

**Interpreting practices in a Psychiatric Hospital:
Interpreters' experiences and accuracy of interpreting of key psychiatric terms**

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

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30/08/2007

Signature

Date

ABSTRACT

The main objective of this study was to investigate interpreting practices within the psychiatric hospital San Marco¹, in the Western Cape. More specifically, the aim was to determine what factors might lead to the obstruction of accuracy by asking employees that act as official and unofficial interpreters to report on certain issues relating to interpreting practices. The second objective of the study was to gain some understanding of what interpreters experience when doing interpreting especially since unofficial interpreters (nurses, cleaners and administrative staff) are often used to act as interpreters within South Africa's public health services and this may not only have implications for accuracy but also for interpreters' own mental health.

A cross-sectional qualitative interview design was used. The research participants consisted of eight employees of San Marco, (including two administrative clerks/ interpreters, two bilingual security guards, and four bilingual nurses), and two bilingual psychiatrists, who, though not being employees of San Marco, yet have experience in interpreting while working as psychiatrists within psychiatric institutions in South Africa. Participants were asked to respond to semi-structured questions. In addition, participants took part in a structured task in which they were asked to translate and back-translate commonly-used diagnostic questions. Content analysis was used to analyse data collected from semi-structured interviews and participants' translations and back-translations were checked for inaccuracies.

¹ The pseudonym will be used through out the dissertation due to issues of confidentiality.

The analysis of interviews revealed the following information:

- not all of the participants who act as interpreters are in fact functionally bilingual in the context with which they work
- none of the interpreters are trained in interpreting; and
- a clear distinction could be drawn between interpreters who have training in mental health compared to those who lack training in mental health or psychiatry.

Furthermore participants' translations of the nine questions were approximately right.

Participants' translations conveyed more or less the same messages as what was intended with the original English questions. In fact the translations were fairly accurate for untrained interpreters. However, participants were not always specific as to what they were asking about. Interpreters need to translate questions in such a way that it is diagnostically specific in order for the clinician to make an accurate diagnosis. It is crucial that patients have a clear understanding about what the interpreter are asking them and this was not always evident in participants' translations.

The abovementioned results may for obvious reasons lead to the obstruction of accurate interpretation however it should not be attributed to a lack of competence on the interpreters part but should rather be attributed to challenges in a health system which has inherited a history of discrimination and continues to discriminate against certain patients, even when clinicians and interpreters alike may be doing their best not to discriminate. The problem is structural rather than individual, and needs to be addressed as such, and in the context of competing demands in public health care.

Although the interviews did reveal valuable information regarding the obstruction of accuracy it should be kept in mind that an analysis of actual recorded interpreting sessions between the clinician, patient and interpreter is necessary for a more in depth understanding of the obstruction of accuracy as investigated in this study and such a study is currently in the planning phase.

OPSOMMING

Die primêre doel van die studie was om aspekte wat verband hou met vertolking binne die psigiatryse hospitaal San Marco in die Wes-Kaap, te ondersoek. Meer spesifiek, die doel van die studie was om vas te stel watter faktore moontlik tot onakkurate vertolking kan lei, deur werknemers wat die rol van amptelike en nie-amptelike tolke vervul, te vra om hul insig en ervaring te deel oor sekere aspekte wat verband hou met vertolking. Die sekondêre doel van die studie was om meer insig te verkry oor wat werknemers ervaar in hulle hoedanigheid as tolke veral omdat nie-amptelike tolke (verpleegsters, skoonmakers en administratiewe klerke) dikwels optree as tolke binne Suid-Afrikaanse publieke gesondheidsdienste en dit kan moontlik aanleiding gee tot onakkuraatheid en ook spanning plaas op diegene wat optree as tolke.

’n Dwarsnee kwalitatiewe onderhoudsontwerp was gebruik. Die deelnemers het bestaan uit tien deelnemers: ag werknemers van San Marco (bestaande uit twee administratiewe klerke wat ook die rol van tolke vervul, twee sekuriteitswagte, en vier verpleegsters) en twee psigiaters wat nie meer werknemers van hierdie spesifieke hospitaal is nie, maar wat wel ervaring het in vertolking in psigiatryse instansies. Die onderhoud was hoofsaaklik semi-gestruktureerd, maar deelnemers was ook gevra om deel te neem aan ’n gestruktureerde taak. Deelnemers was gevra om diagnostiese vrae, wat gereeld in die hospitaal gebruik word, te vertaal en terug te vertaal. Die kwalitatiewe analiseringsmetode genaamd inhoudsanalise was gebruik om data wat voortgespruit het uit die semi-gestruktureerde vrae te analiseer en deelnemers se vertalings en terugvertalings was ondersoek om vas te stel of enige onakkuraatheid geïdentifiseer kon word.

Die studie se analise van die data het die volgende waardevolle inligting onthul:

- nie al die deelnemers wat as tolke optree, is in werklikheid ten volle tweetallig nie
- geen tolk is opgelei in vertolking nie; en
- `n duidelike onderskeid kon getref word tussen tolke wat opleiding in geestesgesondheid of psigiatrie het in vergelyking met diegene wat geen opleiding het nie.

Verder was deelnemers se vertalings van die diagnostiese vrae redelik akkuraat.

Deelnemers se vertalings het ongeveer dieselfde boodskappe oorgedra as wat bedoel was met die oorspronklike diagnostiese vrae. Alhoewel vertalings redelik akkuraat was vir onopgeleide tolke was dit nie altyd diagnosties spesifiek nie. Dit is belangrik dat tolke diagnostiese spesifiek is sodat die klinikus `n akkurate diagnose kan maak.

Die bogenoemde resultate kan vir voor die handliggende redes aanleiding gee tot die onakkurate vertolking, maar dit moet egter nie toegeskryf word aan tolke wat onbevoeg is nie, maar eerder aan die uitdagings wat bestaan binne `n gesondheidsstelsel wat `n geskiedenis van diskriminasie oorgeërf het en wat steeds diskrimineer teen pasiënte, selfs wanneer klinikus en tolke hulle bes doen om nie te diskrimineer nie. Die probleem is dus eerder struktureel as individueel van aard en moet aangespreek word binne `n konteks van kompeterende eise wat kenmerkend is van publieke gesondheidsorgdienste in Suid-Afrika.

Alhoewel hierdie studie waardevolle inligting oor aspekte wat moontlik kan lei tot onakkurate vertolking onthul het, moet dit in gedagte gehou word dat `n analise van opgeneemde vertolkingsessies soos wat dit in werklikheid plaasvind tussen die klinikus, tolk en pasiënt noodsaaklik is om `n beter begrip te hê van aspekte wat kan aanleiding gee tot onakuraatheid en so `n studie word huidiglik beplan.

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1. INTRODUCTION

This study focuses on interpreting practices in the psychiatric hospital San Marco in the Western Cape. Somewhat unconventionally, perhaps, but for reasons which I hope will become clear, I have chosen to introduce the topic making reference to my own experiences.

My interest in the role of language in mental health services, though I did not realise it at the time, originated early in my high school career when I took Xhosa as a subject. I was one of the very few students that took Xhosa in high school and the only one of my friends who could speak a third language, even though it was on a basic level. It felt that I had a precious gift that no one else in my universe possessed. I soon realised that this gift could also give me access to another world which was not accessible to many people from my community.

As is common, unfortunately, for many white South Africans, the only black South African I knew well as I grew up, was the domestic worker who worked for our family. Before I developed a basic proficiency in Xhosa, this domestic worker, Nomzamo, and I communicated in basic English. We had conversations on a very basic level seeing that English was a second language for both of us and up until high school I really did not know anything about her. When, however, I became able to communicate in her language, my relationship with her changed. We now had the opportunity to communicate on a very different level. This change in our relationship had an irreversible effect on my life. It was a gateway for me to understand to some extent what the fabric of

her life was like and it transformed the way we perceived each other. At the end of my Grade 12 year we had discussions about the violence in Khayelitsha where she stayed. The emotional bond we developed would not have been possible had we not been able to communicate together in Xhosa. Being able to show that one has respect for someone's mother tongue by speaking to that person in their first language, I learned, can lead to a deepening relationship. The simple act of communicating, even if it is on a basic level, can break many boundaries and make a world of difference to someone's life.

My new involvement in Nomzamo's life had a further benefit. It made me especially aware of a common factor that played a role in both of our lives. I took Nomzamo to the police station one afternoon so that she could report her stolen cell phone. She struggled to explain in English to the police officer her account of the theft and he became very impatient. The police officer had an expression on his face that gave the impression that he thought she was unintelligent and waisting his time. Back in the car, after we left the police station, she said to me: "he probably thinks I am stupid". As a first language Afrikaans speaker I could identify with this feeling she had. I often experienced the same feeling when participating in a discussion in English with superiors. I would have difficulty trying to express myself and this frustrated me because I would feel that I came across as less intelligent. However, the incident in the police station also made me aware of the issue of discrimination due to language barriers in public services.

It was however only during my undergraduate years at university that I became aware of the staggering implications of language barriers especially within health and specifically in mental health services. I was the only psychology student who planned to graduate

with both Xhosa and Psychology as major subjects, and what scared me even more was that I perceived my peers and lecturers to be unconcerned about the role that language plays in public mental health services and about discrimination due to language barriers. The issue of language barriers within mental health services was addressed by only one lecturer during all my undergraduate and post-graduate years in psychology. From my own experience, I knew both what a common language could do for empathy and understanding, and how the lack of this common language could reinforce distance and boundaries. I understood how communication difficulties, furthermore, could be blamed on those in less powerful positions, and could be misinterpreted as evidence of their failings. I could not understand why the role of language within mental health services could not be of high importance, since language and psychology should go hand-in-hand. In clinical work of all kinds, and even where technologies such as blood tests and scans are used, language is almost invariably the primary tool that is necessary to make a diagnosis and to treat the patient. A previous study (Crawford, 1996) has shown that illnesses for which doctors can find no physical basis, like inexplicable abdominal pains, painful limbs, headaches, may mask severe depression. In instances like these language plays a crucial role in making a diagnosis and treating the patient. Many diagnostic cues, furthermore, lie not only in the content of what the patient is saying but also in the grammatical structure and the register and voice used by the patient (Marcos, 1979). As psychology students, we received many lectures on diagnostic cues but only one on the primary tool that enables a psychologist or psychiatrist to have access to essential diagnostic information. In addressing language barriers in health and mental health services patients can be prevented from dying. Nurses and clinicians have raised their

concerns over patients who were discharged without knowing what their diagnoses are, without instructions on how to take their medication, and without knowing what to do with the letter they receive on discharge due to language barriers (Schlemmer & Mash, 2006).

For many, the answer to the problem of language barriers within mental health services would be to employ interpreters. Interpreters are used to convey the patient's message to the clinician and vice versa. Interpreting services play a crucial role in reducing discrimination on the basis of language, and in ensuring that more patients have access to mental health services. The use of interpreters seems on the surface to resolve the issue of language barriers in mental health services. However, the employment of interpreting services is not at all a simple solution. The use of an interpreter can in many instances lead to misdiagnosis. Interpreters who are not at least fully bilingual and who are not trained in interpreting and in mental health may lead to the obstruction of accuracy. This in turn may ultimately lead to patients' being worse off than they were prior to seeking the help of a clinician. Employing the use of interpreters is only a starting point in addressing language barriers in mental health services. It is essential that we strive towards understanding what factors lead to the obstruction of accuracy when interpreters are employed so that we can prevent misdiagnosis and ensure that patients receive quality services. Patients should not be discriminated against due to language barriers in mental health services.

In the next chapter I will review available literature on interpreting practices in health and mental health services in order to have a better understanding of the research that has been done on interpreters' experiences and factors that may lead to the obstruction of accuracy.

2. LITERATURE REVIEW

The notion of mental health interpreting brings many issues to mind. Although the current study has, as will be seen, a relatively narrow focus, a better understanding of the context involved requires consideration of some of the broader issues at stake in mental health interpreting. Reference will also be made to issues relating to interpreting in general health care. An overview of the role of language and culture in mental health provides a background to the study, and must be considered prior to consideration of the available conceptual models of mental health interpreting, and, finally, in this review, to consideration of the study's main focus. The review, therefore, will move systematically from the broader to the more focused areas of interest.

2.1 Language and culture

Language plays an essential role in any culture, as it is the structure within which the worldview of a culture is sculptured and it describes the boundaries and viewpoints of a cultural system (Putsch, 1985). Language and culture play fundamental roles in people's lives and are therefore fundamental in mental health service provision (Drennan, 1999). The culture in which people is brought up provides them with a framework for identifying what are meaningful symptoms and for reporting these to health practitioners (Buchwald et al., 1994). In psychiatric services language is considered as one of the central instruments through which patients voice their symptoms, in addition to nonverbal communication and interpersonal behaviour (Westermeyer & Janca, 1997). Woloshin, Bickell, Swartz, Gany, and Welch (1995) focus on a number of functional roles played by language in health service provision. Language is the means by which a clinician

accesses a patient's beliefs about health and illness, as well as a means of creating opportunities for the clinician and patient to address and resolve misunderstandings between different belief systems. The physician and patient can use language to establish an empathic relationship which, in itself, may be therapeutic for both parties concerned (Woloshin et al., 1995). Although language plays a crucial role in mental health service provision, the reality is that, in many countries, personnel in the higher positions of mental health care tend to lack the ability to speak all of the languages spoken by all their patients (Swartz, 1998). In South Africa, interpreters are often used in health service provision, due mainly to the political history of language dominance in the country (Drennan, 1999; Swartz, 1998).

Language and culture can become barriers in health and mental health care services, reducing the communicants' ability to assess meanings, intent, emotions, and reactions, and thereby creating a state of dependency on the interpreter involved in mediating the dialogue (Putsch, 1985). Language barriers may lead to patient-dissatisfaction over health care services and patients may be less likely to return to a specific health care institution (Carrasquillo, Orav, Brennan, & Burstin, 1999). In fact, language barriers can be considered as one of the biggest barriers preventing access to health care. A study conducted on barriers to health care access for Latino children found that language was considered as the single greatest barrier to health care access compared to poverty, lack of health insurance and transport problems (Flores, Abreu, Olivar, & Kastner, 1998). In the USA, patients who face language and cultural barriers receive services at reduced rates and are less likely to adhere to any medication regimen (Flores, 2006). Though patients

with psychiatric conditions who encounter language barriers are more likely than others to receive a diagnosis of severe psychopathology, they are, nevertheless, also more likely to leave the hospital despite medical advice to the contrary (Flores, 2006; Marcos, Urcuyo, Kesselman, & Alpert, 1973). In instances where patients leave despite advice to the contrary may not only be detrimental to their health but may also be more costly for patients in the long run (Jacobs, Shepard, Suaya, & Stone, 2004). Jacobs et al. (2004) studied the possible impact that interpreter services may have on the cost and the use of health care services among patients with limited English proficiency. The improvement of language access for patients may lower the cost of medical care in the long run since interpreting service improved patients' utilization of preventive and primary care services, like follow-up visits and medications that may reduce costs for patients (Jacobs et al., 2004).

2.2 Conceptual models of mental health interpreting

In this review of conceptual models of mental health interpreting, the focus will be on both denotative and connotative forms of interpretation.

Both denotative and connotative forms of interpretation are integral to models of mental health interpreting (Swartz & Turner, 2006; Westermeyer, 1990). While denotative interpretation refers to word-for-word literal interpretation, connotative interpretation refers to the contextual interpretation of the meaning involved (Swartz & Turner, 2006). A connotative interpretation, in particular, may assist the interpreter in providing the clinician with a culturally informed contextual interpretation. The provision of a

culturally contextual interpretation can help a clinician to place the patient and family in context, which, in turn, enables the clinician to make a more accurate diagnosis of the patient's illness than might otherwise have been possible (Swartz & Turner, 2006). In order for interpreters to be able to interpret both denotatively and connotatively, they should be highly competent in at least two languages, and preferably have used both languages for a number of years (Westermeyer, 1990). A number of models of interpreting have been discussed in literature, and these will now be summarized.

2.2.1 Black box model

According to the black box model, the interpreter is the agent who simply takes messages from one person and passes them on to another, without intervening between the patient and the clinician (Westermeyer, 1990). Some health professionals are of the opinion that the black box model is the best model to use when the nature of the situation requires precise translations and no deviations from the original text, such as situations like child abuse and neglect where legal implications are involved (Hatton & Webb, 1993). Levin (2005) found that doctors at the Red Cross War Memorial Children's Hospital in Cape Town tend to adopt the black box model when using nurses as interpreters. Doctors tend to impose this role on the nurses, with the latter coming to feel that they are perceived as merely language vehicles. However, at the Khayelitsha (an area that consists of formal and informal housing in the Western Cape) clinic doctors perceive interpreters as being part of the medical team. The nurses involved appreciated their being perceived in such a way, and expressed trust, satisfaction and job enjoyment with regard to their enhanced role of interpreter (Levin, 2005).

2.2.2 Bilingual worker model

According to the bilingual worker model, the interpreter interviews the patient alone, being seen, in the context of the interview, as the junior clinician. The interpreter later reports back to the clinician concerned (Westermeyer, 1990).

2.2.3 Collegial model

According to the collegial model, the clinician and the interpreter operate as colleagues in gaining a common understanding of the patients' diagnoses (Swartz & Turner, 2006).

However, in such cases the clinician should specify in detail to what extent the interpreter and clinician work together, since the sharing of the clinician's diagnostic and therapeutic role with the interpreter may lead to overlapping roles. The interpreter may for example, repeatedly interrupt the interview and attempt to control the interview. Such unwarranted intervention might otherwise result in misdirection of the interview (Putsch, 1985; Hsieh, 2007).

2.2.4 Sequential versus concurrent translation

Sequential translation refers to interpreting situations where only one person speaks at a time, in contrast to concurrent translation interpretation, where the interpreter translates and speaks at the same time as the patient or clinician is speaking (Westermeyer, 1990).

2.2.5 Forensic evaluation

Forensic evaluation refers to interpreting situations where psychiatric evaluation takes place for legal purposes. Such evaluation usually involves more than one interpreter, thereby adding to the complexity, amount of time, and expense of the interpretation involved (Westermeyer, 1990).

2.2.6 Emergency translation

Emergency translation refers to interpreting situations where the clinician has no other choice but to work with ad hoc interpreters, meaning anyone who is available and who is able to interpret for the patient (Westermeyer, 1990).

2.3 Accuracy in mental health interpretation

Before turning our attention to specific errors that lead to inaccurate interpretation, I will focus on the broader aspects relating to the interpreter and clinician that may impact on the attainment of accuracy in mental health interpretation. The key element for obtaining accuracy is that the interpreter has basic interpreting skills. In a recent study publications between 1996 and 2005 (in Pubmed and PsycINFO) were reviewed in order to obtain a better understanding of the crucial role of professional interpreters (who had training) in health care services. This review revealed that professional interpreters reduce communication problems and increase patient comprehension (Karlner, Jacobs, Chen, & Mutha, 2007). Untrained interpreters may have a very negative impact on the attainment of accuracy. Interpreters working within health care services ideally have to:

- be fluent in two languages (the interpreter have to speak, understand, and write both languages)
- be able to interpret accurately (see section 2.3.2)
- be culturally competent in the cultures of patients that they interpret for
- understand the medical and ethical dilemmas in mental health services
- be able to apply the ethics and professional rules in mental health care interpreting situations
- be skilled in facilitating communication between patient and provider without becoming a barrier to building a treatment relationship (untrained interpreters are likely to become a communication barrier since they do not know how to ensure that the provider and client can build a solid treatment relationship despite the fact that they are not able to communicate in the same language)
- be assertive in instances when it is necessary to prevent a communication breakdown (the interpreter needs to be assertive in asking to stop the communication to give an explanation when he or she notices that despite his or her correct interpretation the clinician and patient still do not understand each other)
- be familiar with the mental health setting and the mental health system
- be familiar with the vocabulary specific to mental health services
- be familiar with the terminology of interpretation (professional interpreting is a profession with its own jargon, techniques, and underlying theories); and
- have extensive general knowledge (Buwalda, 2007).

Health care professionals often make a mistake in employing untrained interpreters, since they assume that a person's bilingualism automatically qualifies him/her to be an interpreter (Diaz-Duque, 1982). Experienced psychiatrists in working with interpreters have suggested that a good interpreter tends to be competent in two or more languages, familiar with the patient's culture, and knowledgeable about clinical psychiatry, since the possession of such competence and knowledge helps to reduce cognitive and emotional distortions (Marcos, 1979). When interviewing a patient, interpreters have to understand the meaning of each and every question asked. Interpreters must be able to ask each question skilfully, appropriately translating idioms from the language of the clinician to that of the patient and vice versa. They must also be able to report to the clinician the patient's response in each case (Bloom, Hanson, Frires, & South, 1966). Interpreters require linguistic training in order to effectively describe and explain terms, ideas and processes that may lie outside the linguistic systems of patients (Putsch, 1985). Furthermore, incompetent or untrained interpreters may have a negative impact on patients' perceptions of how friendly, concerned and respectful clinicians are towards them (Baker, Hayes, Fortier, & Puebla, 1998).

In the overview of the importance of competent and trained interpreters I would like to focus in more detail on one specific competency mentioned by Buwalda (2007) relating to the ethical issues of trust and confidentiality, since ethical issues are often overlooked. Trust between clinician and patient is fundamental to clinical success (Kent, 1996). The interpreter plays a major role in establishing trust between the clinician and patient. The establishment of trust in the clinician, however, can be complicated by doubts about

whether the interpreter will maintain confidentiality, especially when the interpreter is known to the patient outside the clinic (Bolton, 2002). Since interpreters frequently come from the linguistic community that they represent, they may come under pressure to share information about patients with other members of their community. In addition, interpreters may also personally know the patient or the patient's family before any session (Tribe & Morrissey, 2003). Interpreters require training on how to handle trust issues not only in instances like described above but also with regard to refugee patients. Interpreters can, for example, significantly influence the detection of symptoms and exposure to traumatic events, as well as the referral to further care, especially mental health care under asylum seekers during medical interviews (Bischoff, Bovier, Isah, Ariel, & Louis, 2003). Confidentiality is clearly a key issue with vulnerable refugees. Interpreters within a psychiatric setting may play just as important a role regarding refugee patients for whom issues of self-disclosure and openness in communication have a unique meaning. For those emerging from a repressive regime, the disclosure of certain confidential information could endanger the lives of family members remaining in the patients' country of origin, placing them at risk of torture, imprisonment or both. Refugee patients may therefore not trust an interpreter, since they might fear for their own safety or that of their families. More positively, the interpreter may help to facilitate communication where the patient is separated from his or her community or reference group (Tribe & Morrissey, 2003).

2.3.1. The interpreter's qualities and pressures impacting on accuracy

Other issues relating to interpreters' personal characteristics and struggles that may impact on the attainment of accuracy will now be discussed. Interpreters' personal characteristics that may play a role include the manner and personality of the interpreter. These may influence the tone of encounters with patients, which in turn influences what and how clinicians do with patients and how patients act. Fixed characteristics of the interpreter, as gender or age may play a role, but more importantly, the style and manner of any particular interpreter may influence the situation (Bolton, 2002). Interpreters' personal struggles may lead to inaccuracies in interpreting. Interpreters who are unable to modulate their own unique views, emotions, and beliefs in the clinical setting may render certain issues, such as death, suicide threats and ethnicity, difficult issues for interpretations. Many interpreters struggle to deal with issues which are strongly associated with cultural differences. They may fear being associated with 'primitive' beliefs of patients (Putsch, 1985). Another factor that may add pressure on interpreters is the time demand associated with interpreting sessions. Interviews with patients may take double or triple the time when communication is through the interpreter. Interpreters may feel pressured because of the time demands and may try to save time by omitting information that they regard as less important (Serrano, 1989). A study focusing on the effect of different interpretation methods on the length of the patient's visit to the clinic, found that telephone interpreters and interpreters provided by the patient were associated with longer visit times compared to when no interpreter was needed. However, interpreters provided by the hospital (and who were trained) were not associated with longer visit times compared to when no interpreter was needed. The reason for this may

be that interpreters that are employees of the hospital are needed by many departments and this may create the perceived need on the part of interpreters to be maximally efficient with their time (Fagan, Diaz, Reinert, Sciamanna, & Fagan, 2003).

Interpreters may struggle to deal with the pressures caused by dual work roles. Some hospital employees, whose job description does not include interpreting, nevertheless are called on to spend a great deal of time interpreting. The lack of formal training and appropriate pay for the interpreting services that such informal interpreters render arguably impacts on the quality of the interpretation involved. Dual work roles are also likely to lead to job conflicts, with employees concomitantly regarding interpreting as an unpaid burden (Putsch, 1985). Interpreters often face challenges because of the various role expectancies that others have placed on them (Hsieh, 2006). In a study done by Hsieh (2006), interpreters reported that they are bound by the code of ethics and institutional policies to be a mere conduit for information. On the other hand, they experience the emotional impact of the words they translate. They cannot be emotionless professionals (this is contradictory to the 'Black box model' mentioned earlier). Another aspect that interpreters struggled with was their desire, at times, to advocate for their patients. The conduit role does not allow the interpreter to give any comments, or to advocate for patients (Hsieh, 2006).

The role of clinicians' personal issues may lead to inaccurate interpretation. It has been found that interpreters are not always used even when patients thought interpreting was necessary. One of the reasons may be that clinicians and nurses overestimate their

language skills. Clinicians with limited language abilities may be able to meet their own perceived informational needs but not be able to understand information patients perceive as important, and this may result in a discrepancy between clinicians' and patients' need for an interpreter (Baker, Parker, Williams, Coates, & Pitkin, 1996).

Optimal accuracy can only be attained if both clinicians and interpreters are aware of what each party expects from the other. Clinicians, therefore, should be informed of the types of problems that interpreters experience (Diaz-Duque, 1982).

2.3.2 Defining accurate interpretation

One of the basic competencies of an interpreter is that an interpreter give an accurate interpretation. An interpreter should not add or omit information. An interpreter who is truly professional will convey the spirit of the message, and interpret in a way that the listener will understand (Buwalda, 2007). An accurate interpretation is communication from one person that is conveyed to others in a way that faithfully transmits the original meaning that the individual intended (Swartz & Turner, 2006). Accuracy may be thought of at a number of interlocking levels: lexicon (words and idioms); phrase; clause; sentence; and discourse (Swartz & Turner, 2006). A literal interpretation may at first glance be assumed to be the most accurate interpretation. However, the influence that a literal interpretation has on the conveying of figurative language, idioms and metaphors requires consideration. According to Swartz and Turner (2006), the true meaning of the original message is not necessarily preserved by a literal interpretation of figurative language. According to Swartz and Turner (2006), a literal interpretation is an accurate

interpretation only of the individual's words, and not an interpretation, per se, of what the words mean in relation to one another. The meaning of words, furthermore, depends upon the context in which they are used (Swartz & Turner, 2006). The present study, therefore, does not regard a literal interpretation as maximally accurate.

2.3.3 Errors and the obstruction of accuracy

Errors that obstruct accuracy in the context of mental health interpreting relate to various issues. In the current study, the focus is largely on errors relating to technical issues. Putsch (1985) identifies common errors due to technical issues as being: omissions; additions; substitution of terms; incorrect numbering (for example the incorrect numbering of dates and quantities); and the distortion of messages. Putsch (1985), furthermore, focuses on the issues of paraphrasing, linguistic equivalency, and shifts in language use in interpretation. Especially in the field of psychiatry, in addition to the wording of talk, crucial keys as to the patient's mental health status lie in the grammatical structure of the language used, the tone and register adopted, as well as in the use of gestures and the pitch of voice. Interpreters who merely try to make sense of the patient's statements may limit their interpretation to what the patient says, neglecting how the patient says it (Marcos, 1979). Failure on the part of the interpreter to recognise important shifts in language use may cause the clinician to make inaccurate assessments of the patient's mental health status (Putsch, 1985).

Errors relating to issues of register, jargon, semantics, polishing, anecdotal information and nonverbal behaviour may be difficult for clinicians to detect (Diaz-Duque, 1982).

The register used gives a sense of the social or intellectual level at which a given language is placed. The interpreter has, first, to establish the patient's register and then to communicate with the patient in a manner accessible to the patient's own register, without being patronising or disrespectful. If the interpreter is unable effectively to communicate with the patient in such a way, this may lead to the patient feeling alienated or nodding in agreement out of fear of embarrassment because he or she fails to understand the interpretation provided. If the interpreter employs a very erudite register, the patient may fear that such an interpreter may find his/her speech amusing or unsophisticated. Some patients may be completely unused to discussing certain topics, such as very personal issues, including sexual issues. Therefore, the interpreter should at all times maintain an appropriate sense of modesty and discretion (Diaz-Duque, 1982). Ideally, the interpreter should meet the patient before the interview, so that the interpreter can find out about the patient's educational background, attitudes toward health care, and other aspects of his/her social background. Doing so enables the interpreter to determine which register is most appropriate for a particular person in a specific setting. However, register is not determined solely by socio-economic and educational factors, but also by the situation and parties involved, the place, and the nature of the conversation (Diaz-Duque, 1982). Levin (2006) has suggested that it is best if clinicians avoid medical jargon that patients may not understand and that interpreters may struggle to translate. In instances when clinicians feel they have to use medical jargon, the jargon should be explained fully to the patient by the interpreter. It is not only the use of medical jargon that relates to inaccuracies but also health professional's unfamiliarity with jargon of traditional healing. Interpreters may have difficulty in identifying and translating many of

the terms used in traditional healing, since the traditional healer may use unusual terms with which the interpreter is unfamiliar. Consequently, the patient may not be able to explain what really took place or may be unable to give a history of his/her sickness or the traditional treatment he/she received (Diaz-Duque, 1982).

Interpreters who provide only a literal translation of the patient's words may not be as effective as those who take into consideration nonverbal aspects of communication such as nuances, intonation patterns, and facial expressions. Such elements reveal much about the patient that may be crucial to the outcome of the interview. Interpreters who appropriately mirror the intonation, facial expression, or gestures of the communicator are likely to be more effective in conveying the correct message. They also need to be skilled in interpreting the patient's gestures and movements (Diaz-Duque, 1982). The perception that meaning can simply be translated across languages does not always hold true, since words and meaning are not always interchangeable between languages (Putsch, 1985).

If the clinician has no choice but to work with untrained interpreters (as is often the case in South Africa), the clinician and the interpreter can prevent inaccuracy and misunderstandings due to technical errors by applying the following techniques: the clinician can use simply constructed sentences; sentences should be offered in a slow, systematic fashion so that the interpreter does not field multiple questions at the same time; when the physician articulates a symptom or an inference from the interpreter, the interpreter should back-translate it for the patient's verification or correction; and the

interpreter and clinician should create non-verbal rapport with the patient by noticing the patient's behaviour and responding to it with the use of sensitive comments, smiles, or eye contact (Elderkin-Thompson, Silver, & Waitzkin, 2001).

2.4 Mental health interpreting within the institution

Interpreting should not be considered in isolation, since practices are situated (Angelelli, 2004); therefore, accuracy in interpretation and interpreters' experiences must be investigated within the institutional context. According to Swartz (1998), the 'institutional level' refers to the impact the institutional setting has on the interpreting situation, as well as to the institution and its needs. The absence of a policy may seriously detract from the effectiveness of interpreting that takes place within the institution concerned (Swartz, 1998). If such a policy is not in place, clinicians may be forced to use anyone at hand, such as a cleaner, nurse or relative of the patient who is fluent in the home language of the patient, as an interpreter (Swartz, 1998). Although hospitals in South Africa differ in terms of their unwritten conventions with regard to mental health interpreting, the majority appear to rely on anyone who speaks merely a fragment of the patient's language (Drennan, 1996; Levin, 2006).

2.5 Interpreters' experiences

Very little is known about the experiences of interpreters working within the field of health care, despite previous studies indicating that interpreters work in situations that expose them to both physical and psychological harm (Lipton, Arends, Bastian, & Wright, 2002). The lack of research available regarding interpreter experience may be

due to the perception that interpreters are merely language instruments, who are not expected to intervene between the patient and clinician (Westermeyer, 1990). This section, therefore, sets out to review some interpreters' experiences of interpreting, as well as the impact of interpreting on interpreters.

2.5.1 General experiences

Interpreters report that they feel overwhelmed by the content of clinical sessions, due to their lack of emotional and mental preparation for handling disconcerting details of the patients' lives (Lipton et al., 2002). Interpreters appear to have difficulties in representing the speech of the patients faithfully in terms of both semantic and emotional content (Tribe, cited in Lipton et al., 2002).

2.5.2 Impact on interpreters

Interpreters are often privy to extremely sensitive information, resulting in an ongoing need for training and support to assist them to retain the information that they interpret (Tribe & Sanders, 2003), especially in cases where the patient has a life-threatening or chronic illness. Informing a patient that he/she has cancer, HIV or a sexually transmitted disease is an unpleasant task that can involve touching on taboo areas (Hobson, 1996). Patients may become angry if they do not receive the care that they want or expect and those who receive bad news about their health may become aggressive or emotionally upset. Such emotion may be vented at the person who is delivering the news, namely the interpreter (Hobson, 1996).

Interpreters are, in some instances, exposed to vicarious traumatisation by way of either being prompted to revisit their own past experiences, or by way of having to translate information that closely relates to others whom they have known (Lipton et al., 2002). A study examining the influence of vicarious traumatisation on health care professionals reports that professionals often experience disruptions both of their family life and of their own perceptions of personal safety (Pearlman & Saakvitne, cited in Lipton et al., 2002).

Issues relating to boundaries should also be addressed. Interpreters are often placed under considerable pressure by patients and clinicians to take on tasks that are too demanding. A service user who is unable to access services due to his/her lack of familiarity with the English language would be more likely to try and make the most of having access to someone who not only speaks both languages fluently, but who is also familiar with how the different systems work, providing the possibility of being an invaluable help to the service user. Exactly where the boundaries are to be established needs careful consideration. These boundaries need to be negotiated by the clinician and interpreter before a session begins and while out of earshot of the service user (Lipton et al., 2002).

Interpreters may also be unable to integrate information that they find distressing (Lipton et al., 2002). In focusing on the impact of interpreting on interpreters, interpreters' coping mechanisms need to be taken into account, especially in light of the fact that interpreters often use dysfunctional strategies to cope with their distressed feelings (Lipton et al., 2002). The following strategies are reported by interpreters: denying what they hear

during an interpreting session; lying to their families about their experiences of interpreting because they feel obliged to keep the patients' personal details confidential; and involvement with distracting activities (Lipton et al., 2002). All these strategies may carry personal costs for interpreters. In many instances, interpreters are not trained on how to implement coping strategies for dealing with very sensitive material that is potentially psychologically damaging (Lipton et al., 2002). Understandably, in light of the above, interpreters should not only be required to have language skills, but also the ability to deal with difficult material, while maintaining appropriate boundaries in regard to patients (Tribe, cited in Lipton et al., 2002). Interpreters require ongoing support and supervision in order to facilitate maintenance of their own mental health (Lipton et al., 2002).

Both for technical reasons and to support the interpreter, after a session the clinician and interpreter should have a post interview meeting. During this meeting the clinician should seek to clarify both the interview material and the dynamics of the interview. The interpreter should also be given the opportunity to verbalise and process any troubling aspect of the interview (Marcos, 1979).

In South African mental health care, many of the requirements mentioned above for optimal interpreting have been reported to be isolated (Drennan, 1999). Thirteen years into democracy the question arises as to what is happening in mental health interpreting, and the current study provides a partial answer to this question by focussing on interpreters' experiences at a major psychiatric hospital.

3. METHODOLOGY

3.1 Research design

A cross-sectional qualitative interview design was used to assess interpreter experiences.

A cross-sectional design is a research design that involves collecting all data at a single point in time (Bless, Higson- Smith, & Kagee, 2006). In addition, participants took part in a structured task in which they were asked to translate and back-translate commonly-used diagnostic questions.

3.2 Research methodology

3.2.1 Participants

The research participants consisted of ten participants. Eight participants (two administrative clerks/interpreters, two security guards, and six nurses) were employees of San Marco, and the other two participants were psychiatrists, who, though not being current employees of San Marco, had recently worked there, and had experience in interpreting while working as psychiatrists within psychiatric institutions. Participants were selected on the basis that they acted as interpreters within the institution where they were employed, though they were not necessarily employed specifically as interpreters. Individuals who at times fulfilled the role of interpreter within San Marco, but who were not employed there, were excluded from the study, with the exception of the psychiatrists. I collected all the data personally. Respondents knew that I am a graduate student in psychology at Stellenbosch University and not in any position of authority at the hospital itself. The nursing management at San Marco supplied a list of respondents,

and arranged a meeting for me with all participants except for the psychiatrists, during which I informed participants about the nature of the study. I approached the psychiatrists myself by telephone. There was one refusal to participate in the study – this was a nursing sister who said that she was overburdened with work.

The critical case sampling method was used, as the interpreters concerned were central to the service at San Marco, and would be able to provide the most information with regard to the study's focus on certain issues relating to mental health interpreting (Struwig & Stead, 2001).

3.2.2. Methods and procedure of data collection

3.2.2.1 Semi-structured interviews

Data were collected mainly by way of semi-structured interviews. I interviewed each participant individually in an informal and relaxed manner. The interviews took place in the field, which means that the interviews took place at the institution where participants were employed. All interviews were audio-taped. The benefit of conducting semi-structured interviews was that these provided in-depth data relating to the issues concerning mental health interpreting that are investigated in this study. Such interviews also gave the participants the opportunity to express their opinions freely (Denzin & Lincoln, 2000). Though this method of data collection is not a neutral instrument, it is capable of generating an understanding of the issues being studied as they are situated in certain interactional incidents (Struwig & Stead, 2001). In such a study, both the participants and the researcher form part of the research process, with each party being in

a position to influence the other during the interviews (Denzin & Lincoln, 2000). Prompt questions were used in the semi-structured interviews, and the respondents were each in turn asked to explain and clarify all their responses.

3.2.2.2 Practical exercise

In addition to the semi-structured interviews, participants took part in a structured task which consisted of a practical exercise. Participants were asked to translate nine key diagnostic questions in common use in the hospital. These questions had been provided by a psychiatrist working at the hospital, and were chosen as they were very commonly used across all diagnostic interviews in the hospital. Participants were required:

1. to translate the key diagnostic questions from English into Xhosa or Afrikaans, depending on the language (Afrikaans or Xhosa) for which the participant routinely interpreted; and
2. to provide back-translations in English of their own translated items.

3.2.2.2.1 Participants' contribution to the practical exercise

All participants were given the same nine phrases to translate. The two participants who acted as interpreters for Afrikaans speaking patients were asked to translate the English phrases into Afrikaans and to give back-translations for these. The other eight participants that acted as interpreters for Xhosa speaking patients were asked to translate the English phrases to Xhosa and to give back-translations.

3.2.3.2.2 Checking the participants' translations

The translations into Afrikaans

I (a first language Afrikaans speaker) reviewed the Afrikaans translations and back-translations.

The translations into Xhosa

The Xhosa translations were checked by making use of a team of independent back-translators. A Xhosa-speaking interpreter/translator, who has worked on many projects with the supervisor of this study and who is familiar with translation issues in mental health practice, recruited sixteen translators. Translators all met the following criteria:

- first language Xhosa speaker
- second language English speaker
- minimum educational qualification: completed high school; and
- not working within, and not familiar with, a mental health field.

(Individuals working within a mental health field were not suitable since their pre-existing familiarity with the key diagnostic questions might have influenced their back-translations).

Each independent translator was given a sealed envelope with the translations of one participant to back-translate. No information was given to the independent back-translators regarding the nature of the study (this was done also to safeguard against the independent back-translators' using external knowledge of the study to influence their back-translations).

Each participant's Xhosa translations, therefore, were given to two independent back-translators. Two back-translators were used for each participant's translations in order to account to a degree for the possibility that back-translators themselves would provide idiosyncratic or incorrect back-translations. Financial considerations precluded the use of more back-translators per translated text. It was also not possible to allow any back-translator to back-translate more than one set of translations, as the back-translations of any text other than the first administered would be influenced by exposure to previous texts.

3.3. Ethical considerations

This study has been approved by the Committee for Human Research at Stellenbosch University. Before conducting the interviews, the participants were informed that they were free to opt out of the study at any point in the research process and there would be no negative consequences should they choose not to participate. However, they were assured that their anonymity was secure, and that any information that they disclosed would be treated as confidential.

3.4 Data analysis

3.4.1 Semi-structured interviews

The audio-taped interviews were transcribed verbatim. Content analysis (also called thematic analysis), which entails the collecting and analysis of textual content, was used to analyse the transcribed text (Struwig & Stead, 2001). While the concept of 'content' refers to messages, words, meanings (both latent and manifest), symbols and themes, the

concept of 'text' refers to written, spoken or visualised material (Richardson, 1996; Struwig & Stead, 2001). In essence, the aim of content analysis is to classify the multiple words in a text into a number of distinct categories by using certain techniques to make valid inferences (Denzin & Lincoln, 2000; Weber, 1985).

The transcribed interviews were entered into the Atlas.ti 4.2 computer program. Atlas.ti 4.2 assists with the analysis of qualitative data by facilitating textual analysis and interpretation, particularly in terms of selecting, coding, annotating and comparing important segments of text. Furthermore, the use of Atlas.ti validates the process of coding and categorisation and provides visible proof of such processes (Bless et al., 2006).

I reread transcribed interviews several times to first of all familiarise myself with the text. There after I coded the text and assigned codes to categories (see Appendix A). Coding involved the following tasks:

- Selective coding: I developed and defined a predetermined set of codes by referring to the prompt questions asked during the interviews. A predetermined set of codes was used since the main aim of the study was to investigate specific issues relating to interpreting. A predetermined set of codes is usually applied to communicative responses to specific questions rather than to analyses of naturally occurring speech (Neuendorf, 2002). Also, developing a set of rules helps the researcher ensure that he/she consistently codes throughout the textual analysis

- (Bless et al., 2006). The predetermined set of codes was used to selectively code words, phrases or paragraphs that represented the pre-determined set of codes.
- Open coding: I used open-coding to define and code words, phrases, or paragraphs not included in the predetermined set of codes. Doing so allowed for important codes to be incorporated into the coding process that could have significant bearings on the results (Bless et al., 2006).
 - The supervisor of the study reviewed the codes and definitions of these to attain consensus (intercoder agreement). Intercoder agreement indicates that codes and categories have some external validity (Denzin & Lincoln, 2000).
 - I reread the original transcribed interviews and repeated the abovementioned three steps until consensus was attained.

Categorising involved the following tasks:

- I grouped codes into categories by finding patterns, similarities and differences between the codes. Codes that related to the same theme were grouped together and codes did not overlap. Each code was only grouped into one category.
- The supervisor reviewed the categories and I repeated the task of categorisation until consensus was attained.

3.4.2 Practical exercise

Participants' Xhosa translations and back-translations as well as the independent translators' back-translations were entered into various tables (see pp. 76-89). However, the Afrikaans translations and back-translations were not entered into table form (see section 4.3). I compared participants' translations and back-translations with the back-

translations of the independent translators. Furthermore a comparison could be made between the back-translations (of participants and independent translators) and the original psychiatric phrases. The comparison highlighted the differences and similarities in terms of grammar and semantics between translations, back-translations and the original key diagnostic questions.

In the next chapter the results generated by the study will be presented.

4. RESULTS

In order to gain a complete picture of what has emerged from the results, themes that served as a core outline for the study will be considered before those that flesh out the study. Results will be presented in three separate sections. The first section will include themes that relate to some of the broader aspects of interpreting practices. These themes will be investigated in the following order:

- reflections on interviews conducted with participants
- participants' multilingual skills and experience in fulfilling the role of interpreter, as well as their training for this
- aspects relating to the institution where the participants are employed
- participants' views on specific aspects relating to interpreting
- sensitive issues relating to rank, gender, culture, immigrants and ethics; and
- issues relating to coping.

Results concerning techniques and methods of interpretation will be presented in the second section. The third section of the results presents the findings of a practical exercise where in participants gave translations and back-translations of nine diagnostic questions.

4.1 Broader aspects relating to interpreting practices

4.1.1 Reflections on interviews conducted with participants

All the participants gave their full cooperation during interviews and appeared very honest and open about their concerns regarding the interpreting services that they deliver.

One of the male nurses (see dialogue below), openly acknowledged that he felt that he did not always give an accurate interpretation and was concerned since he did not do anything about it.

P: Because sometimes, you feel that you did not convey this thing 'lekker' to the patient or to the doctor. Then you think 'jislaaik', ok but then you keep it to yourself. You just let it go. You don't worry about this.

There were however communication problems between me and two of the ten participants (the male and female security guard). It seemed that the male security guard did not understand many of the questions that I asked him. He did not explicitly state that he did not understand what I was asking him, but in many instances he would repeat questions and remain quiet until I would explain the question to him in a simpler manner. Here is an example:

I: What I firstly want to know from you is how long have you been doing interpreting?

(No response from participant)

I: While working, I know you are not a professional interpreter but for how long have they been asking you to do the interpreting?

P: The first time now I interpret. Are you asking about the job?

Another example of the miscommunication between the male security guard and me:

I: Um would you encourage other people that work here or wherever to do interpreting?

P: When interpreting to the patients?

I: Ja would you encourage other people to do that?

(No response from respondent)

I: Would you maybe say to them: “Yes, I think I would tell them to do interpreting” or “no”. Out of your experience?

P: No the doctor inform me why he call me.

I also had difficulty in understanding the male security guard’s pronunciation of certain words and this was the same for the female security guard. Furthermore, I got the impression that the female security guard became upset when she could not give her understanding of certain diagnostic terms (detailed results of participants’ responses to questions relating diagnostic terms are presented in section 4.1.3). She argued that she did not have intensive formal training in psychiatry. An example of the abovementioned:

I: And your definition or understanding of psychosis?

P: Psychosis?

I: Ja

P: What is that thing?

I: Um, it is when someone is, or psychotic have you heard of that?

P: Mm

I: So what do you understand under then psychotic?

P: Ok, I then, as I told I just have little bit of basic

4.1.2 Participants' multilingual skills and experience in fulfilling the role of interpreter, as well as their training for this

Participants were asked which languages they spoke and how fluently they perceived themselves as speaking such languages. Participants reported the following according to their own assessments:

- one of the administrative clerks/interpreters reported that she regarded herself as being fluent in four languages
- three participants (the two psychiatrists and the other administrative clerk/interpreter) regarded themselves as being fluent in three languages; and
- six participants (the four nurses and the two security guards) reported that they regarded themselves as being fluent in only one language.

The work experience of participants fulfilling the role of interpreter was explored by asking participants how long they have been involved in interpreting within any field. All participants, apart from the male security guard (who said he estimated he had a few years' interpreting experience), were able to give me a specific time indication regarding how long they had been acting as interpreters. The female security guard reported that she had had five months' experience. While the female psychiatrist stated that she had had 23 years experience, the male psychiatrist had had eight years' experience. One of the male nurses had less than a year's experience, while the other two male nurses had individually three and ten years' experience, with the one female nurse having had more than eight

years' experience. One of the administrative clerks/interpreters had had one year's experience and the other administrative clerk/interpreter had had between five to six years' experience.

All ten participants reported that they had had no formal training in interpreting.

4.1.3 Interpreters' skills and training in Psychiatry

Participants' formal training that they may have had in mental health or psychiatry was explored by asking about the training they had had in mental health and what they understood by certain key diagnostic terms, such as anxiety, mania, psychosis and depression. Eight out of ten participants (the two psychiatrists, the four nurses, the female security guard and one of the administrative clerks/interpreters) reported that they had had formal training in mental health or psychiatry. The two psychiatrists reported receiving psychiatric training in order to be able to register as psychiatrists. The four nurses had received psychiatric training as part of their nursing training. The female security guard reported that she had undergone a course provided by the Department of Health, and one of the administrative clerks/interpreters reported that she had received formal training through San Marco. However, neither the security guard nor the administrative clerk/interpreter specified what such training entailed. The two remaining participants without formal training reported the following: one of the administrative clerks/interpreters had received informal training in mental health/psychiatry while working as an interpreter at San Marco . The male security guard (see the dialogue

below) reported that his training in psychiatry or mental health consisted of his security guard training at San Marco.

I: Ok, ok, in psychiatry and mental disorders?

P: Yes I work on psychiatric

I: And did you get any training on psychiatry when you first started working or while training?

P: As I work for private company here

I: Ok

P: The senior, the senior was here when I start

I: Ok

P: When he sends me to the ward he learned me how to work on a ward

Participants were asked what they understood by the following key diagnostic terms: anxiety, depression, psychosis and mania. Eight out of ten participants (the two security guards, the two administrative clerks/interpreters and the four nurses) responded to the abovementioned theme. The two security guards gave very vague and inaccurate descriptions of what they understood by the terms ‘mania’, ‘psychosis’ and ‘depression’. The female security guard did not know what the term ‘psychosis’ meant, stating that psychosis is when someone “has another mind”. The following dialogue arose between the female security guard and me²

I: Can you give me just your explanation or definition of depression?

P: Depression is like when you feel that something hurts you or something that you are not clear about that makes you angry

² Part of dialogue has been presented previously in section 4.1.1.

I: Mhm

P: Then you don't know what the outcome, you don't have the solution of this and then it is stuck in your mind and it makes your head ache and then you can't cope just leave it like that

I: And your definition or understanding of psychosis?

P: Psychosis?

I: Ja

P: What is that thing?

I: Um, it is when someone is, or psychotic, have you heard of that?

P: Mm

I: So, what do you understand under then psychotic?

P: Ok, I then, as I told I just have little bit of basic

I: Ja, no, I'm not looking for a right or wrong answer I just want to know how you understand it

P: Ok, I understand when the patient is psychotic because sometimes he can say just imagining and then you must understand there is sometimes the mind that she is thinking and not the mind she have before. It's just the other mind now

I: Ok

P: What's going on to the head it's just up in the head, in her head

I: Ok and your definition of mania. Have you heard of mania?

P: No.

One of the administrative clerks/interpreters, though not precisely defining or explaining any terms, gave accurate examples of symptoms that are usually associated with the

conditions about which she was asked. Five of the eight participants (the three male nurses, the one female nurse, and the other administrative clerk/interpreter) provided basic definitions and explanations of the abovementioned diagnostic terms. All five participants, except for the female nurse, were able to give accurate definitions and examples of the associated symptoms. The following dialogue arose between the female nurse and me:

I: Ok I just want your definition; I am not looking for a direct academic definition but what is your understanding of depression?

P: Uh, depression is like feeling sad

I: Ok

P: At a specific time

I: Ok

P: Ja, its just feeling sad at a specific time

I: Ok and your definition of psychosis?

P: Psychosis is just a, how can I say it, for me it's a thought disorders

I: Ok and mania. If someone is manic?

P: When the person is like feeling like childish things.

4.1.4 Aspects relating to the institution

Certain aspects relating to the institution were investigated by focusing on the job descriptions of employees who at times have to fulfil the role of interpreter.

Consideration was also given to whether the employees were financially rewarded for

fulfilling such a role and how employees came to be called to act as interpreters at the institution.

Seven out of ten participants (the two psychiatrists, the four nurses, and the male security guard) reported that interpreting was not included in their job description. The two psychiatrists elaborated on how they experienced the additional role of interpreter, saying that they saw themselves first and foremost as clinicians who formed part of the treatment team and not as interpreters, though they were called upon to apply their language skills as an instrument for the treatment of patients. The following dialogue arose between the female psychiatrist and me:

P: You know, I think generally for me those are one on one situations, so I no longer see myself as an interpreter

I: Ja

P: But actually as a clinician working in a different language.

The two administrative clerks/interpreters reported that interpreting did form part of their job descriptions and the female security guard was unsure as to whether interpreting did, indeed, form part of her job description. The following dialogue arose between the female security guard and me:

I: Ok is interpreting part of your job description?

P: Um, not sure

I: But when they, um they appointed you did they say that you have to do interpreting as well or is it just a favour they ask of you?

P: Um, I think its part of my work because I'm in the ward then I have to be between the doctors and nurse, assist wherever

I: O, ok

P: Because it's also the patient because I'm there for the patient anything they need according to the patient then I can assist.

All ten participants responded to the question of how they generally were called upon to do interpreting. Both psychiatrists (both of whom had since left San Marco), reported that they were generally part of the treatment team that conducted ward rounds and therefore tended to be present when the use of an interpreter was required. The four nurses reported that they were generally asked to interpret within the ward where they performed their nursing duties. The two security guards reported that they were asked to interpret within the ward where they fulfilled their duties as security guards. One of the administrative clerks/interpreters, at the time of the study, was acting as an interpreter in a number of different wards, while the other administrative clerk/interpreter interpreted only within the ward to which she was allocated as administrative clerk.

None of the participants reported being financially rewarded for fulfilling the role of interpreter.

4.1.5 Participants' views on fulfilling the role of interpreter

Nine participants reported on how they felt about being called to do interpreting and six of the nine participants (the female psychiatrist, the three male nurses, the female security

guard, and one of the administrative clerks/interpreters) did not report any objection to being called to act as interpreters. Reasons given by some of these six participants were the following: one of the male nurses reported that no one demanded that he fulfilled the role of interpreter. All three of the male nurses reported that they perceived interpreting to be part of their nursing duties as the patients' advocate. The female security guard reported that she felt honoured to be called on to act as an interpreter.

P: I feel really proud

I: Is it?

P: Yes

I: And why do you say so?

P: I just tell myself I must be honest because by the time they call me that show they trust me.

However, three of the nine participants objected to being called to interpret. The male psychiatrist and the female nurse reported that when they are very busy with their normal duties being called upon to act as interpreters became problematic.

The following dialogue arose between the male psychiatrist and me:

P: On certain days if one is busy you get a little bit irritated actually

I: Ja

P: But often I don't mind.

One of the administrative clerks/interpreters who had objections reported that she was concerned about her petrol costs, since she had to cover her costs of travel between the different wards to do interpreting.

Participants were also asked how they experienced the role of interpreter at times within the institution where they are employed. Five of the eight participants (the female psychiatrist, the female nurse, one of the male nurses, and the two security guards) reported only positive experiences of fulfilling the role of interpreter. Two of the five participants gave detailed explanations as to why they perceived the role of interpreter as a positive one. The female psychiatrist reported that interpreting provided an opportunity to explore and learn about the social issues that might play a role in the patient's life and that it created an opportunity for people who spoke different languages to share the same space. The female nurse reported (see the dialogue below) that interpreting gave her, as nurse, an opportunity to build a trusting relationship with the patient which might not have been possible if she had not been involved in interpreting.

P: Yes, like you learn more. You feel like the patient who talks to the doctor

I: Yes

P: Then sometimes she won't talk to you as a nurse the things that she is talking to the doctor. Now when you interpret then she's having that confidence that you are going to help her in this thing

I: Ok

P: That you also learn from this the situation

I: Ok

P: And you do learn from interpreting.

Three participants (two of the male nurses and one administrative clerk/interpreter) reported experiences that were partly negative. One of the administrative clerks/interpreters reported that she, at times, found it difficult to do interpreting, since

clinicians did not always show their appreciation for the interpreting work that she did. One of the male nurses reported that at times he experienced technical difficulties with regard to interpreting. One of the other male nurses reported that he found interpreting difficult, since he tends to place himself in the patient's position.

Participants were also asked about their experiences in working with patients within a psychiatric institution. Eight out of ten participants (the two security guards, the four nurses and the two administrative clerks/interpreters) reported on this theme. Two participants (the female nurse and one of the male nurses) reported on working within the field of psychiatry and not specifically on working with patients within a psychiatric institution, with both of them reporting that they experienced the field of psychiatry as a very interesting field in which to work. The male security guard also reported that, as patients were at times aggressive, he was concerned for his own safety. One of the other male nurses reported that it was at times stressful to work in the field of psychiatry, especially due to issues of substance abuse, as he felt that substance abuse was the reason why the patients suffered from psychiatric disorders. The male nurse mentioned above gave the following response:

P: But now in psychiatry of late most people we are also admitting are people who are drug addicts, people who are using 'tik³'. It's also difficult sometimes

I: Mm

P: Because those people they come here, maybe to give you an example, this week and then you give them medication which stabilise them and then just

³Methamphetamine

before they go out of the hospital they will give you many promises: “I won’t use that again”. Three or four days later they come back and you feel like hu-uh

I: Ok

P: This is too much, you see

I: Ja

P: Those people are not really sick those are people who go out to invite the sickness because you know for a fact if they stay away from this drug

I: Ja

P: Then they won’t get sick.

One of the administrative clerks/interpreters reported that she, at times, felt that some patients were not suffering from a psychiatric disorder, but rather from a cultural phenomenon. The other administrative clerks/interpreters and one of the male nurses reported having compassion for the patients and feeling blessed to be in a position to help them. The female security guard enjoyed working with the patients, since she felt that she knew some patients very well through her security work in the ward to which these patients were admitted

Eight out of then participants (the two psychiatrists, the four nurses and the two administrative clerks) reported on whether they supported conducting interpreting work within psychiatric institutions. The two psychiatrists reported that interpreting services were essential to ensure quality of care and for the development of a trusting patient–health care professional relationship. The female nurse reported that patients often had to wait for a long time before an interpreter became available. One of the administrative

clerks/interpreters reported that interpreting services helped to ensure that patients received the correct medication and dosage. The other administrative clerk reported (see the dialogue below) that patients might feel that their culture would be understood by the interpreter, making them more comfortable with expressing themselves in their first language.

P: Yes and the interpreter will understand what they are saying. Sometimes, especially when it comes to cultural things because sometimes, I also tell the doctor “no that’s the cultural thing it’s not about the sickness, it’s the cultural things”

One of the male nurses also reported that patients could not be forced to speak English and that interpreters with a background in mental health should be employed. Another male nurse reported that one could not expect all health care professionals to be fluent in Xhosa and therefore providing an interpreting service was essential.

4.1.6 Ideal and problematic interpreting

Participants were asked what they regarded as ideal and problematic interpreting. Seven out of ten participants reported on what they considered to be ideal interpreting: The female psychiatrist reported that ideal interpreting occurred where patients who were previously not given the opportunity to express their experiences and emotions, due to language barriers, were given the opportunity to express themselves and to see how this opportunity led to an improvement in the patient’s condition. One of the male nurses reported that interpreting was ideal when a patient was able to express him/herself openly and the interpreter was able to interpret all that the patient wished to convey. The female

security guard reported that ideal interpreting took place when the patient was satisfied with the interpreting and when the interpreter was able to help the patient by interpreting. One of the administrative clerks/interpreters considered ideal interpreting to be when the patient received the correct medication due to the interpreting services provided, while the other administrative clerk/interpreter stated that ideal interpreting was when the patient understood the communication. One of the male nurses reported that ideal interpreting involves an accurate interpretation that the patient and clinician clearly understand. Another male nurse reported that ideal interpreting took place when no conflict existed between the patient, interpreter and clinician and when all three of these parties were satisfied with the interpretation, enabling the clinician to make an accurate diagnosis. The following dialogue arose:

I: Ok and would you be able to give me an example of when everything goes well in terms of interpreting? When you did interpreting and you thought by yourself that was a good interpreting session, if one can put it in that way?

P: Let me see, I have never thought about it in such a way

I: Yes one do not tend to think of it like that

P: What I can say I think was a good

I: Or what you think is ideal, an ideal interpreting session?

P: For me?

I: Yes for you

P: It is when I feel that I have without a doubt conveyed the message from the patient to the clinician and the clinician's questions and message to the patient. And I am able to see that the patient agrees and realises and feel satisfied.

All ten participants shared their views on problematic interpreting. The female psychiatrist reported that interpreting became problematic when the patient was expressing him/herself with circumstantiality and expansiveness and when clinicians were focused on getting a 'yes' or 'no' response from the patient. The male psychiatrist reported that interpreting became problematic when he had to explain issues relating to psycho-education to the patient's family. He furthermore reported that such a situation became problematic if all family members were speaking at the same time and the interpreter had to interpret for all the family members. The following dialogue arose between the male psychiatrist and me:

P: One recent one was when we were seeing the family of a patient

I: Ok

P: I think that becomes very difficult with more than one person. When we, it was about three or four family members and they spoke Xhosa and the social worker spoke Afrikaans

I: Ok

P: So then I had to go to and fro the different people. That was a bit difficult

I: Ok

P: When there are a number of different parties and they also want to have their say. So that is slightly different. So that was a bit difficult.

One of the male nurses reported that interpreting became problematic when the patient went to a traditional healer before seeking the help of a clinician. The other two male nurses each reported that interpreting was problematic when acting as interpreters for a patient who was Xhosa speaking when they themselves were not fluent in Xhosa, and

when the patient made racist remarks about the clinician in the language that the clinician did not understand. The female nurse reported that interpreting was problematic when the patient had a negative attitude towards her. The male security guard found that problematic interpreting occurred when the patient became aggressive and violent, while the female security guard reported that problematic interpreting took place when the patient did not want to accept the diagnosis that the clinician made. One of the administrative clerks/interpreters reported that problematic interpreting was experienced when the patient was aggressive and unwilling to communicate in any other language than his/her mother tongue. The other administrative clerk reported that interpreting became problematic when the patient thought that the interpreter was making the diagnosis and accusing him/her of being mentally disturbed, see the dialogue presented below:

I: Ok and in terms of interpreting when is it sometimes difficult, when do problems occur?

P: It's when the patient think everything is coming from me when I tell the patient, the patient is mentally disturbed and then he says: "don't tell me".

4.1.7 An exploration of sensitive issues relating to interpreting

We will now turn our focus to the participants' views on the role that rank, gender and ethnicity play in interpreting. Nine out of ten participants reported on the role of rank and five of these participants (the two psychiatrists, the two administrative clerks/interpreters and one of the male nurses) were of the opinion that rank played a role in interpreting and two of the five participants gave reasons. The two psychiatrists reported that much value

was attached to the rank of psychiatrist. One of the administrative clerks/interpreters reported that her rank as interpreter enables her to play a role in helping patients to recover. The remaining four participants (two of the male nurses, the female nurse and the female security guard) were of the opinion that rank does not play a role.

Seven out of ten participants reported on ethnicity, and six of the seven participants (the two psychiatrists, the three male nurses and one of the administrative clerks/interpreters) were of the opinion that ethnicity played a role. The female security guard was the only participant that did not think that ethnicity plays a role. Some of the six participants gave the following reasons. The female psychiatrist reported that there was more room for error when the patient and interpreter were from different ethnic groups. The male psychiatrist reported that if the patient and interpreter were of the same ethnicity it helped the interpreter to give a better interpretation of cultural issues. One of the male nurses reported that if the interpreter lacked knowledge of the patient's ethnicity, the clinician would not be able to understand the interpretation. The following dialogue arose between one of the male nurses and me:

P: It plays role when there's a culture involved, you see?

I: Ok

P: Ja, because I mean if I had to interpret for a Muslim guy

I: Yes

P: And I'm a Christian, you know some of the stuff it would not be so easy to interpret to the doctor, you see?

I: Ok

P: Because sometimes as I've said earlier on some of the things you've got to understand for yourself, because

I: Ja, ja

P: For you to interpret to the doctor, because if you don't understand then the doctor would automatically not understand it as well. So, you've got to make sure do you mean this and this.

Nine participants reported on the role of gender, and four of these participants (the female nurse, the male security guard, one of the administrative clerks/interpreters and one of the male nurses) were of the opinion that gender played a role, and three of the participants gave reasons. The male security guard reported that a patient of the opposite sex might accuse the interpreter of sexual harassment. The female nurse, one of the male nurses and one of the administrative clerks/interpreters reported that certain gender-related issues were very sensitive and that a patient might not want to discuss such issues in the presence of an interpreter who was of the opposite sex. The following dialogue arose between one of the administrative clerks/interpreters and me:

P: Uh, yes sometimes because I was working at the male ward and they think that a man don't want to talk to me but if I was a man they would say everything to me

I: Ok

P: Like cultural things, there are things I must not know but if I was a man they will say everything to me.

The remaining five participants (the male and female psychiatrist, two of the male nurses, and the female security guard) did not think that gender played a role.

4.1.8. Culture and interpreting

In exploring the topic of culture and interpreting, I explored the participants' understanding of common indigenous explanatory models such as 'amafufunyana' and 'ukutwasa' (Swartz, 1998), about which they were asked whether they held any personal belief. Eight participants (the female psychiatrist, the three male nurses, the female nurse, the male and female security guard and one of the administrative clerks/interpreters) reported that they did not personally believe in traditional explanatory models like 'amafufunyana' and 'ukutwasa' and some of the following reasons were given. The female security guard did not believe in traditional explanatory models like 'amafufunyana' and 'ukutwasa' since she only believes in God. The following dialogue arose between the female security guard and me:

P: Hey, that mafufunyana. I really don't know because sometimes the person she said she saw something and she is gonna do this or maybe the neighbour gave him those goggatjies, mafufunyana inside and now this mafufunyana makes her angry

I: Ok, ok

P: And then I don't believe that because it's God that created us how can that people have some power to put goggatjies.

Furthermore, the female security guard reported that she would advise patients with a Xhosa culture not to seek the help of a sangoma (indigenous healer), since doing so would, in fact, make them worse. One of the male nurses and the female nurse reported that, prior to working in the field of psychiatry, they he believed in certain traditional explanatory models; however, he stopped believing after learning about the existence of

psychiatric disorders. The following dialogue arose between one of the male nurses and me:

P: You know before doing psychiatry I believed in things, I believed that maybe someone, actually to be precise I believed that when somebody is mentally ill then it's because he's bewitched

I: Mm

P: But then after doing psychiatry and understanding all the different conditions within psychiatry then I actually stopped believing in that.

However, four of the eight participants mentioned above, reported that they did not reject the idea that patients did, in fact, believe in explanatory models such as 'amafufunyana' and 'ukutwasa'. One of the abovementioned four participants (the female psychiatrist) reported that she strove to implement the Western approach side-by-side with traditional explanatory models. Two participants (the male psychiatrist and one of the administrative clerks/interpreters) reported that they personally believed in traditional explanatory models, such as 'amafufunyana' and 'ukutwasa'.

In addition to the abovementioned theme, the role of the participants' own cultural and religious beliefs was explored by asking participants whether they thought that their own beliefs helped them to understand and interpret for the patient. Six of the eight participants who reported on the abovementioned topic (the two psychiatrists, the three male nurses and one of the administrative clerks/interpreters) reported that their own religious and cultural beliefs aided them in understanding and interpreting for patients

from the same cultural and religious background. Furthermore, the female psychiatrist also reported that her familiarity with other cultures aided her in interpreting for patients who were from different cultural backgrounds. However, two of the eight participants (the female nurse and the male security guard) reported that sharing cultural and religious beliefs with patients made it harder at times. The female nurse reported that certain issues relating to gender power were taboo to those of the Xhosa culture, and that, despite not being able to speak freely about such topics; she yet had to ask the patients to express themselves on such subjects. The following dialogue arose between the female nurse and me:

P: It is difficult sometimes because you know you'll find things that some Xhosa people don't want to say

I: Ok

P: It's difficult you must try and scratch it out because you know they don't talk about certain things

I: Ok

P: That must be said maybe in front of the doctor. They feel it's something that must be hidden

I: Can you give an example maybe of?

P: Like a patient will say: "woo maybe if my husband do something wrong you know maybe he was angry, maybe I make him angry".

The male security guard reported that his own cultural and religious beliefs made it difficult for him to act as interpreter, since patients would tell him that they did not suffer from any psychiatric condition, but that their conditions were caused by cultural factors.

Participants were asked if they interpreted the patient's cultural beliefs. Seven participants (the two psychiatrists, one of the male nurses, the female nurse, the two security guards and the two administrative clerks/interpreters) responded to the abovementioned theme. The female psychiatrist, the female nurse, the two security guards and one of the administrative clerks/interpreters reported that they did not interpret the patient's cultural beliefs and some of the following reasons were given. The female psychiatrist stated that she did not regard herself as qualified to interpret the patient's cultural beliefs. One of the male nurses reported that he assumed that all clinicians working within the hospital had some general understanding of different cultures and that, therefore, he did not interpret the patient's cultural beliefs. The male security guard reported that he had not been given the opportunity by clinicians to interpret cultural beliefs or to give his interpretation thereof after the interpreting session. Three participants reported that they interpreted the patient's cultural beliefs only under certain conditions. Two of the three participants (one of the administrative clerks/interpreters and one of the male nurses) reported that they tend to give their interpretation of cultural beliefs after the interpreting session. The male psychiatrist reported that he only gave his interpretation when the clinician did not understand, or was unfamiliar with, the patient's cultural beliefs.

4.1.9 Interpreting for immigrants and refugees

The abovementioned theme was explored by focusing on the views of the three participants that reported on this theme. Two of the male nurses reported that they had experienced that immigrants and refugees from Nigeria, Namibia, the Congo, Kenya and

Ethiopia were admitted to the hospital. One of these two male nurses reported that they found it very difficult to communicate in English with immigrants, even when the immigrants were able to speak English. The female psychiatrist reported that she felt that languages barriers faced by immigrants should be addressed, since no policies addressed the issue at the time of the study. The following comment was made by the female psychiatrist:

P: Now we are going into a new realm because now it's not only black languages now we are facing French, Portuguese. We've got all the migrant people or refugees coming in and we still don't have a policy as to or a central system.

4.1.10 Patient-confidentiality

I assessed participants' understanding of the term 'patient confidentiality' in order to facilitate the informal assessment of their familiarity with the term. Seven out of eight participants (the three male nurses, the female nurse, the female security guard and the two administrative clerks/interpreters) were familiar with the term and were able to explain how they understood the term and some of the participants' responses were the following. One of the male nurses reported that nurses were obliged to keep the patient's information confidential, though such information might be shared with others in the team treating the patient. One of the other male nurses reported that he was involved in looking after a patient who was his neighbour and that such situations could become very complicated. However, one of the eight participants (the male security guard) expressed lack of familiarity with the term 'patient confidentiality' and the following dialogue arose:

I: How do you understand patient confidentiality? Are you familiar with that term, when they say you must keep everything confidential with regards to the patient? Are you familiar with that?

P: I must keep?

I: Everything confidential. So when the patient comes you are not allowed to say anything outside of what the patient said. Are you familiar with that do you know about that?

P: No.

4.1.11 Issues relating to coping and interpreting

The theme of coping will be explored by focusing on participants' responses to questions such as whether they experienced any psychological distress while doing interpreting; whether they had been taught any coping strategies on dealing with distressing information that could be encountered while interpreting; whether they would like to have support and supervision concerning the interpreting work that they did; and whether they would interpret for acquaintances, friends and relatives.

Six out of ten participants (the female psychiatrist, one of the male nurses, the female nurse, the two administrative clerks/interpreters, and the female security guard) responded when asked whether they experienced any psychological distress while interpreting. The female psychiatrist, one of the male nurses and the female nurse reported that issues relating to abuse were especially distressing. The female psychiatrist, furthermore, reported that the disclosing of the patients' HIV status is very distressing.

The female nurse reported that the abuse of women was a very sensitive issue for her. One of the administrative clerks/interpreters reported that she tends to become distressed due to the patients' behaviour towards her, such as when a patient yelled at her. The female security guard reported that she sometimes felt sorry for patients, especially with regards to marital problems, since she regarded marital problems as being very sensitive topics. One of the administrative clerks/interpreters reported that most of the time when she was interpreting she felt very sad, since she was able to relate to what was happening to the patient. The following dialogue arose between one of the administrative clerks/interpreters and me:

P: Some of them have got some problems and if you can listen to them they is putting the problems to the doctor, then you feel so sad most of time

I: Ok, um do you think when you feel sad and so on, when you do the interpreting that it plays a role when you are doing the interpreting?

P: Yes

I: And why do you say that?

P: I say that it's playing a role because um the thing what is happening to the patient is the things that is happening to our lives.

Participants were furthermore asked whether they had been taught any strategies for coping with distressing information that might be encountered while interpreting. Seven participants reported on the abovementioned topic, and six of these participants (the two security guards, the two administrative clerks/interpreters, and two of the male nurses) reported that they had received no training on strategies to cope with distressing

information that might be encountered while interpreting. Only one of the male nurses reported that he received basic training in coping skills while training to become a nurse.

I asked the participants whether they would like to have support and supervision for fulfilling the role of interpreter. Five out of ten participants (the female psychiatrist, two of the male nurses, and the two administrative clerks/interpreters) reported on their need for and openness to receiving support and supervision. All were in favour of such intervention. Some of the following reasons were given: One of the administrative clerks/interpreters reported concerns over misdiagnosis that she had come across. The other administrative clerk/interpreter had concerns over contracting TB while occupied with interpreting and furthermore reported (see the dialogue below) that she often had problems with the clinicians present during interpreting and that she would like to report those clinicians to someone that is in a position of authority.

P: Um sometimes if I can report the doctor especially if I have a problem with, a problem with the doctor that I can go to someone who's in charge

I: Ok

P: And report the doctor.

One of the male nurses reported that he was, at times, uncertain as to whether he had given an accurate interpretation.

The following dialogue arose in this regard⁴:

I: Um, if such a facility was available on the hospital's premises. Say for instance a doctor or someone professional with who you could talk about what you

⁴ A part of this dialogue has been presented in section 4.1.1

experience, or when it was difficult or when it went well. Will you make use of it if you had someone to your disposal?

P: Definitely

I: Ok and why do you say that?

P: Because sometimes you feel that you have not interpreted something the doctor or patient said correctly. Then you think 'jislaaik', but then you keep it to yourself, you let it go

I: Yes

P: Yes, but it is a problem because what if I did not talk 'lekker' to that man.

Participants' responses to being asked whether they would interpret for acquaintances, friends and relatives are presented below. All ten participants were in favour of doing such interpreting and some of the following reasons were given: one of the male nurses reported that his first priority was to help the person concerned and not whether the person was someone he knew. The female nurse reported that she would interpret for an acquaintance, friend or relative if the person in question was unconcerned about the issue of confidentiality. The female security guard reported that, as she would try to put herself in the other person's position, she would, indeed, interpret for acquaintances, friends and relatives. One of the administrative clerks/interpreters reported that she interpreted for someone in her community before and that her interpreting, together with her knowledge of the patient's condition, may have helped the person to receive treatment sooner than otherwise might have occurred. The following dialogue arose between one of the administrative clerks/interpreters and me:

I: Ok, um can you maybe tell me if some of your friends or family members had to come to a psychiatric hospital in the Western Cape would you do the interpreting for them?

P: Yes

I: And why do you say that?

P: I'd like to do, I can do the interpretation because I know if I can do that they can help, and they can get help quickly.

The other administrative clerk/interpreter reported that she did not distinguish between patients with whom she was acquainted and patients whom she did not know. One of the male nurses argued that he would regard the opportunity to interpret as being an opportunity to play a role in helping an acquaintance, friend or relative. One of the other male nurses reported that he would interpret for an acquaintance, friend or relative, since he believed that he was able to distinguish between his personal capacity outside the work environment and his professional capacity within the work environment.

4.2 Technical aspects and methods of interpretation

The following issues are addressed in this section:

- do participants convey uncertainty to the clinician regarding issues relating to the patient's condition and to the interpretation?
- participants' views on possible differences in interpreting needs when working in different wards and with different clinicians
- participants' views on the role of the clinician's presence while interpreting
- participants' use of paraphrasing and word-for-word interpreting

- whether the participants' used a standard set of questions that were cued by the clinician, or whether they improvised their own wording, based on the clinician's wording
- whether the participants chose to use their own clarifying questions, or whether they tend to use the clarifying questions of the clinician present; and
- participants' views on the potential time difference between the average interpreted interview and that of the average non-interpreted interview.

Each of these issues will be discussed in turn.

4.2.1 Conveying uncertainty

All ten participants reported on this theme and only the two security guards reported that they did not convey uncertainty to the clinician regarding any issues relating to the patient's condition and the interpretation. One of the two security guards (the female security guard) explained that she did not convey uncertainty since she did not know what the patient was feeling and was therefore not in any position to convey uncertainty to the clinician regarding any issues relating to the patient's condition and the interpretation. The following dialogue arose between the female security guard and me:

I: Ok, do you convey uncertainty about a symptom to the doctor. So if the patient said he or she has got this symptom and you are not certain that that is actually the symptom would you then tell that to the doctor?

P: No, I just say what the patient said because I sometimes, I don't know what's happening to the patient

I: Ok

P: If she said she is feeling nauseous I know it's maybe just a way of saying that she wants to go home I don't have to say that

I: Ok

P: I don't have to think myself I just have to say what the patient said, because I don't know what she is feeling

I: Ok, um do you base a judgement on your own previous experience and convey this to the doctor or do you convey information directly?

P: I convey the information directly

I: Ok and why do you do it in this way?

P: Because we don't feel in the same way and I am not a patient

I: Ok

P: I don't feel the same as the patient.

Eight participants reported that they conveyed uncertainty to the clinician regarding any issues relating to the patient's condition and the interpretation. Five of the eight participants (the two psychiatrists, the female nurse, one administrative clerk, and one of the male nurses) stated that they conveyed uncertainty and voiced their opinions. It may be assumed that these participants do this under all conditions since they did not state that they only conveyed uncertainty under certain conditions. Some of the participants' reasons were the following. One of the male nurses reported that he conveyed uncertainty and voiced his opinion since he spent more time with the patients than did the clinicians; the female psychiatrist stated that she found it relatively easy to express her own opinions since, in most instances, she was one of the clinicians that was in the treatment team; and

one of the administrative clerks/interpreters reported that the clinician gave her an opportunity to voice her own opinion and uncertainties after the interview. However, three of the eight participants (two of the male nurses and one of the administrative clerks/interpreters) told of conveying uncertainty only under certain conditions: one of the male nurses reported that he conveyed uncertainty when the interview covered cultural issues with which the clinician was unfamiliar, while the other male nurse only stated that he conveyed uncertainty and voiced his opinion if the clinician asked him to do so. One of the administrative clerks/interpreters reported that she gave her opinion as to whether the patient had a psychiatric disorder or not, though she did not give the clinician her opinion of the patient if she disagreed with the clinician's opinion of the patient's condition, since the former was knowledgeable and therefore better positioned to voice an opinion.

4.2.2 Participants' views on possible differences regarding wards and clinicians

All ten participants reported on the abovementioned theme. Five participants (the male psychiatrist, the two security guards, and the two administrative clerks/interpreters) thought that no differences existed in interpreting when working in different wards and with different clinicians and some of the following reasons were given. The male security guard reported that he only interpreted from English into Xhosa, as well as vice versa, and therefore there were no differences involved. The female security guard reported that she tends to give direct interpretations, so that there were essentially no differences. One of the administrative clerks/interpreters attributed the lack of difference to the similarity

in the questions cued by the clinicians, while the other administrative clerk stated that the lack of difference resulted from the patients having similar psychiatric disorders.

Five participants (the female psychiatrist and the four nurses) reported that there were differences in interpreting needs when working in different wards and with different clinicians and some of the reasons given were the following: the psychiatrist reported that within the field of general medicine a physician can more easily treat a patient without engaging in complex communication, while, within the field of psychiatry, such non-engagement was highly problematic, resulting in each clinician having a different way in which to communicate with the patient. One of the male nurses reported differences in interpreting between the acute and forensic wards. In the forensic ward the interpreter becomes familiar with the patients and their psychiatric disorders, which makes interpreting easier, while such is not the case in the acute ward, since patients do not stay in this ward for a long period. The following dialogue arose regarding the abovementioned:

P: I think there (forensic ward) the patients they are not moving like in the acute ward they are coming and moving. There you are dealing with the same patient all the time every time you are dealing with them, they are there you see

I: O, ok

P: Hence in the acute side the patient comes immediately. When they are ok they are calm and stable then they go to another ward, they go home to visit and so

I: Ok

P: Hence in forensic side you are dealing with the same guys all over again and sometimes it becomes easy for you to get to know what kind of problems they are having.

4.2.3 The role of the clinician's presence

Participants reported the following when asked about their views on the role of the clinician's presence while interpreting. All ten participants reported that they preferred the clinician to be present whenever they acted as interpreters and some participants gave the following reasons. The female psychiatrist reported that the clinician's presence eased the relationship between the patient and clinician. The response of the female psychiatrist:

P: I think it's useful to have clinicians present

I: Mmm

P: If you have a good enough relationship with a client where you have already established dialogue

I: Ja

P: I think it's useful because there is so much around body language and interestingly people do follow the train and the mood and the intonation. All those things are as important. So, I think the non-verbal stuff and the background noise is important

I: Ok

P: And so particularly if you are not the primary physician looking after the patient, if you are assisting with interpretation and somebody else is looking after

the patient at least at some level they have contact whereas seeing a patient on your own

I: Ja

P: And then having that person look after the patient means the experiences are different.

The male psychiatrist was of the opinion that any uncertainties experienced by the clinician regarding the interpretation can be resolved before the patient leaves the interview room. One of the male nurses reported that the clinician might detect non-verbal aspects and any verbal aspects on which the interpreter missed out. One of the administrative clerks/interpreters reported that the clinician's presence might prevent the patient from thinking that it was the interpreter who was making the diagnosis.

4.2.4 The use of techniques and methods

All ten participants reported on their use of word-for-word interpreting and paraphrasing. Three participants (the two psychiatrists and one of the male nurses) reported that they only used paraphrasing and some of the following reasons were given: The female psychiatrist reported that through paraphrasing she was able to gain an initial understanding of what the patient was saying, though with paraphrasing greater possibility of error of interpretation existed than when using word-for-word interpreting. She also reported that word-for-word interpreting was often complicated since many English words did not have equivalent Xhosa words. One of the male nurses reported that he used paraphrasing, since patients often elaborated on their problems, which complicated word-for-word interpreting. Four of the participants (the two security guards,

one of the administrative clerks/interpreters and one of the male nurses) reported that they used only word-for-word interpreting. Some participants gave the following reasons: the female and male security guard reported that word-for-word interpreting enabled an interpreter to stay true to what the patient and clinician were saying and prevented omissions.

Three participants reported that they used both paraphrasing and word-for-word interpreting. One of the male nurses reported that he started with word-for-word interpreting when interpreting the clinician's words to the patient and the patient's words to the clinician – however, if the patient did not understand what the interpreter was saying, he would use paraphrasing. The female nurse reported that she used paraphrasing when interpreting the clinician's words to the patient, since it was at times difficult for the patient to understand the clinician's terminology. However, when interpreting the patient's words to the clinician she would use word-for-word interpreting if she thought that what the patient said made sense. One of the administrative clerks/interpreters used both word-for-word interpreting and paraphrasing when interpreting the clinician's words to the patient, depending on whether the clinician's wording had an acceptable Xhosa equivalent and on whether the Xhosa-speaking patient was able to make sense of her interpretation of what the clinician was saying. The response of one of the administrative clerks/interpreters mentioned above:

P: Um sometimes I listen and say directly but sometimes I have to do it in my traditional ways

I: Ok

P: Because there are things I can't say, just you are mad, it doesn't sound to us

I: Ok can you just give me an example?

P: Like when the doctor says you are mad. I can't just say 'uyaphambana', you understand?

I: Ok

P: Which means mad, which is rude in our culture

I: Ok

P: I must put it in a right way, you are mentally disturbed. Then the patient understand but if I say you are mad

I: Ja

P: The patient will like fighting with me

I: Yes

P: So I must have a way to say

I: How do you explain that to the patient cause that's quite difficult to do?

P: Uh, 'uyaphambana' is you are mad, but I must say you are mentally disturbed and I will say 'uphazazemekile uqonwe' so which the person understand

I: So the sickness of the head?

I found the following when participants were asked whether they used the standard set of questions cued by the clinician or whether they used their own new wording based on the clinician's words. Only two out of nine participants (one administrative clerk and one of the male nurses) used the standard set of questions cued by the clinician. The other seven participants (the two psychiatrists, the two male nurses, the one female nurse and the two

security guards) reported that they used their own new wording, based on the clinician's wording.

Participants were furthermore asked whether they used their own clarifying questions or whether they used the clarifying questions of the clinician. Two out of the nine participants (the female psychiatrist and one of the male nurses) that responded, reported that they used their own clarifying questions. Two participants (one of the male nurses and the female nurse) claimed to use both their own clarifying questions and the clarifying questions of the clinician. The two participants gave the following reasons: One of the male nurses reported first using the clinician's clarifying questions, and then, if the clinician did not understand what the patient was saying, the interpreter would use his own clarifying questions. The female nurse reported (see the dialogue below) that she would firstly use her own clarifying questions and, if the clinician needed further clarification, she would then use the clinician's clarifying questions.

I: Ok do you use clarifying questions or do you wait for the doctor to give you the clarifying questions?

P: I use clarifying questions

I: Do you use your own clarifying questions?

P: Ja then I will sometimes if doctor is unsatisfied with this patient then he can put it more clear

I: Ok, so sometimes you would do it yourself but if the doctor is not satisfied with that he or she gives his own?

P: Yes.

The other five participants (the male psychiatrist, one of the male nurses, the two security guards and the two administrative clerks/interpreters) reported that they only used the clarifying questions of the clinician.

4.2.5 Time differences

The ten participants reported the following when they were asked whether there was a time difference between the average interpreted interviews compared to that of the average non-interpreted interview. Six participants (the two psychiatrists, two of the male nurses, the female nurse, and the male security guard) reported that there was a considerable time difference when an interpreter was used, since such use made the interview much more time consuming. The female psychiatrist reported that, on average, double the time was taken when an interpreter was used than for an average interpreted interview. One of the male nurses reported that it took approximately 25 minutes longer on average when an interpreter was used. One of the administrative clerks/interpreters was of the opinion that there was no time difference between the two.

One of the male nurses, the female security guard and one of the administrative clerks/interpreters interpreted the question of whether there was a time difference when no interpreter was needed compared to when an interpreter was needed as whether there was a time difference between when an interpreter was needed and when one was present compared to when an interpreter was needed but was not present. These participants argued that it was more time consuming when an interpreter was needed but was not present.

4.3 A practical exercise on translating and back-translating

As mentioned in the methodology chapter participants were asked to translate nine diagnostic questions from English into Xhosa and Afrikaans and to give back-translations. The aim of this part of the study was to gain an indication of whether participants were able to give accurate translations and to see if any inaccuracies occurred. The translations of the diagnostic questions from English to Afrikaans and the back-translations thereof are not presented in table form. Both participants acting as interpreters for Afrikaans speaking patients gave literal translations of the nine diagnostic questions and their back-translations were therefore the same as the original English questions.

The translations and back-translations of the participants acting as interpreters for Xhosa speaking patients are presented in various tables (see pp.76-89). Each table consists of the English diagnostic questions, participants' Xhosa translation and the back-translations thereof, along with the independent translators' back-translations of participants Xhosa translations. Diagnostic questions will be presented individually. It should be noted that the female psychiatrist's translation of one of the diagnostic questions was lost due to recording difficulties and is therefore not presented in table 4.3.6.

Table 4.3.1.
Translations and back-translations of the question: ‘Do you hear voices?’

Do you hear voices?	Response and dialogue	Respondent’s own back translation	Independent back translation #1	Independent back translation #2
Male security guard	P: Akhona amazwi owavayo?	P: Do you hear voices. Do you hear someone talking?	Are there any words you hear?	Are you hearing voices?
One of the administrative clerks/interpreters	P: Uva amazwi na athetha ezindlebeni zakho zabantu ongababoniyo?	P: Do you hear voices?	Are you hearing voices of people you can not see, talking in your ears?	Are you hearing the voices of unseen people in your ears?
Female security guard	P: Uva amazwi?	P: Do you hear voices?	You are hearing voices?	You hear voices?
Female nurse	P: Uva amazwi?	P: Is how do you hear voices, or do you?	Are you hearing voices?	Are you hearing words?
Female psychiatrist	P: uya kuva amazwi?	P: Do you hear voices?	You will hear voices?	You will hear voices?
Male psychiatrist	P: Uyeva amazwi?	P: Do you hear voices?	Do you hear voices?	You are hearing voices?
One of the male nurses	P: Uva amazwi?	P: Are you hearing any voices?	You are hearing voices?	Do you hear voices?
One of the administrative clerks/interpreters	P: Uyaweve amazwi?	P: Do you hear voices?	Can you hear the words?	Can you hear the words?

Table 4.3.2.
Translations and back-translations of the question: 'Have you been bewitched?'

Have you been bewitched?	Response and dialogue	Respondent's own back translation	Independent back translation #1	Independent back translation #2
Male security guard	P: Ingaba uligqwira?	P: Are you, are you been bewitched?	Are you a witch?	Are you a witch?
One of the administrative clerks/interpreters	P: Wakha wathakatwana?	I: And that is the same in English? P: Yes.	Have you ever been bewitched?	Have you ever bewitched?
Female security guard	P: Wakha wathakathwa ngaphambili?	P: Have you been bewitched before?	Has anyone used witchcraft on you?	Have you been bewitched before?
Female nurse	P: Ukhe wathakathwa?	P: Also have you been bewitched?	Have you been witchcraft?	Have you been bewitched before or have you been cast a spell at before?
Female psychiatrist	P: Utwasile?	I: Ok, and that's just straightforward the same (as 'have you been bewitched')? P: Ja.	Translators were unable to translate this question.	Translators were unable to translate this question.
Male psychiatrist	P: Uthakathiwe?	P: Have you been bewitched?	Are you bewitched?	You are bewitched?
One of the male nurse	P: Ukholelwa uba uthakathiwe?	P: Are you being bewitched?	You believe that you have been bewitched?	Do you believe you have been bewitched?
One of the administrative clerks/interpreters	P: Wakha wathakathwa?	P: Have you been witched?	Have you ever been bewitched?	Have you ever been bewitched?

Table 4.3.3.

Translations and back-translations of the question: 'Do you have special powers or abilities?'

Do you have special powers or abilities?	Response and dialogue	Respondent's own back translation	Independent back translation #1	Independent back translation #2
Male security guard	P: Ok, this question like someone who got mafufunyana? I: Ja P: Ingaba unamandla owafumana ngoku?	P: Do you have a power more than before, you see?	Do you have power that you get immediately?	Do you have power that you are gaining now?
One of the administrative clerks/interpreters	P: Unawo amandla okuphilisa abantu okanye ukunceda abantu?	P: Do you have special powers?	Do you have powers to heal people or helping others?	Do you have the power to make people feel better or help them?
Female security guard	P: Uxa usenza lento unayo into ova ingathi iyakuncedisa okanye uyenza ngokunokwakho?	P: When you do this do you have another power more power than this but more power. Do you feel that you have more power?	When you do something there's something helping you?	When this is happening to you, you feel as if something is helping you or you are doing it yourself?
Female nurse	P: Unamandla onawo ozicingela ukuba umkhulu kunabanye abantu?	Do you have special powers or do you have powers that makes you feel you are better then other people?	You've got power and you think that you are bigger than other people?	You have the powers that make you think that you are superior than the others?
Female psychiatrist	P: Unawo isiphiwo? I: Mm P: Those are gifts okanye into ukwazo kuyenza ngaphezu kwabanye abantu?	P: Are there things you can do better then other people?	You are gifted or you can perform things above other people?	You have gifts or maybe something you can do better than others can?
Male psychiatrist	P: Kukhona izinto okwazi ukuzenza?	P: ... is there anything that you, only you can do or is there anything special that you can do?	Are there anything you can do?	There are things you can do?

Table 4.3.3 (Continued).

Do you have special powers or abilities?	Response and dialogue	Respondent's own back translation	Independent back translation #1	Independent back translation #2
One of the male nurses	P: Ukholelwa ekubeni unamandla onawo abanye abantu abangenawo onokwenza izinto abanye abantu abangenakukwazi ukuzenza?	P: Do you believe you have special powers. Then the patient would still not understand. Then maybe powers that maybe other might not have or powers to do extra-ordinary things?	You believe that you have certain powers that other people do not have, that you can use to do things other people cannot do?	Do you believe you have the strength others don't? You can do things other people cant do?
One of the administrative clerks/interpreters	P: Unawo amandla angamanye mhlawumbi okanye isiphiwo?	P: Ja, have you got power or anything or what you have that other people haven't got. Or do you experience any power or energy that other people haven't got?	Do you have other strengths or special gifts?	Do you have other strengths or special gifts?

Table 4.3.4.

Translations and back-translations of the question: 'Do you feel sad'

Do you feel sad?	Response and dialogue	Respondent's own back translation	Independent back translation #1	Independent back translation #2
Male security guard	Participant unable to translate the question.	Not applicable.	Not applicable.	Not applicable.
One of the administrative clerks/interpreters	P: Uziva ukhathathazekile?	I: Ok and that's the same as in English? (Participant nods her head)	Are you sad?	Are you feeling sad?
Female security guard	P: Uziva ukhathazekile?	P: Do you feel sad?	You are sad?	You feel upset?
Female nurse	P: Uziva ukhathazekile?	P: That is the same (as 'do you feel sad')	Are you feeling sad?	You feel worried?
Female psychiatrist	P: ... ukhathazekile? I: Ja P: Which has a slightly different flavour to udakumbile I: Mm P: So probably if I was just asking about sadness I: Ja P: Khatazekile?	P: Do you feel sad?	Feeling hurt?	He is worried?
Male psychiatrist	P: Uphatheke kakubi?	P: Do you feel sad?	Are you abused?	You are not feeling very well?
One of the male nurses	P: Uziva ungonwabanga, you see that is in Xhosa do you feel sad oziva khathazekile, you see? I: So that's also more or less the same (as 'do you feel sad')? P: Ja, ja, exactly.	P: Do you feel sad?	You are feeling unhappy?	Are you unhappy?
One of the administrative clerks/interpreters	P: Wonwabile. Are you unhappy are you sadly awonwabanga?	Are you unhappy, are you sadly?	Are you happy?	You are happy?

Table 4.3.5.

Translations and back-translations of the question: 'Do you feel depressed?'

Do you feel depressed?	Response and dialogue	Respondent's own back translation	Independent back translation #1	Independent back translation #2
Male security guard	P: Ingaba ikhona into ekukhathazayo?	P: Yes, do you feel depressed or do you feel something goes wrong?	Is there something bothering you?	Is there anything that worries you?
One of the administrative clerks/interpreters	P: Uziva udandulukile?	P: Do you feel depressed?	You feel very sad?	Are you feeling very sad?
Female security guard	P: Uva ingathi kukho into ekuxinaniseleyo okanye awonwabanga emphefumlweni?	P: Do you feel depressed? You don't feel comfortable also?	You are feeling like something is very heavy on you, or you are not happy, or you feel you have a heavy burden?	You are feeling, depressed, unhappy and sad? Or it is as if you are down, depressed etcetera?
Female nurse	Uziva ukhathazekile?	P: It's still the same (as 'do you feel sad') I: So you would say it then the same as 'do you feel sad'? P: Uh	Are you feeling sad?	You feel worried?
Female psychiatrist	P: Uziva udakumbile?	Do you feel depressed?	Feeling depressed?	Translator were unable to translate this question
Male psychiatrist	P: Umoya wakho uphantsi?	P: That means is your spirit down I: Ok P: There is no word for depressed	Is your spirit down?	You are feeling drained emotionally?

Table 4.3.5 (Continued).

Do you feel depressed?	Response and dialogue	Respondent's own back translation	Independent back translation #1	Independent back translation #2
One of the male nurses	<p>P: You see, you said sad first I: Ja P: Depressed uziva ukhathazekile okanye ungaphethekanga kakuhle emphefumleweni.?</p>	<p>P: I asked the person, how are you feeling? Are you feeling that something is not right? Because people they normally take the depression thing with their soul as well I: O, ok P: If they are down their spirit is down then they normally classify it as depression.</p>	You are feeling sad or there is something that is bothering you?	Are you sad or not well at heart?
The response of one of the administrative clerks	P: Unoxinzelelo. That is depressed. When somebody's got depressed...	P: That is depressed. When somebody's got depressed.	Do you feel trapped?	Do you feel trapped?

Table 4.3.6.

Translations and back-translations of the question: ‘Do you feel anxious?’

Do you feel anxious?	Response and dialogue	Respondent’s own back translation	Independent back translation #1	Independent back translation #2
Male security guard	P: Uziva uphilile?	P: Are you still ok?	Do you feel healthy?	Are you feeling well?
One of the administrative clerks/interpreters	P: Uziva onwabile like unemisindo?	P: Anxious (participant very limited in her response)	Are you feeling happy or angry?	Are you happy or sometimes angry?
Female security guard	P: Can you explain to me firstly what is anxious?	Not applicable	Not applicable	Not applicable
Female nurse	P: Uziva uxhalabile?	P: Is do you feel anxious, anxiety?	Are you worried, worried?	You’re alert?
Male psychiatrist	P: Unamatata?	P: It means are you anxious or worried.	Have you got problems?	You are having worries?
One of the male nurses	P: Uziva ungonwabanga unento ekuhluphayo emphefumleweni?	P: Do you feel anxious? That one is where you’ve got to elaborate I: Ok P: Ja, you see do you feel that something you feel that you are not well. There are something that makes you not to be ok I: Ok P: Ja, not to be, just not be happy, not to be comfortable, to be stressful. I think that’s how I put it as well.	You feeling unhappy, there is something that is bothering you?	Are you unhappy, or something bothering you at heart?
One of the administrative clerks/interpreters	P: Uziva mhlawumbi ingathi akukho ndlini?	P: I mean if you feel anxious, somebody who doesn’t feel herself.	Do you maybe feel like your not at home?	Do you maybe feel like you are not at home?

Table 4.3.7.

Translations and back-translations of the question: ‘Have you felt excessively happy, irritable or energetic?’

Have you felt excessively happy, irritable or energetic?	Response and dialogue	Respondent’s own back translation	Independent back translation #1	Independent back translation #2
Male security guard	P: Ingaba uziva wonwabile?	I: Irritable, irritable is like irritated P: I don’t know I: Ok and energetic. You’ve got lots of energy? (No response from participant) I: Ok so what is excessively happy what is that in Xhosa? P: Wonwabile.	Do you feel happy?	Are you feeling happy?
One of the administrative clerks/interpreters	P: Uziva unamandla angapha kokuqonda okanye uziva udikwe yinto le yonke?	P: Irritable. (participant very limited in her response)	Are you feeling very strong or do you always have no interest in everything?	Do you feel like you have more power or ambition or you just tired of everything?
Female security guard	P: Uziva unamandla wonwabile okanye ukhe wachuphuka uzive ucaphuka unamandla uzive njani?	P: Energetic, happy.	You feel powerful or you are feeling very angry or you have a lot of strength or power?	You feel energetic or you have been angry, feeling angry or energetic. How do you feel?
Female nurse	P: Uziva wonwabile kakhulu unamandla?	P: Are you feeling happy and energetic?	Are you feeling so happy and you’ve got energy?	You feel very happy and have energy?
Female psychiatrist	P: Uziva uphezulu kakhulu, unamandla kakhulu, unochuku?	P: Excessively happy or irritable or energetic again unamandla kakhulu.	Feeling high functioning, very energetic, irritable?	To feel high above, full of energy.
Male psychiatrist	P: Ukhe waziva ujabule kakhulu okanye ucophola lula okanye unamandla amakhulu?	P: Have you felt excessively happy, irritable or energetic?	Do you sometimes get very happy, or get angry easily, or get really strong?	You have been feeling very excited and very powerful?

Table 4.3.7 (Continued).

Have you felt excessively happy, irritable or energetic?	Response and dialogue	Respondent's own back translation	Independent back translation #1	Independent back translation #2
One of the male nurses	P: Ubukhe waziva wonwabe kakhulu udikiwe okanye unamandla nje,okwenza izinto kwezintsuku zidlulileyo?	I: So what would happy be? P: Wonwabile I: Ok, and irritable? P: Irritable is udikiwe I: Dikiwe? P: Ja I: And energetic? P: Energetic unamandla nje.	You have felt very happy, uninterested. Or you were very powerful or strong to do a lot of things, a few days ago?	Did you get very happy, bored or just strong to do things in the past few days?
One of the administrative clerks/interpreters	P: Wonwabile wonwabe kakhulu okanye awonwabanga. That is happy or irritable I: And um excessively? P: Ukonwaba kakhulu	P: That is happy or irritable I: And um P: Awonwabanga. That is happy or irritable I: And um excessively? P: Ukonwaba kakhulu.	Are you happy, are you very happy or are you unhappy?	Are you happy, are you very happy or are you happy?

Table 4.3.8.

Translations and back-translations of the question: ‘Have you lost interest in pleasurable activities?’

Have you lost interest in pleasurable activities?	Response and dialogue	Respondent’s own back translation	Independent back translation #1	Independent back translation #2
Male security guard	P: Ingaba kukho izinto ezikulahlekeleyo ozithandayo?	P: Have you lost something that you like to do?	Are there some lost things that you love?	Have you lost valuables?
One of the administrative clerks/interpreters	P: Uziva ungasenamndla ukwenza izinto mhlambi uziva ungenamndla?	P: You lost I: Ok and interest what is? P: Uziva ungenamndla ukwenza ntoni na. Anything.	You are not interested to do anything anymore?	Are you distractive of doing things?
Female security guard	P: Ukhe waziva ungenamndla nakweyiphipina imidlalo?	P: Lost interest in activities?	You have no interest?	Have you ever felt that you have no energy irrespective of any games?
Female nurse	P: Uphelwe ngumndla kwizinto ezikonwabisayo?	P: Have you lose interest in things that make you happy?	You’ve lost interest to exciting things?	You feel you’ve lost interest in the things that excites you?

Table 4.3.8 (Continued).

Female psychiatrist	P: Uphelelwa ngumdlakwezinto ubuqheleukozonwabela ngaphambili?	P: Um in other words 'have you lost uphelelwa ngumdlakwezinto ubuqheleukozonwabela ngaphambili?' Is a kind of appetite if you like. So 'have you lost interest in things that previously made you happy?'	You have lost interest in everything that you used to engage in before?	To get bored of old amusing things?
Male psychiatrist	P: Usafuna ukwenza izintoubuthanda ukuzenza?	P: Have you lost interest in things that you liked to do before?	Do you still want to do the things you've enjoyed doing?	You still like doing things you used to do?
One of the male nurses	P: Ulahlekelwa ngumdlakwezinto ubuzithanda?	P: It's something that the person normally likes. Then the patient will say "things like?" Then you say "like maybe soccer, you like soccer? Have you lost interest in soccer?" Now, you see?	You have lost interest in doing things you liked to do?	You've lost interest in things you liked before?
One of the administrative clerks/interpreters	P: Unelo ixesha lokukhe ungonwabi abanye abantu bonwabile	P: Like activities, like you don't know how to do things anymore?	Do you sometimes feel unhappy when other people are happy?	Do you sometimes feel unhappy when other people are happy?

Table 4.3.9.*Translations and back-translations of the question: 'Are you afraid that people want to hurt or poison you?'*

Are you afraid that people want to hurt or poison you?	Response and dialogue	Respondent's own back translation	Independent back translation #1	Independent back translation #2
Male security guard	P: Ingaba uyoyika woyika abantu ukuba bakuphathe kakubi okanye bakwenze into engalulanganga?	P: Are you scared for the people to make something wrong for you?	Are you scared, scared of people who will treat you bad or do bad things on you?	Are you scared, are you scared that people will ill treat you or do bad things to you?
One of the administrative clerks/interpreters	P: Ucinga ukuba kukho abantu abafuna ukulimaza abakuleqayo?	P: Are you afraid people hurt you?	Do you think that there are people who are trying to hurt you?	Are you thinking of people that are chasing, trying to traumatize you?
Female security guard	P: Unalo uloyiko lokuba lomntu ufuna ukukhathaza okanye akutyise ityhefu?	P: Are you afraid of that the person can hurt you?	You feel or you are afraid that there is someone wanting to kill you, or hurt you, or poison you?	You always feel scared as if this person is going to hurt you or poison you?
Female nurse	P: Uyoyika kukho abantu abazakonzakalisa okanye baza kutyisa ityhefu?	P: Are you scared that people are going to hurt or give you poison?	Are you scared of people who want to hurt you, or they want to poison you?	Are you afraid that there are people trying to hurt you or want to poison you?
Female psychiatrist	P: Uyoyika ingathi abantu bafuna ukonzakalisa okanye bafuna ukunika i-poison?	P: Again are you afraid that people might want to hurt you? I: Mhu P: Or want to poison you?	You are scared as if people are going to hurt you or poison you?	You will fear that people want to harm you or give you poison?

Table 4.3.9 (Continued).

Are you afraid that people want to hurt or poison you?	Response and dialogue	Respondent's own back translation	Independent back translation #1	Independent back translation #2
Male psychiatrist	<p>P: Um, uyoyika ukuthi kukho abantu abafuna ukulimaza okanye abafuna uku...</p> <p>I: Ja</p> <p>P: what's the word um I can't think of the word right now</p> <p>I: Ok</p> <p>P: I can't think of the word right now.</p>	<p>P: Are you afraid that there are people that want to hurt you?</p>	<p>Are you afraid to say that there are people who want to hurt you or who want to?</p>	<p>You are afraid to say that there are people who want to kill you?</p>
One of the male nurses	<p>P: Uyoyika mhlawumbi ukuba kukho abantu bafuna ukuvisa ubuhlungu?</p>	<p>P: Are you fearing that someone want to hurt you or poison you?</p>	<p>You are scared or afraid that there are people who want to hurt you?</p>	<p>Are you scared there are people who want to hurt you?</p>
One of the administrative clerks/interpreters	<p>P: Uyaboyika abantu ukuba bangakubetha okanye bakudlise?</p>	<p>P: Are you afraid of the people who can hurt you or poison you?</p>	<p>Are you afraid of people hitting you or poisoning you?</p>	<p>Are you afraid of people hitting you or poisoning?</p>

5. DISCUSSION

The discussion chapter will be divided into three separate sections as it was done in the results chapter. The first section will consist of a discussion of the broad aspects relating to interpreting practices. This second section will consist of a discussion of techniques and methods of interpretation and the third section will consist of the practical exercise.

5.1 Broad aspects relating to interpreting practices

5.1.1 Reflections on interviews conducted with participants

A discussion on communication problems that occurred and on the views expressed by participants during the interviews creates a platform for further discussions on the topics that will follow. The two security guards seemed to have difficulty in understanding basic and simply structured questions asked in English, and this occurred on more than one occasion. This may imply that there is a high probability that the two security guards misunderstand at least some of the questions given by clinicians. The fact that the female security guard became upset when she was unable to explain a common diagnostic term may possibly imply that interpreters are aware of their lack of training in psychiatry and in interpreting. This can be supported by one of the male nurse's comments that he is sometimes unsure as to whether he gives an accurate interpretation. It may be that some of the other participants have similar uncertainties.

Participants' openness and willingness to discuss issues regarding their knowledge of diagnostic terms and interpreting skills may suggest that they care about the interpreting

work that they do and that they would like to improve their knowledge of psychiatry and their interpreting skills. It may also be a reflection of participants' willingness to receive training in interpreting and psychiatry.

5.1.2 Skills and competency

Skills and competency of interpreters may have a major impact on accuracy. The competence of the interpreter is directly related to the quality of the clinician's explanation and to the quality of the patient's explanation. The accuracy of the clinician's diagnosis is also directly related to the quality of the interpreter's explanation of the patient's problem (Buthelezi, 1996). In this section the focus will be on training in interpreting, language skills, and training in mental health or psychiatry.

All ten participants reported that they had no formal training in interpreting. This may have a major negative impact on the attainment of accuracy since these employees acting as interpreters may not have the necessary skills to perform this duty.

According to the participants' own assessment, the two administrative clerks/interpreters fall within the group of participants with fluency in three or four languages. I only had participants' own assessments, and no additional language tests, as indication of their fluency. However, if the two administrative clerks/interpreters are, indeed, able to speak at least one language fluently and are able to speak the other three and two languages which they claimed they could on a basic level, the information gleaned may be extremely valuable. If patients in health care settings can be greeted in their home

language and be informed that an interpreter who is fluent in their home language will be made available to them, such reassurance may make patients feel calm and more at ease. The immediate establishment of such rapport may build a trust relationship between the patient and the service provider. For the purposes of this study, the majority of the participants, six in all, regarded themselves as fluent in only one language. Such a self-assessment poses many problems, since the aforementioned participants were, at the time of the study, being called on to do a great deal of interpreting at San Marco on a regular basis. The basic requirement for interpreters within any field, as indicated in the literature review, is to be at least bilingual (Buwalda, 2007). If interpreters are unable to speak the patient's language fluently, their inability to do so may well impact on the quality of the interpreting service that patients receive.

The two participants (the two psychiatrists) with the highest qualifications are among those who regard themselves as fluent in three languages. The two registered psychiatrists may, therefore, play a valuable role in mental health interpreting, since knowledge and training may enable an interpreter to detect valuable clues about the patient's mental health status, especially clues that lie in the grammatical structure, intonation and gestures used during an interview (Putsch, 1985). Employees with psychiatric training may feel more comfortable in interpreting for patients. Schlemmer and Mash (2006) have found that personnel with a medical background felt more comfortable with acting as interpreters than personnel without a medical background.

Furthermore, interpreters were asked about the training they have in psychiatry and to give their understanding of key diagnostic terms. The two psychiatrists who participated in this study have advanced knowledge and training in the field of psychiatry; however the same does not hold true for the other participants. For example, the male security guard responded, when asked about the training he has in psychiatry, by saying that he has training in as a security guard at a psychiatric institution. He had a very vague understanding of key diagnostic terms. It was not expected of participants to give a detailed definition of the key diagnostic terms presented to them. I did, however, want to see whether participants had a reasonable understanding of the key commonly used diagnostic terms being used, at the time of the study, in the institution. The male security guard described psychosis as: “sometimes when there is someone maybe smoking dagga or use other thing but he says his not alright. Maybe other people they smoke dagga they make it to the cigarette, after that they smoke dagga without mix, after that they can get mental”. A statement such as this strongly suggests that this participant has a very limited understanding of the term ‘psychosis’. The female security guard, likewise, although reportedly being trained in psychiatry, was able to only give a vague explanation of the term ‘depression’, when asked. She described depression as: “when you feel that something hurts you or something that you are not clear about that makes you angry”. Furthermore, she did not know the meaning of the commonly used diagnostic terms ‘psychosis’ and ‘mania’, and claimed not to have heard of the latter term. The female nurse was able to give only a vague description of the terms ‘mania’ and ‘depression’. One would not expect a trained nurse to define mania as: “when the person is like feeling like childish things”, and the term ‘depression’ as: “feeling sad at a specific time”⁵.

⁵ These quotations have been presented previously in section 4.1.3

Interpreters' inability to give their understanding of commonly used diagnostic terms will most probably result in an inaccurate interpretation since interpreters will not be able to pick up on diagnostic cues. In instances like these the most suitable short-term solution to finding trained interpreters is to develop training programs for bilingual staff (Bührig & Meyer, 2004).

5.1.3 Interpreters' experiences

Interpreters' experiences will be discussed under the following themes:

- work roles
- financial reward
- cultural aspects
- issues relating to power; and
- support and supervision.

5.1.3.1 Work roles

The two administrative clerks/interpreters were the only two participants (out of 9 participants) who reported that interpreting was part of their official job descriptions. No hospital records served to verify this finding. However, due recognition must be given to the fact that participants had this perception. All ten participants, except for one participant, reported that they acted as interpreters whenever they fulfilled their official duties as psychiatrists, nurses, security guards and administrative clerks/interpreters. These participants are therefore fulfilling dual work roles, and they may view interpreting as directly conflicting with their official work roles. The literature review revealed that

dual work roles and work conflicts may lead to employees feeling pressurised, distressed and overworked (Putsch, 1985). Overworked and distressed bilingual staff acting as interpreters may have a negative impact on accuracy and overall service delivery. Three out of the four nurses reported that they regarded the additional role of interpreter as forming part of their nursing duties. Such a perception may interfere with their official nursing duties, since nurses may therefore feel obligated to act as interpreters since they perceived interpreting to form part of their official work. This perception of the nursing staff may also hinder them from asking to be financially rewarded for fulfilling the role of interpreter, since they may feel that they are already being remunerated for doing so. Although the nurses reported that they perceived interpreting as forming part of their nursing duties, such a perception may not be the only reason why they were prepared to act as interpreters. The additional role of interpreter may advantage nurses who act as interpreters. The female nurse reported that the role of interpreter plays a crucial role in establishing a trust relationship between the nurse and patient, which might not have been possible if she did not act as an interpreter. However, the additional role of interpreter may also have disadvantages for the nurses since it may lead to them having to neglect their official nursing duties.

In addition to the abovementioned, consideration should be given to whether the role of interpreter can truly be considered a free choice. One of the male nurses reported that no demands were made on him to act as an interpreter and therefore he did not mind interpreting. Based solely on the interpreter's point of view, the need arises to consider what the implications would be if an employee was to refuse to act as an interpreter. The

possibility exists that employees may act as interpreters because they do not want to create the impression that they are unwilling to work. They may be concerned that a failure to act as an interpreter might jeopardise their official work.

5.1.3.2 Financial reward

Furthermore, all participants stated that they were not paid for fulfilling the additional role of interpreter. Although hospital records were not available to confirm whether participants were in fact paid for interpreting services the participants still had the perception that they were not paid to act as interpreters. Such a perception may negatively impact on their willingness and attitude to fulfil the role of interpreter and, of even greater importance, might negatively impact on the quality of the interpreting services. For example, one of the administrative clerks/interpreters expressed her concerns about having to pay her own petrol expenses when travelling between wards to act as interpreter. Her perception of not being paid to act as an interpreter might aggravate her concerns about having to pay for her own petrol expenses.

5.1.3.3 Cultural and religious beliefs

It is critical that mental health services implement strategies to make better use of the cultural skills of bilingual professionals (Mitchell, Malak, & Small, 1998). Buwalda (2007) for instance has argued that a competent interpreter in mental health is not only a language broker but also a cultural broker. Certain signs or symptoms may be under-reported or over-reported in a culture due to their taboo status or their valued status. Interpreters acting as cultural brokers may play a prominent role regarding cultural

proscriptions (or taboos) that may exist regarding the disclosure of information of psychiatric importance. Certain topics may be acceptable for routine inquiry by a clinician in one culture while it is unacceptable or taboo in another culture and interpreters may play a crucial role in informing clinicians what are considered as taboo issues within the patient's culture (Westermeyer & Janca, 1997). Interpreters may be aware of the crucial role they play as cultural brokers. One of the male nurses reported that he informs the clinician about the patient's cultural beliefs and act as cultural broker when acting as interpreter. One of the administrative clerks/interpreters also reported that patients may feel that their culture will be understood by the interpreter.

Interpreters' own cultural and religious beliefs may have an influence on the role of cultural broker. Eight out of ten participants reported that they did not personally believe in traditional explanatory models such as 'amafufunyana' and 'ukutwasa'. Belief entails regarding the thing believed in as part of one's reality. Interpreters who do not believe in traditional explanatory models may interpret patients' expression of their traditional beliefs as delusional and hallucinatory. However, the reverse situation can also occur. One of the administrative clerks/interpreters reported that she, at times, felt that patients were not suffering from psychiatric disorders, but that some patients were suffering from a cultural phenomenon. One of the male nurses reported that his own cultural and religious beliefs made it difficult for him to act as an interpreter, since patients told him that they did not suffer from a psychiatric condition, but that their condition was caused by cultural factors.

There is ample evidence suggesting that the majority of interpreters participating in this study were aware of the complexities that were related to the interpretation of cultural beliefs. Seven out of the ten participants reported that they did not interpret the patient's cultural beliefs while interpreting. Participants reported that they do inform the clinician about the patient's cultural beliefs and what it entails at some point during the interpreting session. Four out of the eight participants, which do not believe in traditional explanatory models such as 'amafufunyana' and 'ukutwasa', reported that they did not disregard their patients' belief in it. Nine participants reported that their own religious and cultural beliefs facilitated their understanding and interpreting for patients from the same cultural and religious background.

One participant's response does however illustrate the importance of trained interpreters with regard to the interpretation of cultural and religious beliefs. The female security guard reported that she would advise Xhosa patients not to seek the help of a sangoma (traditional healer), since doing so might worsen their condition. Advice like the abovementioned may lead to the patient feeling alienated and the patient may feel that the interpreter and clinician are disrespectful towards his/her culture.

5.1.3.4 Power issues

Five out of nine participants, consisting of the two psychiatrists, the two administrative clerks/interpreters and one of the male nurses, reported that rank played a role in their interpreting. Not one of the security guards perceived rank to play a role. It may be that

the security guards did not perceive that their own ranks played a role since they may perceive their ranks (compared to that of the psychiatrists and nurses) as less superior.

The role of rank is related to power differentials, and may impact on the accuracy of interpretation (Hobsin, 1996). This is supported by the following: One of the administrative clerks/interpreters reported that she tends to give her opinion as to whether the patient had a psychiatric disorder or not; however, she did not give the clinician her opinion if she disagreed with the clinician's opinion of the patient, since the clinician was knowledgeable and therefore in a better position to give his/her opinion. Furthermore, the two psychiatrists reported that they perceived themselves first and foremost as clinicians and not as interpreters. Such a perception may explain why they reported uncertainty to the clinician about the patient's condition and, in general, voicing their opinions regarding any issues relating to the patient's condition and the interpreting, while the security guards reported that they don't convey uncertainty⁶. Power differentials between the interpreter and clinician may determine how much each participant speaks, how much value is placed on what is said and the way in which each participant is treated. It also determine the status each participant has (Hobsin, 1996). Interpreters that perceive their rank as being subordinate to that of the clinicians may consequently feel that they are disempowered from conveying uncertainty.

Psychiatrists relying on interpreters for linguistic access to the patient are no longer the direct mediator of change. Although psychiatrists can still reach the patient directly through non-linguistic means the interpreter determines the impact of statements, which

⁶ The theme of conveying uncertainty will be discussed in more detail in section 5.2.

is the psychiatrist's most powerful tools (Bolton, 2002). All participants, except for the two security guards, reported conveying uncertainty to the clinician about the patient's condition and, in general, voicing their opinions regarding any issues relating to the patient's condition and the interpreting. Such reportage may indicate that the majority participants concerned perceived that they had a degree of power within the clinician–patient–interpreter triad. The perception of power was furthermore illustrated by the one male nurse who reported that he conveyed uncertainty and voiced his opinion, since he spent more time with the patients than the clinicians. The interpreters' possible perception of power may lead to more accurate interpreting, since the interpreters would convey any uncertainties to the clinician, thereby avoiding errors.

5.1.3.5 Psychological impact, support and supervision

The following quote⁷ illustrates the psychological impact that interpreting can have on interpreters and the importance of support and supervision.

P: I say that it's playing a role because um the thing what is happening to the patient is the things that is happening to our lives.

Results that emerged from the interviews strongly indicate that interpreters identify with the problems that patients disclose and that certain sensitive issues lead to distress. One of the male nurses reported that he found interpreting difficult, since he tends to place himself in the patient's position. Distressing issues mentioned by some of the participants were issues relating to abuse; the disclosure of HIV status, marital problems, substance abuse, patients' aggressive behaviour towards the interpreter, and contracting TB when

⁷ This quote has been presented previously in section 4.1.8

interpreting for patients. All of these issues may lead to vicarious traumatising through interpreters' identification with the abovementioned issues that may also play a role in their personal lives and in the lives of their loved ones. This is very problematic in light of the fact that seven out of ten participants that reported on the theme of support and supervision reported that they have no training on strategies to cope with distressing information. Furthermore five out ten participants were in favour of receiving support and supervision when acting as interpreters. A similar finding was reported in a recent study focusing on interpreters' needs working within mental health institutions. Miletic, et.al. (2005) found that the majority of interpreters that participated in the study acknowledged their need for debriefing and indicated that they had never been offered debriefing, and would prefer to receive it from a mental health clinician.

Participants were asked whether they would interpret for acquaintances, friends and relatives and all ten participants were in favour of such interpreting. This question was posed to participants in order to see what perceptions interpreters have on doing such interpreting. Interpreting for acquaintances, friends and relatives may have more of a psychological impact on interpreters compared to interpreting for strangers. Interpreters may find it difficult to be objective and not to intervene when interpreting for individuals with whom they share a personal connection. Only two participants stated having experience in interpreting for acquaintances, only one of whom reported that such demands can become problematic especially regarding issues of confidentiality. The other participant seemed to be optimistic about the benefits to be gained from interpreting for an acquaintance. This participant, one of the administrative clerks/interpreters,

reported that she interpreted for someone in her community and that her interpreting, along with her knowledge about the patient's condition, might have helped the person to receive treatment sooner than might otherwise have occurred. Some of the other participants without experience in the abovementioned explained why they would interpret for acquaintances, friends and relatives. One of the male nurses reported that his first priority was to help the patient and not whether the patient was someone with whom he was acquainted. It is possible that the participant's perception, of patients' needs that should receive top priority, relates to the issue of its being perceived as the nurse's duty to help and act as advocate for the patient. One of the other male nurses reported that he would interpret for an acquaintance, friend or relative if he was required to do so, since he believed that he was able to distinguish between his personal capacity outside the work environment and his professional capacity as a nurse. Personal matters would therefore not interfere with his work as nurse or interpreter. The fact that all ten participants were in favour of interpreting for acquaintances, friends and relatives does not imply that interpreters do not perceive that such interpreting may have more of a psychological impact on them. Only two of the ten participants reported that they have experience in interpreting for someone they knew and this may have an impact on interpreters' perceptions of such interpreting. However, it may be that interpreters will willingly expose themselves to interpreting situations that may have a psychological impact on them in order to help those that they care about.

It is not only sensitive issues or interpreting for acquaintances, friends and relatives that may have a major psychological impact on interpreters but also some of the following

issues. One of the administrative clerks/interpreters reported that interpreting becomes problematic when the patient thought that the interpreter was making the diagnosis and accusing him/her of being mentally disturbed. The male security guard reported that patients were at times aggressive and, therefore, that he was concerned for his own safety. Patients may become aggressive or emotionally upset due to the clinician's diagnosis and project their feelings on the interpreter who delivers the news (Hobsin, 1996). Interpreters expressed similar concerns in the study of Bot (2005) and reported that they felt concerned over patients not being aware of the procedure of interpreting and that they might be under the impression that the rendition of the therapist's words originated from the interpreter. One way of solving this problem would be for the interpreter to add a reporting verb to his or her renditions of the therapist's words (Bot, 2005).

One of the administrative clerks/interpreters and one of the male nurses reported that they had compassion for patients and felt blessed to be in a position to be able to help others. Such feelings in the absence of further training may paradoxically lead to the interpreter becoming over-concerned about the patients, which may lead to the interpreter leaving out certain information that might place the patient in a negative light. The female security guard reported that she became familiar with patients and that this may also lead to the interpreter being over-concerned about patients, especially in light of the fact that only one out of eight participants reported having received any formal training on boundaries. One male nurse also reported that the patients could not be forced to speak English, while the other male nurse reported that one could not expect all health care professionals to be able to speak Xhosa, making interpreting services essential. Such

views might lead to interpreters going out of their way to act as interpreters for clinicians and patients, that may, in turn, exert pressure on the interpreters. The male nurses involved in the study reported seeing themselves as being solely responsibly for solving problems caused by a lack of interpreters in San Marco. Furthermore, the participants perceived ideal interpreting as entailing that interpreters providing patients with the opportunity to express themselves; an improvement of the patient's condition; being able to interpret all that the patient wanted to convey; delivering a satisfying interpretation from which both patients and clinicians could improve; and ensuring that patients received the right medication. This perception of what the role of the interpreter entails is an unrealistic perception. Interpreters, who have no training in interpreting and who are unofficial interpreters, should not feel responsible for all of the abovementioned. The institution should stipulate interpreters' responsibilities.

Also, interpreters' difficulties with technical issues may lead to distress. The female psychiatrist reported that interpreting became problematic when the patient was focused on circumstansiveness and expansiveness and the clinicians were focused on receiving a 'no' or 'yes' response from the patient. The male psychiatrist reported that interpreting became problematic when he had to explain issues of psycho-education to the patient's family. One of the male nurses reported that he was, at times, uncertain as to whether he had given an accurate interpretation. This may indicate that the interpreters concerned were perhaps aware of the technical difficulties that accompany interpreting and that they felt that they did not have the necessary training to be able to deal with it.

5.1.3.6 Ethical issues

One out of eight participants was unfamiliar with the term ‘patient confidentiality’. Such lack of familiarity is problematic, since it might lead to the interpreter divulging information regarding the patient and this could lead to legal complications and give the institution a bad reputation.

5.2 Technical aspects and methods of interpretation

The aim of the study is not to dictate what an accurate interpretation is but rather to understand to some extent what factors might lead to or prevent the obstruction of accuracy. This section discusses techniques and methods of interpretation that might play a role in obtaining accuracy.

All ten participants reported that they preferred the clinician to be present while they act as interpreters. Some participants reported that the clinician might detect certain issues that they were unable to detect. The clinician, especially in the case of untrained interpreters, may play a valuable role in detecting diagnostic cues that lies in intonation and non-verbal aspects (Putsch, 1985).

The following factors were found to influence preference as to the use of either paraphrasing or word-for-word interpreting: problems relating to language equivalency; failure of the patient to understand the clinicians’ terminology; the tendency of patients to elaborate widely; and more subjective factors. One participant perceived that word-for-word interpreting enabled an interpreter to stay true to what the patient and clinician were

saying and to prevent omissions. However, such word-for-word interpreting may not always enable an interpreter to stay true to the meaning of what was being said. A literal interpretation may not be maximally accurate as indicated by Swartz and Turner (2006). Another participant used word-for-word interpreting in instances that she gained the impression that what the patient said held meaning. The literature review revealed that interpreters trying to make sense of the patients' statements may, lead to a limited interpretation to what the patients said, neglecting how the patients said it (Marcos, 1979).

Another issue relating to the interpreters' use of different methods is whether the interpreters used a standard set of questions that were cued by the clinician or whether they used their own new wording based on the clinician's wording. Only two out of nine participants were found to use a standard set of questions that were cued by the clinician, while the other seven participants reported that they used their own new wording based on the clinician's wording. The reason for the majority of participants using their own new wording may be due to patients having different registers than the clinician and by using their own new wording interpreters may try to ensure that there is equivalence in terms of content.

The majority of participants reported that they used the clinician's clarifying questions and not their own. Participants may perceive the clinicians to be more knowledgeable than themselves regarding diagnostic information leading to a decision to use the clinician's own clarifying questions. The minority of participants, that reported that they

rather use their own clarifying questions, may be more experienced and knowledgeable of diagnostic aspects. Another reason mentioned by one of the male nurses is that he spend more time with the patients than the clinician and is therefore able to provide crucial information about the patient's condition.

Another factor that may relate to register is that of patients seeing traditional healers before the former are admitted to San Marco. One of the male nurses reported that interpreting becomes problematic when the patient went to a traditional healer before seeking help from psychiatric services. As indicated in the literature review, errors relating to jargon often involve language problems related to the health professional's unfamiliarity with traditional health practices and the associated vocabulary (Diaz-Duque, 1982). Interpreters may also find it difficult to identify and translate many of the terms used in traditional healing, since a traditional healer might use unfamiliar terminology that the patient did not understand. Consequently, the patient might neither be able to explain what really took place nor to give a history of his/her sickness or the traditional treatment that he/she had received (Diaz-Duque, 1982).

Time constraints may also influence accuracy. Nine out of ten participants reported that use of an interpreter was much more time-consuming than when no interpreter was needed. They are therefore aware of the time constraints due to the use of an interpreter. Such time constraints might influence the clinicians' attitude towards interpreters, since the former might become frustrated during very busy periods. The time constraints may also influence employees who have to fulfil dual work roles, since they might be

concerned about the amount of time that they have to spend each day on interpreting. Such employees may invest much time and energy in their extra work role, for which the participants reported that they were not being remunerated.

5.3 Practical exercise

In this section the following issues will be discussed:

- possible implications of a literal interpretation
- additional information and variations of the same question
- omissions
- discrepancies between the questions that interpreters were given to translate and their back-translations of these questions; and
- an inability to translate certain words and phrases.

The abovementioned issues will be discussed by focussing on the practical exercise (see tables 4.3.1-4.3.9). Translations and back-translations of key diagnostic questions will be discussed only if it is relevant to the discussion topic under each sub-heading. The key diagnostic question will be presented prior to the discussion thereof. In the following discussion emphasis will be placed on independent-translators' back-translations of participants' translations. Independent translators' back-translations may be representative of patients' interpretations of these translations within an actual interpreting session.

5.3.1 Literal interpretation

As mentioned in the Results chapter, the two participants commonly used to interpret for Afrikaans-speaking patients gave literal translations of all the English diagnostic

questions. Participants might have given literal translations due to the existence of equivalent Afrikaans words. However a literal translation is not necessarily optimally accurate as will be seen in the discussion on literal translations that arose from the Xhosa translations.

- Do you hear voices?

A literal translation of the abovementioned question is not optimally accurate. In the field of psychiatry this question refers to an abnormal phenomenon. The aim of the question is to establish if the patient is hearing voices of someone they can not see. Only one out of the eight participants took this into consideration and added the question “voices of people you cannot see?”.

- Are you afraid that people want to hurt or poison you?

Six out of eight participants gave a literal translation of the abovementioned question. A literal translation may not elicit information that may be indicative of psychopathological issues such as delusions or hallucinations.

- Have you been bewitched?

Six participants gave literal translations of the abovementioned question. A literal translation does not explain what is meant by the word ‘bewitched’. Patients may not be familiar with the term or patients may know a different term and may therefore deny that they feel that they have been bewitched. It may be beneficial for interpreters to first of all

establish if patients are familiar with the term ‘bewitched’ and to explain what is meant by it.

- Do you feel sad?

A literal translation of the abovementioned question may not convey that this is a question asking about extreme sadness that can be considered as abnormal. The patient may interpret this literal translation of the question as a question asking about sadness that is not pathological in nature.

5.3.2 Additional information and variations of the same question

Additional information and variations of the same question was gleaned by looking at participants’ own and at independent translators’ back-translations.

- Have you been bewitched?

One participant used the question ‘have you been cast a spell at before?’ and the word ‘believe’ in addition to the question ‘have you been bewitched?’. The word ‘believe’ may aid in establishing if the patient is convinced of being bewitched which may be indicative of delusions. It may be beneficial to add the question ‘have a spell been cast on you in the past?’ since patients may be more familiar with this phrase than with the term ‘bewitched’. The male security guard translated the question ‘have you been bewitched?’ as “are you a witch?”. This is not at all the same as the question asked and should not be used as substitute for the question ‘have you been bewitched?’.

- Do you have special powers or abilities?

One of the participants added the phrase “powers to heal people” to the question ‘do you have special powers or abilities?’. This additional phrase may be interpreted by the patient as a normal gift to help people and it may not elicit cues indicative of an abnormal belief in his or her powers and abilities. It also limits the meaning of “special powers” as patients may believe they have special powers, but not to heal people. There were discrepancies between the male psychiatrist’s own back-translations and that of the independent translators regarding the question ‘do you have special powers or abilities?’. The independent translators translated the male psychiatrist’s translation as “anything you can do”. This does not at all have the same meaning as ‘do you have special powers or abilities?’. The patient may interpret this as a question asking about his or her talents.

- Do you feel depressed?

The male psychiatrist and one of the male nurses used the phrase “spirit feeling down” in stead of asking ‘do you feel depressed?’. This phrase may be a better description of the word ‘depressed’ especially in instances where patients come from a more traditional back-ground and when they are unfamiliar with the term ‘depressed’. The following phrases were also used interchangeable with the term ‘depressed’: ‘feeling worried’, ‘something bothering’, ‘feeling uncomfortable’ and ‘feeling very sad’. All of the abovementioned phrases are to some extent descriptive of the term ‘depressed’ but should not be used as substitute since these phrases are also descriptive of other aspects not particularly related to the term ‘depressed’ and can for instance be used to ask about ‘sadness’.

- Do you feel anxious?

The word 'worried' was used interchangeably with the term 'anxious' in the translation of the question 'do you feel anxious?'. The word 'worried' should rather be used in addition to the word 'anxious' and not as substitute. None of the eight participants asked whether patients were excessively worried. One of the independent translators back-translated one of the participant's translation of the abovementioned question as "you're alert?" which may elicit cues indicative of physical symptoms that are normally accompanied by a state of anxiety. The male security guard back-translated his translation of 'do you feel anxious?' as "are you still ok?" This phrase is not at all the same as the question 'do you feel anxious?'. The patient may perceive him or herself to be 'ok' in general but may still be anxious. One of the administrative clerks/interpreters back-translated her translation of the question 'do you feel anxious?' as "not feeling you?" This phrase may be indicative of dissociation that may accompany a state of anxiety and should not be used as substitute but rather in addition to the question 'do you feel anxious?'.

- Do you feel sad?

The word 'worried' was also used as substitute for the word 'sad'. The problem here is that the same word may be used for 'sad' or 'worried' in Xhosa.

- Have you lost interest in pleasurable activities?

One of the independent translator's back-translations (of the of the female security guard's translation of the abovementioned question) contained the additional phrase “have no energy irrespective of any games?” The interpreter should explain to the patient not to interpret this literally since it may lead to some confusion. It should be clear to the patients that the interpreter is referring to pleasurable activities, which extend further than games or sport activities. One of the administrative clerks/interpreters added the phrase “pleasurable activities like soccer” to the original question. This phrase may clarify what is meant by pleasurable activities.

- Have you felt excessively happy, irritable or energetic?’

The independent translator’s back-translations (of one of the administrative clerks/interpreters' translation of the abovementioned question) included the additional question “feeling very strong?”. The patient may interpret this as a question asking about physical strength and not about mental or emotional strength. The independent translators’ back-translations of the male nurse’s translation of the original question included the additional phrase “very uninterested” and the word “bored”. This word and phrase do not convey the same message as intended with the original question since it does not relate to the words ‘happy’, ‘irritable’ or ‘energetic’. Furthermore, two participants’ own back-translations and that of six of the independent translators revealed that the word ‘energetic’ was replaced by the following phrases: “feeling very strong” and “have more power and ambition”. These phrases should not be used as replacement but rather in addition to the term ‘energetic’.

I am not suggesting that interpreters should be extremely rigid and use only specific words and phrases to translate the nine questions given to them since each patient has his or her own jargon and register. However the above discussion clearly suggests that the use of certain words and phrases may lead to errors and misunderstandings. It would be best if the clinician and interpreter discuss which words and phrases would be best to use within a particular interpreting session.

5.3.3 Omissions

- Are you afraid that people want to hurt or poison you?

Two participants' (the male security-guard and one of the administrative clerks/interpreters) translations and their back-translations as well as that of the independent translators did not include the word 'poison' nor were there any words or phrases referring to it. One of the male nurse's own back-translations included the word 'poison' however the Xhosa word for 'poison' was not included in his translation nor was it included in the back-translations of the independent translators.

- Have you felt excessively happy, irritable or energetic?

The female nurse's own back-translations and that of the independent translators did not include the word 'irritable' nor were there any words or phrases that referred to this word. Furthermore, there was no reference to the words 'happy' and 'irritable' in the back-translations given by the independent translators of one of the administrative clerks/interpreters. One of the administrative clerk's translations and back-translations as

well as the back-translations of the independent translators did not include the word 'energetic'.

All of the abovementioned omissions may for obvious reasons lead to an inaccurate interpretation and since the clinician is unable to understand the patient's language he/she will most likely be unable to pick-up on these omissions.

5.3.4 Inability to translate

The male security guard was unable to translate the question 'do you feel sad' and unable to translate the words 'irritable' and 'energetic'. It may be that the participant was anxious during the interview and could not on the spot recall what the translations of these words were. However one would expect someone that act as an interpreter on a regular basis to know how to translate these frequently used words and questions. Furthermore, the male psychiatrist was unable to translate the word 'poison'. Again, it might be that the participant was unable to translate this word on the spot. This was the only occasion that he could not translate a word or question. The female security guard did not know what the term 'anxious' meant. This is very worrying since the term 'anxious' is a commonly used term in psychiatric institutions and according to the female security guard she has been acting as interpreter on a regular basis for five months. If interpreters do not inform the clinician present that they are unable to translate certain words and phrases and merely leave out this information, it may lead to a lack of accurate information which may have a negative impact on the diagnosis.

In conclusion, participants' translations of the nine questions were approximately right. Participants' translations conveyed more or less the same content as what was intended with the original English questions. In fact the translations were fairly accurate for untrained interpreters. However, participants were not always specific as to what they were asking about. Interpreters need to translate questions in such a way that it is diagnostically specific in order for the clinician to make an accurate diagnosis. It is crucial that patients have a clear understanding about what the interpreter are asking them and this was not always evident in participants' translations.

The discussion chapter has provided a detailed discussion on the study's findings. In the next chapter the essence of this study's findings will be highlighted and suggestions for further research will be given.

6. CONCLUSION

The study's finding regarding the distress that interpreters experience due to various issues relating to interpreting is consistent with other studies focusing on the psychological impact of interpreting on interpreters (Lipton et al., 2002). It is crucial that interpreters are provided with support and supervision to cope with the psychological impact that interpreting may have on them. Support and supervision also plays an essential role in the obtainment of an accurate interpretation.

An analysis of actual recorded interpreting sessions between the clinician, patient and interpreter is necessary for a more in depth understanding of the obstruction of accuracy as investigated in this study. The analysis of data collected in this study did however reveal the following important information:

- not all of the participants who act as interpreters are in fact functionally bilingual in the context in which they work
- not one interpreter is trained in interpreting; and
- a clear distinction could be drawn between interpreters who have training in mental health compared to those who lack training in mental health.

These problems are basic. It is reasonably obvious that a lack of linguistic skills and a lack of training can lead to inaccurate interpretation. However, the difficulty is not with the commitment of interpreters such as those I interviewed. Eight out of the ten participants do interpreting as an additional work duty for which they are not financially rewarded. All of the participants declared a strong commitment to act as interpreters,

even though this added to their work load, but did not give them any financial rewards or recognition in terms of job descriptions. I perceived all participants to be very concerned and caring for patients and for patients' right to speak in their mother tongue. Some of the participants stated that they are eager to have training in interpreting. The problem therefore can be attributed rather to challenges in a health system which has inherited a history of discrimination and continues to discriminate against certain patients, even when clinicians and interpreters and clinicians alike may be doing their best not to discriminate. The problem is structural rather than individual, and needs to be addressed as such, and in the context of competing demands in public health care.

The information gleaned in this study is indicative but not sufficient to make the best case possible for a dramatic reconceptualization of language issues in public mental health in this hospital and province. Data are needed on practices from other health care centres in the Western Cape. Data are also needed on what happens in terms of language, understanding and misunderstanding in actual interpreted interviews, and such a study is currently in a planning stage. This study is probably more urgent in terms of providing convincing data for policy-makers than more subtle issues and questions that emerge from the current study, such as that of whether, as claimed by a respondent in the current study, particular language barriers may arise when the patient has consulted a traditional healer before seeking the help of a clinician. This question, which is a question about discourse and register of language used, is an important one, but the fundamental issues of interpreters who are not fully bilingual, who are untrained both in interpreting and in mental health, and who are not always financially rewarded, need urgent attention. Paid

interpreters will have a place in the health care system only if they receive comparative status and if institutions prove that they have the ability to contain radical social change and if they commit to thoroughgoing change (Crawford, 1996). Much of the literature on language and mental health services in South Africa comes from the apartheid era, furthermore. We need to be bold enough to ask questions as to why it remains politically acceptable in a democracy which prides itself on inclusion and the promotion of human rights, for the language practices at a major public health facility to be beset by substantially the same challenges which occurred when exclusion and discrimination were written into policy. These issues are complex and costly, but progressive realisation of policies of equal access and non-discrimination is something that needs to be addressed and measured.

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APPENDIX

In this section each category will be given followed by the codes (with definitions thereof) that fall within a particular category and each code will be followed by those participants' report that represent a code. Each participant's report is numbered from one to ten (see below). Dialogue significantly illustrating the essence of a particular code will at times be presented.

- No.1: The female psychiatrist
- No.2: The male psychiatrist
- No.3: One of the male nurses
- No. 4: The female nurse
- No.5: The male security guard
- No.6: The female security guard
- No.7: One of the administrative clerks/interpreters
- No.8: One of the administrative clerks/interpreters
- No.9: One of the male nurses
- No.10: One of the male nurses

INTERPRETERS' TRAINING AND SKILLS

Interpreting experience: the time that participants have been acting as interpreters within any field.

- (1.) The participant had approximately 23 years experience in interpreting.

- (2.) The participant had approximately 8 years experience in interpreting.
- (3.) The participant had less than a year experience in interpreting.
- (4.) The participant had more than 8 years experience in interpreting.
- (5.) The participant had approximately a few years (the participant was unable to give an exact indication) experience in interpreting.
- (6.) The participant had approximately 5 months experience in interpreting.
- (7.) The participant had approximately 5 to 6 years experience in interpreting.
- (8.) The participant had approximately one year experience in interpreting.
- (9.) The participant had approximately 3 years experience in interpreting.
- (10.) The participant had approximately more than 10 years experience in interpreting.

Interpreting experience within a period of : a few months to 1year	Interpreting experience within a period of: 1 to 5 years	Interpreting experience within a period of : 5 to 10 years	Interpreting experience within a period of : 10 to 25 years
3 participants	1 participant	4 participants	1 participant

Training in interpreting: participants' formal training in interpreting.

- (1.) The participant had no formal training in interpreting.
- (2.) The participant had no formal training in interpreting.
- (3.) The participant had no formal training in interpreting.
- (5.) The participant had no formal training in interpreting.
- (6.) The participant had no formal training in interpreting.
- (7.) The participant had no formal training in interpreting.

- (8.) The participant had no formal training in interpreting.
- (9.) The participant had no formal training in interpreting.
- (10.) The participant had no formal training in interpreting.

Training in psychiatry: participants' formal training in psychiatry and their understanding of key diagnostic terms such as 'anxiety', 'mania', 'psychosis' and 'depression'.

- (1.) The participant was a registered psychiatrist.
- (2.) The participant was a registered psychiatrist.
- (3.) The participant received formal training in psychiatry as part of his training in nursing.
- (4.) The participant was not specific to the training she had had in psychiatry. She merely reported that she did psychiatry. It may be assumed that the participant referred to psychiatric training that formed part of her training in nursing, since she reported that she was a qualified nurse.
- (5.) The participant had no formal training in psychiatry. However, the participant reported that he had informal training in psychiatry since he had received training as a security guard at a psychiatric institution.
- (6.) The participant received basic formal training in psychiatry through completing a free course at the department of health.
- (7.) The participant was formally trained in psychiatry by San Marco.
- (8.) The participant had no formal training in psychiatry but had informal training while working as an interpreter at San Marco.

- (9.) The participant received formally training in psychiatry as part of his training in nursing.
- (10.) The participant received formal training in psychiatry as part of his training in nursing.
- (3) The participant gave basic explanations of the key diagnostic terms and his understanding of these terms was fairly accurate. He gave accurate examples of symptoms to illustrate his understanding of the diagnostic terms.
- (4) The participant gave vague and inaccurate explanations of the diagnostic terms that she was asked to explain.

P: Ja it's just feeling sad at a specific time

I: Ok and mania if someone is manic?

P: When the person is like feeling like childish things.

- (5) The participant was unable to give accurate explanations of the key diagnostic terms and gave vague examples thereof.

I: Ok, and what do you understand about psychosis?

P: Sometimes when there's someone maybe smoking dagga or use other thing but he says his not alright maybe other people they smoke dagga they make it to the cigarette. After that they smoke dagga without mix, after that they can get mental.

- (6) The participant had a vague idea of the meaning of the diagnostic terms and was unable to give accurate explanations thereof.

I: Can you give me just your explanation or definition of depression?

P: Depression is like when you feel that something hurts you or something that you are not clear about that makes you angry

I: Mhu

P: Then you don't know what the outcome, you don't have the solution of this and then it stuck in your mind and it makes your head ache and then you can't cope just leave it like that

I: And your definition or understanding of psychosis?

P: Psychosis

I: Ja

P: What is that thing?

I: Um, it is when someone is or psychotic have you heard of that?

P: Mm

I: So what do you understand under then psychotic?

P: Ok, I then as I told I just have little bit of basic

I: Ja, no I'm not looking for a right or wrong answer I'm just want to know how you understand it

P: Ok, I understand when the patient is psychotic because sometimes he can say just imagining and then you must understand there is sometimes the mind that she is thinking and not the mind she have before it's just the other mind now

I: Ok

P: What's going on to the head it's just up in the head in her head

I: Ok and your definition of mania? Have you heard of mania?

P: No.

(7) The participant was able to give simple yet accurate explanations of the diagnostic terms and gave accurate examples to illustrate her explanations.

(8) The participant was unable to give an explanation of the diagnostic terms.

However, the participant was able to give examples of specific symptoms that are illustrative of the terms.

I: But you're understanding of depression?

P: Um a person who is depressed you can even see her or she in her face the person is depressed

I: Ja

P: The way they speak, saying things, the looks

I: Ok and what is your definition of psychosis?

P: Um you can see a person who is, I don't know how to say it

I: So when a person is psychotic

P: Exactly ja

I: How would you see it?

P: A the looks first of all

I: And how would that look?

P: Sometimes the way their laughing

I: Ok

P: And smiling and the appearance

I: Ok

P: Ja and what can I say now. The way they talk saying things

I: Mhu

P: They jump to point to point

I: Ok and what is your understanding of mania?

If someone is manic?

P: Uh someone who is manic is today is sort of, today his nice after 5 minutes he's smiling and after that crying.

- (9) The participant gave basic accurate explanations of the diagnostic terms and gave accurate examples thereof.
- (10) The participant gave basic accurate explanations of the diagnostic terms and gave accurate examples thereof.

Coping skills: participants' training on coping skills to deal with distressing information that may be encountered while interpreting.

- (3) The participant received basic training on coping skills as part of his training in nursing.
- (5) The participant received no training on coping skills.
- (6) The participant received no training on coping skills.
- (7) The participant received no training on coping skills.
- (8) The participant received no training on coping skills.
- (9) The participant received no training on coping skills.
- (10) The participant received no training on coping skills.

Language proficiency: the languages spoken by participants and their fluency in these languages.

- (1.) The participant speaks English, Xhosa and Afrikaans and regarded herself as being fluent in all three of these languages.
- (2.) The participant speaks English, Xhosa and Zulu and regarded himself as being fairly fluent in all three of these languages.
- (3.) The participant speaks Xhosa, English and Afrikaans. He is reportedly fluent in Xhosa, fairly fluent in English and not fluent in Afrikaans.
- (4.) The participant speaks Xhosa, English and Afrikaans. She is reportedly fluent in Xhosa and to a certain extent fluent in English and Afrikaans.
- (5.) The participant speaks Xhosa fluently and is to a certain extent fluent in English.
- (6.) The participant speaks Xhosa and English and is able to understand, but can not speak, Afrikaans. The participant is fluent in Xhosa, to a certain extent fluent in English and not fluent in Afrikaans.
- (7.) The participant speaks Xhosa, Zulu, English and Afrikaans and regarded herself as fluent in all these languages.
- (8.) The participant speaks Afrikaans, English and Xhosa and regarded herself as fluent in all these languages.
- (9.) The participant speaks Afrikaans, English and has basic Xhosa language skills. He is reportedly fluent in Afrikaans, to a certain extent fluent in English and not fluent in Xhosa.

(10.) The participant speaks Afrikaans, English and has basic Xhosa language skills.

The participant regarded himself as fluent in Afrikaans, to certain extent fluent in English and not fluent in Xhosa.

ASPECTS RELATING TO THE INSTITUTION

Job descriptions: participants' perceptions of whether interpreting was part of their job descriptions.

(1.) The participant reported that interpreting was not part of his job description.

(2.) The participant reported that interpreting was not part of his job description.

(3.) The participant reported that interpreting was not part of his job description.

(4.) The participant was unable to indicate whether she perceived interpreting to be part of her job description and reported that she considered it to be part of her nursing duties.

(5.) The participant reported that interpreting was not part of his job description.

(6.) The participant reported that she was unsure if interpreting was part of her job description.

I: Ok is interpreting part of your job description?

P: Um, not sure

I: But when they um appointed you did they say that you have to do interpreting as well or is it just a favour they ask of you?

P: Um, I think its part of my work because I'm in the ward then I have to be between the doctors and nurse, assist wherever

I: O, ok

P: Because it's also the patient because I'm there for the patient, anything they need according to the patient then I can assist

- (7) The participant reported that interpreting was part of her job description.
- (8) The participant reported that interpreting was part of her job description.
- (9) The participant reported that interpreting was not part of his job description
- (10) The participant reported that interpreting was not part of his job description.

Financial compensation: whether or not participants were financially rewarded for acting as interpreter.

- (1) The participant reported that she was not financially rewarded for fulfilling the role of interpreter.
- (2) The participant reported that he was not financially rewarded for fulfilling the role of interpreter.
- (3) The participant reported that he was not financially rewarded for fulfilling the role of interpreter.
- (4) The participant reported that he was not financially rewarded for fulfilling the role of interpreter.
- (5) The participant reported that he was not financially rewarded for fulfilling the role of interpreter.
- (6) The participant reported that she was not financially rewarded for fulfilling the role of interpreter.

- (7) The participant reported that she was not financially rewarded for fulfilling the role of interpreter.
- (8) The participant reported that she was not financially rewarded for fulfilling the role of interpreter.
- (9) The participant reported that he was not financially rewarded for fulfilling the role of interpreter.
- (10) The participant reported that he was not financially rewarded for fulfilling the role of interpreter.

Institutional set-up: the institutional set-up with regards to how participants were called to do interpreting within the institution.

- (1) The participant was generally part of the treatment team going on ward rounds and was therefore present when the use of an interpreter was required.

P: No, it's very much ad hoc. Often for me it's generally a clinical situation

I: Ja

P: Where the person is Xhosa speaking and nobody else is available either in ward rounds, in tea meetings, seeing patients often I would take on all the Xhosa-speaking patients in that section um to be able to manage the language aspects and then occasionally I'd be asked to come and see a patient with someone

I: Mm

P: In order to be able to interpret

(2) The participant was generally part of treatment team that go on ward rounds and was therefore present when the use of an interpreter was required. There were only a few occasions where the participant was not present and was called to act as interpreter.

(3) The participant worked within the ward as a nurse and was called to act an interpreter when needed within the ward.

P: How do they call me. No people normally ask me people while working maybe one of the doctors has got a problem a language barrier then they would just go out of there maybe

(4) The participant worked within a particular ward as a nurse and was called to act as interpreter when needed within the ward.

(5) Previously the participant worked as security guard at the main gate of San Marco and was called to act as interpreter at the different wards. However, at the time of the study, the participant was allocated at a specific ward and only acted as interpreter at this ward.

P: I was working there by the main gate before

I: O ok. I see

P: They call me there by the gate to go to admission ward.

(6) The participant was allocated to a different ward each day and was called to act as interpreter at the ward where she was allocated for the day.

(7) The participant used to work as a cleaner in one of the wards and was called to act as interpreter within this ward. However, at the time of the study, the participant

was employed as an administrative clerk/interpreter at the same ward and was called to act as interpreter within this ward while conducting administrative work.

P: When I was working here, I was just working here at San Marco as a cleaner

I: Ok

P: And when I was just doing the cleaning I found out that most of the patients and the doctors and the sisters as well, they do struggle to get exactly what does the patient say and about the sickness or her sickness.

- (8) The participant was called to act as interpreter at different wards whenever needed and had to travel between the wards.
- (9) The participant worked as a nurse within one of the wards and was called to act as interpreter within this ward.
- (10) The participant worked as a nurse within one of the wards and was called to act as interpreter within this ward.

TECHNIQUES AND METHODS OF INTERPRETATION

The clinician's presence: participants' views regarding the role of the clinician's presence while interpreting.

- (1) The participant preferred the clinician to be present since it benefited the relationship between the clinician and patient. However, the participant would not interpret sensitive issues in the presence of a group of clinicians when the patient was paranoid.

P: I think it's useful to have clinicians present

I: Mhu

P: If you have a good enough relationship with a client where you have already established dialogue

I: Ja

P: I think it's useful because there is so much around body language and interestingly people do follow the train and the mood and the intonation all those things are as important so I think the non-verbal stuff and the background noise is important

I: Ok

P: And so particularly if you are not the primary physician looking after the patient, if you are assisting with interpretation and somebody else is looking after the patient at least at some level they have contact where as seeing a patient on your own

I: Ja

P: And then having that person look after the patient means the experiences are different one.

- (2) The participant preferred the clinician's presence since it gave the clinician the opportunity to clarify uncertainties and to give additional questions.
- (3) The participant preferred the clinician to be present, since the clinician was able to identify diagnostic cues that lied in non-verbal aspects and this made the work of the interpreter easier.
- (4) The participant preferred the clinician to be present. The clinician was able to pick up on anything that was missed or omitted by the interpreter.

- (5) The participant preferred the clinician to be present.
- (6) The participant preferred the clinician to be present.
- (7) The participant preferred the clinician to be present since the clinician was able to make field notes on the patient's behaviour and on anything missed or omitted by the interpreter.

P: And he's gonna say exactly. It's better when the doctor is here

I: Ok and why do you say its better?

P: I said it's better because the doctor while you do interpreting

I: Yes

P: He's busy writing

I: Ok

P: Otherwise I might miss something some stuff what is suppose to be saying that same time if the doctor was here.

- (8) The participant preferred the clinician to be present so that the patient was aware of the fact that it was not the interpreter but the clinician making the diagnosis.
- (9) The participant preferred the clinician to be present, since the clinician was able to identify diagnostic cues that lied in non-verbal aspects and this made the work of the interpreter easier.
- (10) The participant preferred the clinician to be present, since the clinician was more knowledgeable of diagnostic cues.

Paraphrasing vs. word-for-word interpreting: participants' use of paraphrasing and word-for-word interpreting.

- (1) The participant reported that she generally used paraphrasing. The participant was of the opinion that through paraphrasing she was able to firstly comprehend what the patient wanted to convey to the clinician. The participant reported that there was a bigger room for error when using word-for-word interpreting and that language equivalency made the use of word-for-word interpreting more difficult.

The following dialogue arose:

P: Generally paraphrase

I: And why do you do it that way? Why do you paraphrase?

P: Because sometimes the words don't exist

I: Mm

P: In Xhosa

I: Ja

P: And mainly Xhosa, Afrikaans is not such not so much of an issue

I: Mm

P: But, there particularly rather emotional terminology um there are sometimes much more concrete ways of describing what in English is described in an emotional way. So I find it much more useful to really understand where the patient is at

I: Mm

P: To paraphrase that I might miss, if I do word-for-word interpreting there's a bigger room for error.

- (2) The participant reported that he generally used paraphrasing since word-for-word interpreting was too problematic.

- (3) The participant reported that he would start the interpreting session with the use of word-for-word interpreting. However he would use paraphrasing in instances where the patient was uncertain about the message conveyed to him/her.
- (4) The participant reported that she used paraphrasing since patients often don't understand the terminology used by clinicians. The participant also used paraphrasing when the patient gave a lot of information and when there was no meaning in the patient's dialogue. However, word-for-word interpreting was used instances that the participant was of the opinion that there was meaning in what the patient was saying.

I: Um do you tell the doctor exactly what the patient said word for word or do you say it in your own words in a little bit of a shorter version?

P: Uh sometimes I do tell word for word

I: Ok

P: When I feel it's got a sense in it but sometimes the patient will put very long and then I have to make it shorter.

- (5) The participant used word-for-word interpreting since this method of interpretation enabled him to stay true to that being said by the patient and clinician.
- (6) The participant used word-for-word interpreting since it enabled her to stay true to that being said by the patient and clinician and it prevented omissions.
- (7) The participant used word-for-word interpreting since this method of interpretation ensured that she stayed true to that being said by the patient and clinician and it prevented omissions.

- (8) The participant used both word-for-word interpreting and paraphrasing depending on language equivalency.

P: Um sometimes I listen and say directly but sometimes I have to do it in my traditional ways

I: Ok

P: Because there are things I can't say just "you are mad", it doesn't sound to us

I: Ok can you just give me an example?

P: Like when the doctor says you are mad I can't just say "uyaphambana", you understand?

I: Ok

P: Which means mad, which is rude in our culture

I: Ok

P: I must put it in a right way you are mentally disturbed. Then the patient understand but if I say you are mad

I: Ja

P: The patient will like fighting with me

I: Yes

P: So I must have a way to say

I: How you explain that to the patient cause that's quite difficult to do?

P: Uh 'uyaphambana' is you are mad, but I must say you are mentally disturbed and I will say "uphazazemekile uqonwe" so which the person understand

I: So the sickness of the head.

- (9) The participant used paraphrasing since patients often elaborated to a great extent.
- (10) The participant used word-for-word interpreting since it ensured that the interpretation was true to that being said by the patient and clinician.

The use of a standard set of questions: participants' use of a standard set of questions cued by the clinician or the use of their own new wording based on the clinician's words.

- (1) The interpreter used her own wording since she was well informed about the nature and aim of the questions being asked as she was a psychiatrist and often a member of the team treating the patient.

P: So, I have an understanding because of training

I: Ja

P: Of what we are looking for say in a psychiatric interview around mood, around affect, around anxiety, um psychosis

I: Mhu

P: So there's a group of words that I've got accustomed to using with patients

I: Ok

P: That I would tend to stick with.

- (2) The interpreter used his own wording since he was well informed about the nature and aim of the questions being asked as she was a psychiatrist and often a member of the team treating the patient.

- (3) The participant used his own new wording based on the clinician's words.
- (4) The participant used her own new wording based on the clinician's words.
- (5) The participant used his own new wording based on the clinician's words.
- (6) The participant used her own new wording based on the clinician's words.
- (8) The participant used a standard set of questions cued by the clinician.

I: Do you have a standard set of questions that the doctor gives you or do you use your own new words based on the doctor's words?

P: Um I'm using the doctor's words

I: Ok so um does the doctor give you a standard set of questions?

P: Yes, the doctor tell me tell the patient that and that and that and I tell the patient that and that

I: So it's normally the same questions they give

P: Yes, normally the same.

- (9) The participant used his own new wording based on the clinician's words.
- (10) The participant used a standard set of questions cued by the clinician.

Clarifying: participants' views on the use of their own clarifying questions or those provided by the clinician present.

- (1) The participant used her own clarifying questions.
- (2) The participant used the clarifying questions of the clinician present.
- (3) The participant used the clarifying questions of the clinician present. However, he used his own clarifying questions in instances where the clinician was uncertain about the message conveyed by the patient.

I: Um, and then do you use clarifying questions or do you wait for the doctor?

P: Ja, I wait for the doctor if the doctor doesn't understand and then I clarify further or even if I don't exactly understand what the patient is trying to say then I clarify it before I interpret it to the doctor

I: Ok

P: Because sometimes the patient says something quite vague. Something that you would also find it difficult to translate to the doctor

I: O, ok

P: Then you've got to clarify it further what the person really mean do you mean this and this and this then if the patient said yes then you translate to the doctor after that.

- (4) The participant used her own clarifying questions. However, she used the clinician's clarifying questions in instances where the clinician was unsatisfied with the patient's response.

I: Ok do you use clarifying questions or do you wait for the doctor to give you the clarifying questions?

P: I use clarifying questions

I: Do you use your own clarifying questions?

P: Ja then I will sometimes if doctor is unsatisfied with this patient then he can put it more clear

I: Ok so sometimes you would do it yourself but if the doctor is not satisfied with that he or she gives his own?

P: Yes.

- (5) The participant used the clarifying questions of the clinician present.
- (6) The participant used the clarifying questions of the clinician present.
- (7) The participant used the clarifying questions of the clinician present.
- (8) The participant used the clarifying questions of the clinician present.
- (9) The participant used his own clarifying questions.

Different interpreting needs: participants' views on possible differences in interpreting needs when working in different wards and with different clinicians.

- (1) The participant was of the opinion that there were differences in interpreting needs when working in different wards and with different clinicians. The participant reported that in general medicine the patient can be diagnosed and receive treatment without communication; however in psychiatry communication was the primary diagnostic tool. Furthermore, there were differences in interpreting needs when working with different clinicians since each clinician has his or her own way of connecting with the patient.
- (2) The participant was of the opinion that there were no differences in interpreting needs when working in different wards and with different clinicians
- (3) The participant was of the opinion that there were differences in interpreting needs when working in different wards and with different clinicians. In the forensic ward the interpreter worked with the same patients for a long time period and was therefore familiar with the patient's psychiatric disorder(s). However, in

the acute ward the interpreter worked with different patients and was unfamiliar with their psychiatric disorder(s).

P: I think there the patients they are not moving like in the acute ward they are coming and moving. There you are dealing with the same patient all the time every time you are dealing with them, they are there you see?

I: O, ok

P: Hence in the acute side the patient comes immediately. When they are ok, they are calm and stable then they go to another ward they go home to visit and so

I: Ok

P: Hence in forensic side you are dealing with the same guys all over again and sometimes it becomes easy for you to get to know what kind of problems they are having.

- (4) The participant was of the opinion that there were differences in interpreting needs when working in different wards and with different clinicians.
- (5) The participant was of the opinion that there were no differences in interpreting needs when working in different wards and with different clinicians since he only interpreted for Xhosa-speaking patients.

I: Say for instance you work in this ward do you think they ask you to do differently interpreting then when you go to another ward and you work with another doctor?

P: No, no I don't think, there is no difference because the doctor asks the question in English I must tell the someone in Xhosa and when some one talk to me in Xhosa I must talk to the doctor in English. No differences.

- (6) The participant was of the opinion that there were no differences in interpreting needs when working in different wards and with different clinicians since she always gave an interpretation that was true to the messages conveyed by the patient and clinician.
- (7) The participant was of the opinion that there were no differences in interpreting needs when working in different wards and with different clinicians since patients had similar psychiatric disorders.
- (8) The participant was of the opinion that there were no differences in interpreting needs when working in different wards and with different clinicians since the clinician always asked patients the same questions.
- (9) The participant was of the opinion that there were differences interpreting needs when working in different wards and with different clinicians.
- (10) The participant was of the opinion that there were differences in interpreting needs when working in different wards and with different clinicians.

Time factors: participants' views on possible time difference between the average interpreted interview compared to the average non-interpreted interview.

- (1) The participant was of the opinion that it took double the time when an interpreter was needed compared to when no interpreter was needed.

- (2) The participant was of the opinion that it was much less time consuming when no interpreter was needed compared to when an interpreter was needed.
- (3) The participant was of the opinion that it was much less time consuming when no interpreter was needed compared to when an interpreter was needed.
- (4) The participant was of the opinion that it was much less time consuming when no interpreter was needed compared to when an interpreter was needed.
- (5) The participant was of the opinion that it was much less time consuming when no interpreter was needed compared to when an interpreter was needed.
- (6) The participant interpreted the question of whether there was a time difference between the average interpreted interview compared to the average non-interpreted interview, as whether there was a time difference between when an interpreter was needed and one was present compared to when an interpreter was needed but there was not one present. The participant reported that it was more time consuming when an interpreter was needed but there was not one present.
- (7) The participant interpreted the question of whether there was a time difference between the average interpreted interview compared to the average non-interpreted interview, as whether there was a time difference between when an interpreter was needed and one was present compared to when an interpreter was needed but there was not one present. The participant reported that it was more time consuming when an interpreter was needed but there was not one present.
- (8) The participant was of the opinion that there was no time difference between the average interpreted interview compared to the average non-interpreted interview.

- (9) The participant was of the opinion that the average interpreted interview took 25 minutes longer than the average non-interpreted interview.
- (10) The participant interpreted the question of whether there was a time difference between the average interpreted interview compared to the average non-interpreted interview, as whether there was a time difference between when an interpreter was needed and one was present compared to when an interpreter was needed but there was not one present. The participant reported that it was more time consuming when an interpreter was needed but there was not one present.

Conveying uncertainty: participants' views on conveying uncertainty to the clinician about the diagnosis or about any other aspect relating to the interpretation.

- (1) The participant reported that she conveyed uncertainty since she was an interpreter that was also part of the treatment team.
- (2) The participant reported that he conveyed uncertainty.
- (3) The participant reported that in general he did not convey uncertainty since the clinician was responsible for making an accurate diagnosis. However, he did convey uncertainty in instances where the clinician was unfamiliar with cultural issues and when he was under the impression that the clinician misunderstood the interpretation.

P: No, no I don't normally give my own opinions, unless maybe it's an issue of culture involved and then the doctor is not really familiar with the culture

P: I, I wouldn't say my opinions because it is for the doctor to draw up a conclusion about its effect. Ja, ja, or I will just make sure that I say exactly what the patient is saying

I: Ok

P: Then if his really sick or not, then it's for the doctor to make that call.

- (4) The participant reported that she did convey uncertainty.
- (5) The participant reported that he did not convey uncertainty.
- (6) The participant reported that she did not convey uncertainty since she did not know what the patient was feeling and experiencing.

I: Ok, do you convey uncertainty about a symptom to the doctor, so if the patient said he or she has got this symptom and you are not certain that that is actually the symptom would you then tell that to the doctor?

P: No, I just say what the patient said because I sometimes I don't know what's happening to the patient

I: Ok

P: If she said she is feeling nauseas then I know it's maybe just a way of saying that she wants to go home I don't have to say that

I: Ok

P: I don't have to think myself I just have to say what the patient said, because I don't know what she is feeling

- (7) The participant reported that she conveyed uncertainty in instances where she was under the impression that the clinician and patient misunderstood the

interpretation. However, she did not convey uncertainty regarding diagnosis since the clinician was more knowledgeable about these issues.

- (8) The participant reported that she did convey uncertainty and that the clinician gave her the opportunity to do this.
- (9) The participant reported that he did convey uncertainty since he was also a psychiatric nurse and often he would spend more time with the patient than the clinician and therefore his opinion played a valuable role in making a diagnosis and treating the patient.
- (10) The participant reported that he did not convey uncertainty regarding issues relating to the diagnosis. However, he would convey uncertainty in stances that the clinician asked his opinion.

THE ROLE OF INTERPRETER

Interpreters' experiences of the institutional set-up: participants' attitudes and views about being called to do interpreting.

- (1) The participant did not view it as an inconvenience since she was generally part of the treatment and was normally present when required to interpret.
- (2) The participant was ambivalent about his experiences. He reported that at times he was irritated when called to act as interpreter while occupied with his official duties as a psychiatrist.

P: On certain days if one is busy you get a little bit irritated actually

I:Ja

P: But often I don't mind

- (3) The participant felt that being called to act as interpreter was part of his nursing duties and that he did not mind since no demands was made on him to act as interpreter.

P: And also with the goal in mind it's not all about this person, you see.

It's all about the patient as well. So if you've got that kind off mentality it becomes easy for you.

- (4) The participant reported that she felt uncomfortable with acting as interpreter when she was occupied with her official nursing duties.
- (6) The participant felt proud about being called to act as interpreter and she regarded it as an indication of the trust placed in her by clinicians and nurses.

P: I feel really proud

I: Is it

P: Yes

I: And why do you say so?

P: I just tell myself I must be honest because by the time they call me that's shows thy trust me.

- (7) The participant felt very positive about being called to act as interpreter since she felt that her role of interpreter played a valuable role in the prevention of misdiagnosis.
- (8) The participant felt that it was unfair that she had to pay for her own petrol costs when travelling between wards to act as interpreter.
- (9) The participant felt that acting as an interpreter was part of his duty as a nurse to act as an advocate for the patient.

(10) The participant reported that he accepted the additional role of interpreter.

Working within a psychiatric institution: participants' experiences of working with patients.

(3) The participant reported that it was at times stressful to work with patients since he often placed himself in the patient's position. The participant reported that it was difficult for him to work with patients who were admitted for substances abuse since these patients would often return to the habit of substance abuse and be readmitted a few days after their discharge and this was disappointing for him.

P: But now in psychiatry of late most people we are also admitting are people who are drug addicts, people who are using 'tik'. It's also difficult sometimes

I: Mm

P: Because those people they come here maybe to give you an example, this week and then you give them medication which stabilize them and then just before they go out of the hospital they will give you many promises, "I wont use that again", three or four days later they come back and you feel like hu- uh

I: Ok

P: This is too much you see

I: Ja

P: Those people are not really sick those are people who go out to invite the sickness because you know for a fact if they stay away from this drug

I: Ja

P: Then they won't get sick.

- (4) The participant reported that it was interesting to work with patients with psychiatric disorders. She had a special interest in the symptomology of disorders.
- (5) The participant reported that patients were at times aggressive and he was concerned over his own and the clinician's safety when interpreting.
- (6) The participant enjoyed working with patients since she was acquainted with most of the patients through her work as security guard and understood the patients' needs.
- (7) The participant reported that she had empathy for patients and knew how to work with them.
- (8) The participant reported that patients did not always suffer from psychiatric disorders but rather from cultural phenomena.
- (9) The participant experienced the psychiatric setting as an interesting field to work in and was of the opinion that anyone can suffer from a psychiatric disorder.
- (10) The participant reported that he was blessed to work with patients since it gave him a different perspective on mental illnesses and reported that people with psychiatric disorders were often outcasts due to misperceptions.

Interpreters' experiences of interpreting: participants' views on their experiences of fulfilling the role of interpreter.

- (1) The participant reported that interpreting provided the opportunity to explore the social issues that may play a role in the patient's life. It furthermore created an opportunity for people who speak different languages to be in the same space.

P: Well I love it because it's so many times it's provided a real window on what the real issues whether they be social issues, whatever the situation is

I: Mm

P: Would it be in a Pick&Pay

I: Ja

P: Or be in a medical setting. I think the primary thrill of somebody realizing that you can communicate with him and just acknowledgement that we are in different spaces but we can still talk

I: Mm

P: So I have always enjoyed that.

- (2) The participant did not report on this topic.
- (3) The participant reported that the role of interpreter can be difficult at times since he would place himself in the patient's position and wanted to intervene especially when the patient had no support-system.
- (4) The participant reported that the role of interpreter made her feel that the patient trusted her and had confidence in her.

P: Yes like you learn more you feel like the patient who talk to the doctor

I: Yes

P: Then sometimes she won't talk to you as a nurse the things that she is talking to the doctor now when you interpret then she's having that confidence that you are going to help her in this thing

I: Ok

P: That you also learn from this the situation

I: Ok

P: And you do learn from interpreting.

- (5) The participant reported that he was honoured to be called by clinicians and nurses to act as interpreter since it made him feel good about himself.
- (6) The participant reported that as interpreter she was able to make a difference in the patient's life.
- (7) The participant did not report on this topic.
- (8) The participant reported that the role of interpreter was difficult at since clinicians did not always appreciate the work she did.
- (9) The participant reported that due to issues relating to techniques and methods of interpretation the role of interpreter was difficult at times.
- (10) The participant reported that interpreting provides him with an opportunity to have a better understanding of the patient's condition.

Ideal interpreting: participants' idea of ideal interpreting and examples thereof.

- (1) The participant reported that ideal interpreting was when patients who did not have the opportunity to verbalise their experiences and emotions were given this opportunity.

- (3) The participant was of the opinion that ideal interpreting was when the patient was able to express him/herself comfortably in their first language and when the interpreter was able to interpret everything the patient wanted to convey to the clinician.

P: It means that the patient was able to actually express himself comfortably in his own mother tongue language, maybe let's say a Xhosa-speaker was able

I: Mm

P: To translate to say everything that you wanted to say to the clinician, to the doctor who ever. Then I was also able to interpret it precisely

I: O, ok

P: What he told me and also the person that I'm interpreting to also understood me clearly and I think that's my definition of the whole interpreting that goes so well.

- (6) The participant reported that her idea of ideal interpreting was when the patient was satisfied with the interpretation and when the interpreter was able to help the patient through doing interpreting.

- (7) The participant reported that ideal interpreting was when interpreting services played a role in helping the clinician to treat the patient with the correct medication.

P: Maybe doctor just give, maybe he or she did give the medication before because they didn't understand one another

I: Ok

P: So when the interpreter is there then the doctor knows exactly what to give.

- (8) The participant reported that ideal interpreting was when the patient was understanding towards the work of the interpreter.

I: Ok, um can you maybe give me an example of an interpreting session where everything goes well in terms of interpreting?

P: Um like what can I say? Mostly it goes well

I: Ok and what does that involves when it goes well? What would a session like that look like?

P: Uh where the patient is fine and understanding.

- (9) The participant reported that ideal interpreting was when the interpreter delivered an accurate interpretation and the patient was satisfied that he/she understood clearly what was being said.

I: Ok and would you be able to give me an example of when everything goes well in terms of interpreting. When you did interpreting and you thought by yourself that was a good interpreting session, if one can put it in that way?

P: Let me see, I have never thought about it in such a way

I: Yes one do not tend to think of it like that

P: What I can say I think was a good

I: Or what you think is ideal, an ideal interpreting session?

P: For me?

I: Yes for you

P: It is when I feel that I have with out a doubt conveyed the message from the patient to the clinician and the clinician's questions and message to the patient. And I am able to see that the patient agrees and realises and feel satisfied.

- (10) The participant reported that ideal interpreting was when there was no conflict between the patient, interpreter and clinician and when all three of these parties were satisfied with the interpretation. Furthermore, ideal interpreting was when the interpretation played a role in helping the clinician to make an accurate diagnosis.

Problematic interpreting: participants' idea of problematic interpreting and examples thereof.

- (1) The participant reported that her idea of problematic interpreting were instances where other clinicians expected from her to halt the conversation when it was already difficult to establish and maintain flow in communicating with the patient. Another example was when the patient was focused on circumstansiveness and expansiveness and the clinicians were focused on getting a 'no' and 'yes' response from the patient.
- (2) The participant reported that problematic interpreting were instances when the patient's family needed to have psycho-education and all the family members were asking questions at the same time and the interpreter had to simultaneously interpret for all the family members.

P: One recent one was when we were seeing the family of a patient

I: Ok

P: I think that becomes very difficult with more than one person. When we, it was about three or four family members and they spoke Xhosa and the social worker spoke Afrikaans

I: Ok

P: So then I had to go to and fro the different people. That was a bit difficult

I: Ok

P: When there are a number of different parties and they also want to have there say. So that is slightly different. So that was a bit difficult.

- (3) The participant reported that problematic interpreting was when the patient was violent, aggressive and uncooperative during an interpreting session. For example the patient would not respond or responded to something different than what was being asked. The participant furthermore reported that interpreting become problematic when the patient saw a traditional healer before seeking the help of a clinician.
- (4) The participant reported that problematic interpreting was when the patient had a negative attitude towards the interpreter.
- (5) The participant reported that problematic interpreting was when the patient was aggressive and violent towards the interpreter.
- (6) The participant reported that interpreting was problematic when the patient did not want to accept the diagnosis made by the clinician.

P: Only on one day where the patient couldn't want to wait, the patient didn't understand exactly what the doctor said. I mean I did tell the patient exactly what the doctor said but the patient didn't accept it didn't want to accept.

(7) The participant reported that interpreting was problematic when the patient was aggressive and unwilling to communicate in any other language than his/her mother tongue even if he/she was bilingual.

(8) The participant was of the opinion that interpreting was problematic when the patient accused the interpreter of declaring the patient as mentally disturbed.

I: Ok and in terms of interpreting when is it sometimes difficult. When do problems occur?

P: It's when the patient think everything is coming from me when I tell the patient, the patient is mentally disturbed and then he say "don't tell me".

(9) The participant reported that problematic interpreting was when the interpreter had to act as interpreter for a Xhosa-speaking patient when the interpreter was not fluent in Xhosa.

(10) The participant reported that problematic interpreting was when the patient made racist remarks about the clinician when the clinician was unable to understand what was being said.

The role of interpreting services: participants' views and support for the role of interpreting services in psychiatric institutions.

- (1) The participant reported that she supported the role of interpreting services since it was essential for quality psychiatric health care and for the establishment of patient-provider trust.

P: Ja, I think it's invaluable I think if you can speak a language particularly in our society where frequently patients are required to enter environments and enter transfused arguments where nobody speaks their language and so from a point of view of trust that is a huge issue but just in terms of quality of care...

- (2) The participant reported that he supported the role of interpreting services since it played a crucial role in the delivering quality psychiatric services to patients. The participant reported that there were often patients would receive substandard interpretation services within psychiatric and health institutions and that there was a great need for quality and professional interpreting services.
- (3) The participant supported the role of interpreting services since it was unrealistic to expect all health professionals to speak all the languages spoken by patients.
- (4) The participant supported the role of interpreting services since patients were those that were the most affected by the lack thereof. The participant reported that due to a lack of interpreting services patients often had to wait for a long time before someone could interpret for them.

P: It would be better to have professional participants that would be alright. Employ more actually in the hospital

I: Ok and why do you say that?

P: Because sometimes they need an interpreter in one ward and the other ward one also wait for an interpreter

I: And then they all wait?

P: Ja they must.

- (7) The participant supported the role played by interpreting services.
- (8) The participant supported the role played by interpreting services since it gave patients the opportunity to communicate in their first language.
- (9) The participant supported the role played by interpreting services since patients can not be forced to speak English. The participant stressed the importance of employing interpreters trained in psychiatry.
- (10) The participant supported the role played by interpreting services since there were 11 official languages in South Africa and this created many language barriers within psychiatric services.

Impact of interpreting on interpreters: the psychological impact that interpreting may have on participants.

- (1) The participant reported that interpreting information relating to trauma and abuse was especially distressing at times as well as disclosing HIV status to patients.
- (3.) The participant reported that interpreting information relating to abuse was distressing at times.
- (4.) The participant reported that interpreting information regarding the abuse of women and children was very distressing for her.

- (6.) The participant reported that interpreting information relating to marital problems was very distressing. She regarded marital problems as a very sensitive topic area.
- (7.) The participant reported that she would often feel sad when acting as interpreter since she could relate to the patient's problems.

The following dialogue arose:

P: Some of them have got some problems and if you can listen to them they is putting the problems to the doctor then you feel so sad most of time

I: Ok, um do you think when you feel sad and so one when you do the interpreting that it plays a role when you are doing the interpreting?

P: Yes

I: And why do you say that?

P: I say that it's playing a role because um the thing what is happening to the patient is the things that is happening to our lives.

- (8.) The participant reported interpreting was distressing at times especially when patients were aggressive and hostile.

The following dialogue arose:

P: Um person who was shouting at me

I: Ok

P: Looking me badly, insulting me like hey who are you, you are not a doctor

Support and supervision: participants' views on support and supervision for interpreters.

- (1) The participant reported that she would like to verbalize her concerns over misdiagnosis due to language issues within psychiatric institutions.

The following dialogue arose:

P: Yes, it's funny I've never really verbalized that um there is such a huge need and I've been in clinical situations where

I: Mm

P: I have come across information that is either withheld or completely misinterpreted

I: Mm

P: Which is quite scary?

I: Ja

P: And um where clear misdiagnosis I've been there because of directly related to language issues and there is not really a space in our environment

- (3) The participant was in favour of support and supervision especially in instances that he encountered technical problems.
- (7) The participant was in favour of support and supervision.
- (8) The participant was in favour of support and supervision especially since she often had problems working with clinicians and was concerned about contracting TB when interpreting for patients with TB.

The following dialogue arose:

P: Um sometimes if I can report the doctor especially if I have a problem with a problem with the doctor that I can go to someone whose in charge

I: Ok

P: And report the doctor

- (9) The participant was in favour of support and supervision since he had concerns over the accuracy of his interpretations.

SENSITIVE ISSUES

Patient-confidentiality: participants' familiarity with the term 'patient-confidentiality'.

- (3) The participant was familiar with the term 'patient-confidentiality'.
(4) The participant was familiar with the term 'patient-confidentiality'.
(5) The participant was unfamiliar with the term 'patient-confidentiality'.

I: how do you understand patient confidentiality? Are you familiar with that term when they say you must keep everything confidential with regards to the patient? Are you familiar with that?

P: I must keep?

I: Everything confidential. So when the patient comes you are not allowed to say anything outside of what the patient said. Are you familiar with that do you know about that?

P: No

- (6) The participant was familiar with the term 'patient-confidentiality'.
(7) The participant was familiar with the term 'patient-confidentiality'.
(8) The participant was familiar with the term 'patient-confidentiality'.
(9) The participant was familiar with the term 'patient-confidentiality'.

- (10) The participant was familiar with the term 'patient-confidentiality' and reported on his personal experience with a neighbour that was treated in the ward where he worked and how problematic a situation like this could be.

Interpreting for acquaintances, friends and relatives: participants' views on interpreting for acquaintances, friends and relatives.

- (1) The participant reported that she was in favour of interpreting for acquaintances, friends and relatives.
- (2) The participant reported that he was in favour of interpreting for acquaintances, friends and relatives.
- (3) The participant reported that he was in favour of interpreting for acquaintances, friends and relatives since his first priority was to help patients no matter who they were.
- (4) The participant reported that she was in favour of interpreting for acquaintances, friends or relatives, depending on whether they had concerns over confidentiality.
- (5) The participant reported that he was in favour of interpreting for acquaintances, friends and relatives.
- (6) The participant reported that she was in favour of interpreting for acquaintances, friends or relatives since anyone would want to help those close to him or her.
- (7) The participant reported that she was in favour of interpreting for acquaintances, friends or relatives. She had done interpreting for a patient at San Marco that was in her community. She believed that her familiarity with this patient and his/her situation enabled her to give an accurate interpretation.

The following dialogue arose:

P: When the patient arrived here I know exactly what to tell the doctor because I did see this before

I: Ok, um can you maybe tell me if some of your friends or family members had to come to San Marco would you do the interpreting for them?

P: Yes

I: And why do you say that?

P: I'd like to do, I can do the interpretation because I know if I can do that they can help, they can get help quickly"

- (8) The participant was in favour of interpreting for acquaintances, friends or relatives. According to the participant there were no differences between patients she did not know compared those she did know.
- (9) The participant was in favour of interpreting for acquaintances, friends or relatives since he was able to distinguish between his professional and personal life.
- (10) The participant was in favour of interpreting for acquaintances, friends or relatives since he would want to help those close to him.

The role of rank, gender and ethnicity: participants' views on the role played by rank, gender and ethnicity within interpreting.

- (1) The participant was of the opinion that her rank as a psychiatrist fulfilling the role of interpreter played a major role since a lot of value was attached to the rank of a

psychiatrist. Ethnicity played a role since there was a bigger room for error when the patient and interpreter were from different ethnic back-grounds. However, the participant was of the opinion that gender did not play a role.

- (2) The participant was of the opinion that rank played a role and ethnicity played a role since knowledge of the patient's ethnic back-ground may play a role in delivering an accurate interpretation. However the participant did not think that gender played a role.
- (3) The participant was of the opinion that ethnicity played a role however gender and rank did not play a role.

P: It plays role when there's a culture involved you see

I: Ok

P: Ja, because I mean if I had to interpret for a Muslim guy

I: Yes

P: And I'm a Christian you know some of the stuff it would not be so easy to interpret to the doctor, you see

I: Ok

P: Because sometimes as I've said earlier on some of the things you've got to understand for yourself, because

I: Ja, ja

P: For you to interpret to the doctor, because if you don't understand then the doctor would automatically not understand it as well, so you've got to make sure do you mean this and this

- (4) The participant was of the opinion that rank did not play a role. However, gender played a role since men don't discuss certain issues in the presence of females.
- (5) The participant was of the opinion that gender played a role, for example a female patient may accuse him of having sexual intentions towards her.
- (6) The participant was of the opinion that neither rank, gender nor ethnicity played a role.
- (7) The participant was of the opinion that rank played a role.
- (8) The participant was of the opinion that rank, gender and ethnicity played a role. Rank played a role since the patient perceived the interpreter in a positive light seeing that the interpreter provided the patient with assistance. Ethnicity played a role since interpreters that were from the same ethnic back-ground as the patients may place patients under the impression that they will have a better understanding of the patient and his/her needs. Patients would therefore be more open with discussing personal information with the interpreter.

P: Uh yes sometimes because I was working at the male ward and they think that a man don't want to talk to me but if I was a man they would say everything to me

I: Ok

P: Like cultural things there are things I must not know but if I was a man they will say everything to me

- (9) The participant was of the opinion that rank and ethnicity played a role and that gender did not play a role.

- (10) The participant was of the opinion that ethnicity played a role, since patients from a different ethnic back-ground than the interpreter may be unwilling to openly discuss personal issues with the interpreter. The participant was of the opinion that gender played a role, especially when a male interpreter had to ask about issues of a sexual nature. The participant did not think that rank played a role.

Interpreting for immigrants: participants' experiences of interpreting for immigrants and refugees.

- (1) The participant reported that it was not only languages spoken by black people that needed to be addressed within health institutions but also languages spoken by immigrants since there were no policies that addressed this issue.

The following dialogue arose:

P: now we are going into a new realm because now it's not only black languages now we are facing French, Portuguese, we've got all the migrant people or refugees coming in and we still don't have a policy as to or a central system

- (9) The participant reported that patients from Nigeria, Namibia and the Congo have been admitted to the hospital in the past and even though these immigrants were able to speak English it was still very difficult to communicate with them. In instances like these the patient's family members or any other visitor would be used as interpreter.
- (10) The participant reported that in the past immigrants from Kenya and Ethiopia had been admitted to the hospital.

CULTURAL ISSUES

Traditional explanatory models: participants' views on explanatory models like 'amafufunyana' and 'ukutwasa'.

- (1) The participant reported that she did not personally believe in traditional explanatory models like amafufunyana. However, she would take into account that the patient and his or her relatives may believe in these models and she strived in allowing the Western approach to function side by side with traditional explanatory models.

The following dialogue arose:

P: I don't believe in amafufunyana in the sense that when somebody comes in psychotic I wouldn't label it first and foremost as being amafufunyana, I would call it psychotic

I: Mhu

P: But I can't discount the explanatory model that is used by the patient or the patient's family

I: Mhu

P: And as far as I can in situations like that I encourage the patients to acknowledge that we are looking at function and behaviour and the fact that this behaviour is making the patient ill

I: Mm

P: And we need to treat and that you've clearly come from your cultural system into a Western model believing that this, we can help to a certain extent. So, I try and allow those believes to function side by side

- (2) The participant reported that he believed in traditional explanatory models of problems and that certain psychiatric problems were better explained by culture-bound syndromes than by the use of the DSM-IV.
- (3) The participant reported that before working within the field of psychiatry he believed in traditional explanatory models. He believed that someone with a mental disorder was bewitched. However, after working within the field of psychiatry and learning about mental disorders he stopped believing in traditional explanatory. The participant reported that people from Xhosa and Zulu cultures believed in amafufunyana and that an evil spirit was 'put on their bodies'.

The following dialogue arose:

P: You know before doing psychiatry I believed in things I believed that maybe someone actually to be precise I believed that when somebody is mentally ill then it's because he's bewitched

I: Mm

P: But then after doing psychiatry and understanding all the different conditions within psychiatry then I actually stopped believing in that"

- (4) The participant reported that she did not believe in traditional explanatory models like amafufunyana and that it was only an act. However, she grew up with people

who did believe in it. Her work in the field of psychiatry has led her to believe that someone with amafufunyana was merely having hallucinations.

- (5) The participant reported that he did not believe in amafufunyana but was familiar with the phenomena. The participant explained that someone with amafufunyana had to be seen by a sangoma. The sangoma will make an insertion and insert something of an herbal nature. The participant reported that he personally witnessed someone having amafufunyana in high school. The female scholar that had amafufunyana was throwing around heavy objects such as chairs and when someone tried to touch her she accused the person of trying to kill her.
- (6) The participant reported that she did not believe in traditional explanatory models like amafufunyana. The participant explained that amafufunyana was when someone had insects inside of them which made them aggressive. The participant believed that some patients suffered from traditional phenomena like amafufunyana.

The following dialogue arose:

P: Hey that mafufunyana, I really don't know because sometimes the person she said she saw something and she is gonna do this or maybe the neighbour gave him those goggotjies, mafufunyana inside and now this mafufunyana makes her angry

I: Ok, ok

P: And then I don't believe that because it's God that created us how can that people have some power to put goggatjies.

- (7) The participant reported that she did not believe in traditional explanatory models like amafufunyana, however she did believe that some patients were suffering from it. She was of the opinion that someone with amafufunyana spoke in the voice of someone else.
- (8) The participant reported that she did believe in traditional explanatory models like amafufunyana and she believed that some patients suffered from traditional phenomena like amafufunyana. The participant reported that when in High School some of the scholars had amafufunyana and they lied on their backs with their mouths open while the amafufunyana was talking from out their stomachs.
- (9) The participant did not believe in traditional explanatory models like amafufunyana however he did believe that some patients suffered from these phenomena. The participant reported that people with amafufunyana had cuts on their wrists to protect them against amafufunyana.
- (10) The participant reported that he did not believe in traditional explanatory models like amafufunyana. The participant reported patients who suffered from traditional explanatory models like amafufunyana believed that the ancestors spoke to them.

Interpreters' cultural and religious beliefs: participants' views on the role that their own cultural and religious beliefs play when interpreting for the patient.

- (1) The participant reported that she was from a Western culture. However, she was familiar with the Xhosa culture and had close contact with people from this culture. The participant furthermore reported that her own culture as well as her

familiarity with the Xhosa culture had helped her to understand patients from her own culture as well as patients from a Xhosa culture.

- (2) The participant reported that his own cultural and religious beliefs helped him to understand and interpret for patients from the same cultural and religious background.
- (3) The participant reported that he was from a Xhosa culture and that his own cultural and religious beliefs helped him to understand and interpret for patients from the same cultural and religious background.
- (4) The participant reported that she was from a Xhosa culture and that at times it was difficult to interpret for patients from the same cultural background, specifically with regards to gender issues. Women from a Xhosa culture did not speak openly about domestic issues and often did not want to discuss these issues with the interpreter and clinician.

The following dialogue arose:

P: It is difficult sometimes because you know you'll find things that some Xhosa people don't want to say

I: Ok

P: It's difficult you must try and scratch it out because you know they don't talk about certain things

I: Ok

P: That must be said maybe in front of the doctor. They feel it's something that must be hidden

I: Can you give an example maybe of?

P: Like a patient will say woo maybe if my husband do something wrong you know

maybe he was angry, maybe I make him angry

- (5) The participant reported that he was from a Xhosa culture and that he believed in the ancestors. The participant reported that his own cultural and religious beliefs made it difficult to act as interpreter since patients would tell him that they do not suffer from any psychiatric condition but that their conditions were caused by cultural factors.
- (6) The participant reported that she was from a Xhosa culture and that she advised patients from a Xhosa culture not to seek the help of a sangoma since this will worsen their condition.
- (8) .The participant reported that her own cultural and religious beliefs helped her to understand patients from the same culture and that it enabled her to pick up on certain issues that would not be the case if they were from different cultures.

The following dialogue arose:

P: Uh, it plays a big role because I do understand the patient especially the black patients. Especially when they talk about culture then I tell the doctor I think it's a cultural thing

I: Ok

P: So then the doctor will work on it

- (9) The participant reported that he was from a Coloured and Xhosa culture. The participant reported that his own cultural and religious beliefs helped him to understand patients from the same back-ground and that it made him more sensitive towards the role of cultural and religious beliefs when acting as interpreter.
- (10) The participant reported that he was from a Coloured culture and that his own cultural and religious beliefs help him to understand patients from the same back-ground better. He reported that he was more comfortable interpreting for patients from the same back-ground.

Interpretation of cultural beliefs: participants' views on interpreting the patient's cultural beliefs.

- (1) The participant reported that she did not interpret cultural beliefs, since she was not qualified to do this. She would ask the patient's relatives for input regarding cultural beliefs.
- (2) The participant reported that generally he did not interpret cultural beliefs and that he only did this in instances where the clinician present asked him about the patient's cultural beliefs.

The following dialogue arose:

P: Um, I would say what the person said and see if the person, the clinician understands what that means if they don't I would then explain it, but I would definitely say first what the patient said

I: Ok

P: And see if the clinician understands what that means

- (3) The participant reported that he did not interpret the patient's cultural beliefs since the majority of clinicians working at the institution had some understanding of the different cultures in South-Africa.

The follow arose:

P: Ja, I do I mean if actually this is the most important if I have to do I just interpret it to the person so it's up to the person to understand it in his way but fortunately I mean all the clinicians here got some understanding of different cultures now"

- (4) The participant reported that she did not interpret the patient's cultural beliefs, since she may misinterpret a psychopathological belief as that of a cultural belief.
- (5) The participant that he did not interpret the patient's cultural beliefs and that the clinicians never asked him to do so.

The following arose:

P: The doc no, they don't ask me"

- (6) The participant reported that she did not interpret the patient's cultural beliefs since she may misinterpret a psychopathological belief as that of a cultural belief.
- (7) The participant reported that she did not interpret the patient's cultural beliefs and that the clinicians never asked her to do so.
- (8) The participant reported that she did not interpret the patient's cultural beliefs within an interpreting session. However, the clinician would discuss uncertainties regarding cultural beliefs with her after the interpreting session.

The following dialogue arose:

P: Yes they ask me and then we discuss all this cultural thing

I: So you would first just convey it and then afterwards you would

P: Ja

- (9) The participant reported that he did not interpret the patient's cultural beliefs since the clinician had more knowledge of patients' cultural beliefs.
- (10) The participant reported that he did not interpret the patient's cultural beliefs within the interpreting session. He would do this after the interpreting session.