIPAL DUTIES

- To interpret for Xhosa-speaking individual patients in their interaction with health care providers in accordance with the project's code of practice.
- To advise patients of their rights and choices in respect of the health care facility.
- To identify the needs of Xhosa-speaking patients in respect of health care services. To prepare proposals for submission to management of the health care facility in conjunction with the co-ordinator / director.
- To take appropriate action to ensure that the patient receives appropriate services and that the health care provider understands the needs of the patient. This may require, e.g. challenging discriminatory or culturally insensitive behaviour on the part of the health care provider.
- To assist with counselling when necessary.
- To observe confidentiality at all times.
- To help with problems which may arise whilst the patient is attending the health facility.
- To assist with health, e.g. give appropriate explanations to patients; assist with directions of medications; referrals; etc.
- To keep records of work done with detailed information of problem areas, and to present weekly reports in both oral and written form.
- To attend weekly team meetings.
- To be able to function effectively within the multi-disciplinary health team.

APPENDIX 11

QUESTIONNAIRE 4

INTERPRETER UTILISATION VALKENBERG

Date: ----------

Patient's Name: ----------

File Number: ----------

Female ☐ Male ☐

Home language of the patient with whom you wished to communicate?

Xhosa ☐

Other ☐ Specify: ----------

Language of interview (if different from above)?: ----------

Context in which interpreter service was required:

Psychiatric assessment	☐	Group	☐
Family interview	☐	Psychometrics	☐
Ward Round	☐	Other	☐
		(Specify)	----------

An interpreter was:

Available immediately	☐
Available at a later time	☐
Unavailable	☐

Duration of interview ? ----------

Time of interview? ----------

The person who interpreted was a:

Interpreter	☐	Enrolled Nurse	☐
Registrar	☐	Professional Nurse	☐
Psychologist	☐	Social Worker	☐
G.A.	☐	Nursing Assistant	☐
O.T.	☐	Patient	☐
Visitor	☐	Family Member	☐
Student Nurse	☐	O.T. Assistant	☐
Psychologist Intern	☐	Medical Officer	☐
Other	☐ Specify:	----------	

Female ☐ Male ☐

Other observations / comments that you would like to make about this interview:

Thank You

APPENDIX 12

PROGRAMME EVALUATION AND FOCUSED ETHNOGRAPHY: SEMI-STRUCTURED INTERVIEW OUTLINES.

PROGRAMME EVALUATION AND FOCUSED ETHNOGRAPHY: SEMI-STRUCTURED INTERVIEW OUTLINES.

INTERVIEWS WITH CLINICIANS AND NURSES:

- An overall impression of the nature of the language difficulties as encountered in staff-patient and staff-staff interactions.

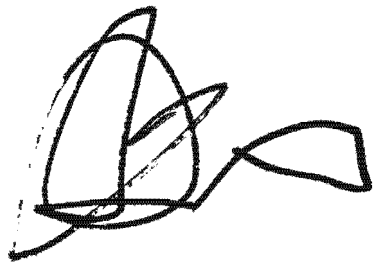
- Opinions on:
  - Performance of the interpreter;
  - Interpreter's impact on service provision;
  - The impact of the interpreter on other members of the multi-disciplinary team and their functioning;
  - The quality of the service offered to speakers of African languages and suggestions for areas of improvement;
  - Suggestions for improvement in the interpreter service.

INTERVIEWS WITH THE INTERPRETERS:

- An overall impression of the nature of the language difficulties as encountered in staff-patient and staff-staff interactions.
- Accommodation to work in a multi-disciplinary mental health team.
- "On the job" learning experiences, areas of insecurity in functioning.
- Experiences of mediating culture for patients and staff.
- Extent of patient advocacy work.
- Sources of stress, frustration, and dissatisfaction.

APPENDIX 13

PROGRAMME EVALUATION VALKENBERG HOSPITAL (JUNE - JULY 1997)



PROGRAMME EVALUATION VALKENBERG HOSPITAL (JUNE - JULY 1997)

Table 6.6: Contexts of interpreter utilisation.

	FAWs	FU	MAWs	Total
Psychiatric Assessment	11	17	46	74
Group	4	0	15	19
Family	1	0	4	5
Ward Round	1	0	7	8
Other	1	0	2	3
Total	18	17	74	109

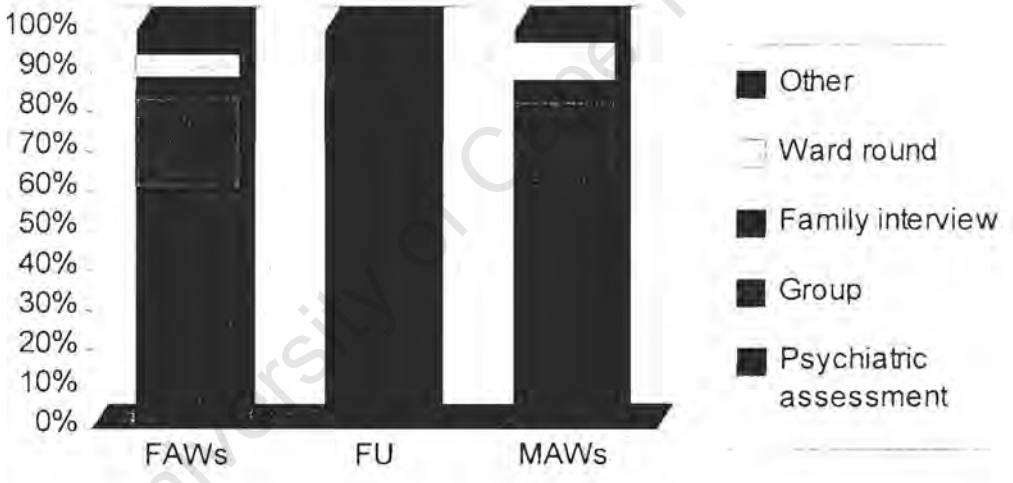


Figure 6.1: Contexts of interpreter utilisation

COMPARISON OF INTERPRETER UTILISATION ACROSS 3 STUDY PERIODS

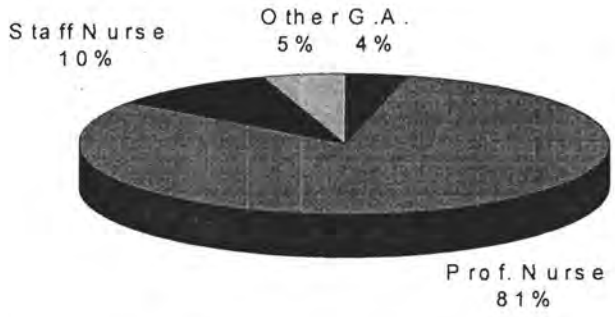


Figure 6.2: Percentage of total time spent interpreting by category (October 1993)

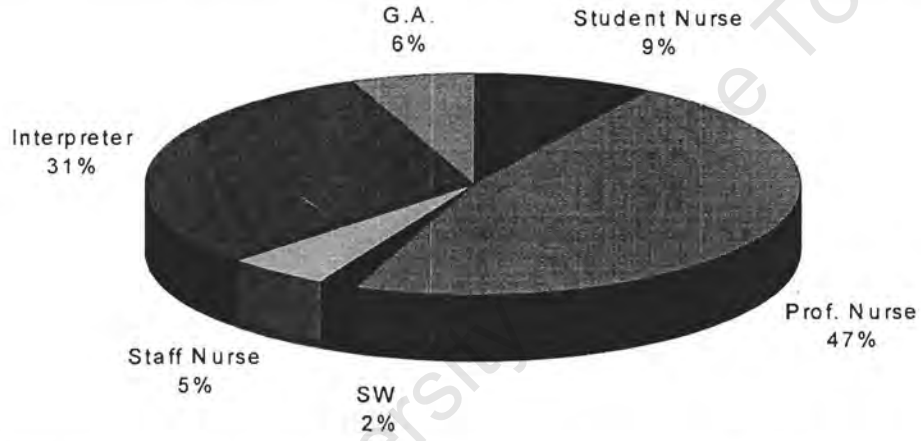


Figure 6.3: Percentage of total time spent interpreting by category (November 1993)

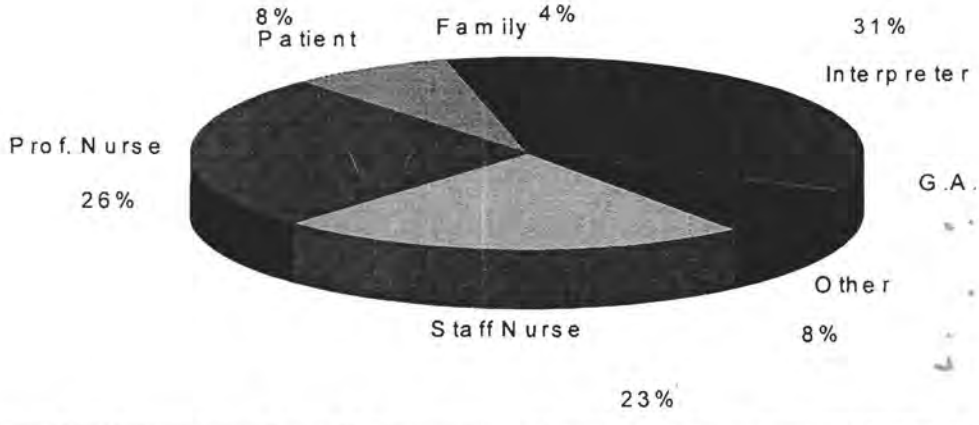


Figure 6.4: Percentage of total time spent interpreting by category (June-July 1997)