INTERPRETING WITHIN A SOUTH AFRICAN PSYCHIATRIC HOSPITAL: A DETAILED ACCOUNT OF WHAT HAPPENS IN PRACTICE

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DECLARATION

By submitting this dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

It is more than 18 years since South Africa became a democratic country. However, many South Africans are still discriminated against when accessing state services, such as healthcare services (Drennan, 1999). The problem is that healthcare practitioners, in the higher positions of the healthcare system, are commonly made up of professionals who speak only one or at most two of South Africa's official languages (Swartz, 1998). Due to the lack of funding ad hoc arrangements are made for interpreter-services (Drennan, 1999). Anyone available that can speak even a fragment of the patient's language, such as nurses, household aides and security guards are called to act as interpreters (Drennan, 1999; Smith, 2011). In many clinical settings, although not ideal, it is possible to treat patients even if there are minimal shared communicative resources (Anthonissen & Meyer, 2008). However, in psychiatric care, language is the primary diagnostic tool, and is one of the central instruments through which patients voice their symptoms (Westermeyer & Janca, 1997).

In the Western Cape (one of the nine provinces in South Africa), clinicians working in psychiatric care are mainly fluent in English and Afrikaans. Many Black isiXhosa-speaking patients are not proficient in these languages. The aim of this dissertation is to gain a better understanding of the language barriers facing isiXhosa-speaking patients by focusing on natural conversations, which take place during psychiatric interviews within a particular psychiatric institution in the Western Cape. I made video-recordings of interpreter-mediated psychiatric interviews (n=13) as well as psychiatric interviews (n=12) conducted without the use of an interpreter. In addition, I had discussions (i.e. through semi-structured interviews) with registrars, interpreters and patients to understand their views about issues related to language barriers and interpreting practices. I used an ethnographic approach and the method of Conversation Analysis to understand the study findings.

The findings, derived from the psychiatric interviews that were not interpreter-mediated, suggest that the Limited English Proficient (LEP) patients had great difficulty communicating with the registrars. The findings (emerging from the interpreter-mediated encounters and semi-structured interviews), strongly suggest that the haphazard use of hospital employees, who are not trained and employed to act as interpreters, have a significant impact on the goals

of the psychiatric interview. In some instances, the use of ad hoc interpreters positively contributed to the successful achievement of the goals of the psychiatric interview.
In most instances, the use of ad hoc interpreters inhibited the successful achievement of the goals of the psychiatric interview. One of the most significant findings was that interpreters' interpretations of patients' words at times suggest that patients appear to be more psychiatrically ill (increasing the risk for over-diagnosis) than it appears when looking at patients' original responses.

In essence, the lack of language services is unjust towards patients, clinicians, hospital staff acting as ad hoc interpreters, and LEP patients caught in a system, which construct them as voiceless, dependent, powerless, healthcare users.

OPSOMMING

Suid-Afrika is vir die afgelope 18 jaar `n demokratiese land, maar ongeag die afskaffing van apartheid word daar steeds teen baie Suid-Afrikaners gediskrimineer. Dit is veral die geval wanneer Suid-Afrikaners gebruik maak van gesondheidsdienste (Drennan, 1999). Baie gesondheidspraktisyne of dokters is alleenlik vaardig in een of op die meeste twee offisiële Suid-Afrikaanse tale (Swartz, 1998). Ongelukkig weens `n gebrek aan fondse, is die meeste hospitale nie instaat om amptelike tolke in diens te neem nie. Gevolglik word ad hoc reëlings getref wanneer pasiënte tolkdienste benodig. Gewoonlik word enige iemand, insluitende verpleegsters, skoonmakers en sekuriteitswagte, wat selfs net tot `n sekere mate die pasiënt se taal kan praat, gebruik as tolke (Drennan, 1999; Smith, 2011). Die gebrek aan tolkdienste is veral problematies wanneer dit kom by psigiatriese dienste. Dit is omdat in psigiatrie word taal en kommunikasie as primêre diagnostiese instrument gebruik, en pasiënte gebruik hoofsaaklik taal om hul simptome en ervaringe met die dokter mee te deel (Westermeyer & Janca, 1997).

In die Wes-Kaap (een van Suid-Afrika se nege provinsies) is die meeste dokters wat in psigiatriese instansies werk hoofsaaklik Engels en / of Afrikaans-sprekend. Baie Swart isiXhosa-sprekende pasiënte, wat gebruik maak van psigiatriese staatsdienste, is egter nie vlot in Afrikaans en Engels nie. Die doel van my proefskrif is om hierdie probleem, wat baie siXhosa-sprekende pasiënte in die gesig staar, beter te verstaan. Ek het besluit om dit te doen deur te fokus op `n spesifieke aspek – natuurlike gesprekke tussen dokters en isiXhosa-sprekende pasiënte. Dokters en pasiënte kommunikeer onder andere gedurende psigiatriese onderhoude, en ek het besluit om video opnames van psigiatriese onderhoude te maak. Ek het die video opnames in `n spesifieke hospitaal in die Wes-Kaap gemaak. Die video opnames het ingesluit psigiatriese onderhoude (n=12) waarin die dokter en pasiënt in Engels kommunikeer, sowel as onderhoude (n=13) waarin die dokter en pasiënt deur middel van (d.m.v) `n ad hoc tolk kommunikeer. Ek het ook gesprekke gevoer (deur middel van semi-gestruktureerde onderhoude) met pasiënte, dokters, en ad hoc tolke om hulle insigte en opinies rakende die bogenoemde taalkwessies beter te verstaan. Verder het ek `n ethnografiese benadering en gespreksanaliese gebruik om die data te benader en verstaan.

Die bevindinge wat voortgevloei het uit die psigiatriese onderhoude (beide waarin daar nie `n tolk gebruik was nie, sowel as die waarin daar `n tolk gebruik was) suggereer dat die gebrek

aan tolkdienste dikwels die doel van psigiatriese onderhoud ondermyn. Dit komvoor dat in die psigiatriese onderhoude, waarin daar nie tolk gebruik was nie, die pasiënte dit baie moeilik gevind het om met die dokters in Engels te kommunkeer. Dit is waarskynlik omdat hulle nie oor die nodige taalvaardighede beskik om hulleself ten volle in Engels uit te druk nie. Dit kom wel voor dat in sommige gevalle gedurende die psigiatriese onderhoude, waarin die dokters en pasiënte d.m.v.`n tolk gekommunikeer het, het die gebruik van `n tolk `n positiewe impak gehad. Die probleem is egter dat in baie gevalle het dit geblyk het die gebruik van tolke `n ongewenste impak gehad. Een van die belangrikste voorbeelde hiervan is dat die tolke se weergawes van die pasiënte se woorde, dit dikwels laat voorkom asof pasiënte nie juis veel insig in hulle psigiatriese versteurings gehad het nie. Wanneer daar egter gekyk word na die pasiënte se oorspronklike weergawes is dit duidelik dat sommige pasiënte wel insig gehad het.

Die bevindinge suggereer hoofsaaklik dat die gebrek aan offisieel en opgeleide tolkdienste onregverdig is teenoor die pasiënte, ad hoc tolke, en die dokters. Dit dra ook by tot `n gesondsheids-sisteem waarin isiXhosa-sprekende pasiënt uitgebeeld word as afhanklik, tot `n groot mate magteloos en sonder `n sê.

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FOREWORD

It is more than 18 years since South Africa became a democratic country and a lot has been done to reverse the injustices of the past. The fall of apartheid has undoubtedly improved the lives of many South Africans. One of the most significant developments that came with the birth of democratic South Africa is the new constitution. Our constitution is one of the most progressive constitutions in the world. Amongst other things, it promotes the protection of human rights; equal access to services and non-discrimination on the basis of language, class and race. In the 'new' South Africa, we also have language policies, which state that citizens may use any of the official languages[1] of a particular province when communicating with government or state institutions. I live in the Western Cape (i.e. one of the nine provinces in South Africa) and according to the province's language policy, any member of the public may use one of the three official languages of the province in his or her communication with any institution of the provincial or local government (Western Cape Language Committee, 2004). The three official languages of the Western Cape are isiXhosa, Afrikaans and English. However, despite our constitution and the language policies that are in place, discrimination particularly on the basis of language is an everyday occurrence in the Western Cape and in the rest of South Africa (Drennan, 1999). This is the case when it comes to state services, such as healthcare services. The problem is that healthcare practitioners, in the higher positions of the healthcare system, are commonly made up of professionals who speak only one or at most two of South Africa's official languages (Swartz, 1998). Complicating matters even further – is that there are very few official interpreter posts in the state healthcare sector (Drennan & Swartz, 2002). Drennan and Swartz (2002) explain that after 1994, when the new government came into power, it created interpreter posts for the judiciary. However, the same was not done for other public sectors. It is therefore the responsibility of individual hospitals to employ their own interpreters (Drennan & Swartz, 2002). Due to the lack of funding public hospitals are unable to employ official interpreters and consequently ad hoc and haphazard arrangements are made for interpreter-services (Drennan, 1999). The patient's family members or anyone available that can speak even a fragment of the patient's language, such

[1] South Africa has 11 official languages (English, Afrikaans, isiNdebele, Northern Sotho,Sotho, Swazi, Tswana, Tsonga, Venda, isiXhosa and isiZulu).

as nurses, household aides and security guards are called to act as interpreters (Drennan, 1999; Smith, 2011).

Fortunately for me, as a middle class, first language Afrikaans-speaker I do not face language barriers when making use of healthcare services in the Western Cape. This is because the majority of clinicians speak either Afrikaans (my first language) or English (my second language). If I were to be a Black isiXhosa-speaker, who was not fluent in English or Afrikaans, I would have a different experience. The truth is that many Black people living in the Western Cape are first language isiXhosa-speakers, and are not fluent in the languages spoken by most clinicians. Even after all these years since South Africa became a democratic country, I am still privileged because of the languages I speak, the colour of my skin, my educational background and socio-economic status. This is something I, for one, find hard to live with and I believe that as a White Afrikaans-speaker, I have an even greater responsibility to do something about the language barriers many South Africans face. This is because during apartheid, my first-language (which is a big part of who I am) was used as a means to discriminate against and oppress South Africans who were not classified as White. Racial groups, such as Coloured (many of whom are first language Afrikaans-speakers), Black and Indian people had very few education and employment opportunities. This is partly why we are facing a situation today, whereby many clinicians are White and not fluent in the languages of Black people (Swartz, 1998). It would be idealistic to say that the aim of the dissertation is to change the status quo I described above and to ensure equal language rights for all South Africans. Instead, I realize that this dissertation, in some small way, addresses the problem of language barriers in the healthcare context (and more specifically in public psychiatric care).

It is difficult for me to write about the issue of language access due to the reasons I explained above. I am unable to ‘let go’ of what I observed through the video camera lens. A personal voice provides me with a means through which I am able to write without falsely claiming that I had no part in the reasons why language barriers exist today. A personal approach allows me to provide a voice to a story that has been a part of me since my childhood (although I only came to realize this while writing the dissertation). It is not a universal practice in the field of psychology to use a personal voice, and as an undergraduate student, I

was unaware that this approach existed. Critics argue that a personal voice distracts from the scientific quality of the study, since researchers are expected to be objective and distant (Behar, 1996). However, a personal voice (if used creatively) does not distract from the scientific nature of the study, but adds to it. As Behar (1996) explains: "The personal voice, if creatively used, can lead the reader, not into miniature bubbles of navel-gazing, but into the enormous sea of serious social issues." In making myself vulnerable by being self-reflective, I am encouraging the reader to be critical about the factors influencing my understanding of the study topic. It creates an opportunity for the reader to scrutinize the connection, intellectual and emotional between the observer and the observed (Behar, 1996).

I hope that the use of a personal voice will allow the reader to gain a more immediate understanding of the dissertation topic. By being transparent and locating myself in the text, I want the reader (through my personal experiences) to relate more closely to the reality that many South Africans face when accessing healthcare services. The use of a personal voice will also make the dissertation more accessible not only to academics but also to students and the very people who participated in the study. Goodall (2007), explains that the use of a personal approach creates an opportunity to reach a broader audience than just a specialist one (Goodall, 2007).

The personal voice is also a means through which I am able to show that my experiences are vastly different from those of many Black people who access healthcare. The aim of this dissertation is not to speak on behalf of Black people facing language discrimination. This is not my place, especially since I am the one that will benefit most from this dissertation. My choice in dissertation topic is not a selfless decision. Insight into the matter of language barriers will allow me, and others I work with, to address the problem of language access. This dissertation is part of a larger language project, which aims to train healthcare practitioners and ad hoc interpreters. A better understanding of language barriers in psychiatric care will assist us in our aims to educate people on the subject matter.

I want to end this section by stating that I hope this story and the way in which I represent my observations move the reader. Behar (1996) warns that when writing an invulnerable text, the worst that can happen is that the reader finds the text boring. However, when the reader finds

that a vulnerable text does not move him or her, the author is more than embarrassed. He or she is also humiliated (Behar, 1996). Like Behar, I believe that a study that does not change you and move you is not worthwhile doing. This study has most certainly changed me in many ways and I hope that you, the reader, will be affected by this study even if only in a small way.

CHAPTER 1: ADDRESSING LANGUAGE BARRIERS IN HEALTHCARE

1.1 Having a critical look at language practices post-apartheid

In the foreword, I explained that clinicians, working in healthcare facilities in the Western Cape, are mainly English and Afrikaans-speaking. The most White and Coloured people are proficient in the languages spoken by the clinicians. However, Black isiXhosa-speaking people who are not proficient in English and Afrikaans are more likely to face language barriers. For this reason, my focus is largely on the provision of interpreter services for isiXhosa-speaking patients.

One might ask why if the issue of language barriers facing isiXhosa-speaking patients is such a major problem, so little has been done about it since 1994. This is because from the outside the healthcare system seems to work despite the lack of official interpreter posts (Drennan & Swartz, 2002). Drennan (1999) explains that healthcare workers' struggle to speak with patients through unprofessional interpreters or in broken English or Afrikaans has become a routine complication of clinical work in hospitals. The language gap and routinized strategies to work around it have become institutionalized aspects of the everyday practice of healthcare (Drennan, 1999). In addition, healthcare staff are often likely to perceive language problems not as part of the institution's inability to treat multilingual patients, but as the patient's problem (Schlemmer & Mash, 2006). Schlemmer and Mash (2006) interviewed hospital staff working at a district hospital situated in the Western Cape and found that non-isiXhosa-speaking staff felt that isiXhosa-speaking patients should try to learn English, and believed that patients sometimes deliberately did not understand what the doctor was saying. Fassin (2008) conducted an ethnographic study of medical and nursing practices in a large general hospital situated in South Africa. Fassin found that health professionals use two kinds of justifications for the discrepancies between proclaimed ethical norms and actual practices. The first justification relates to their workload and environment. Secondly, patients and their attitudes are blamed for the discrepancies (Fassin, 2008). The above studies support the argument I made in the Foreword that apartheid is only partly to be blamed for the problem of language barriers in the healthcare context.

The lack of formal interpreters in the healthcare system is not unique to South Africa or developing countries. Even developed countries, such as Switzerland, face similar challenges

(Bischoff & Loutan, 2004). Bischoff and Loutan (2004) investigated how Swiss hospitals address the problem of language barriers. They found that the majority of Swiss hospitals used bilingual health professionals as interpreters. In other instances embassy staff and refugee organisations were used to provide interpreter services. Many of the Swiss hospitals, participating in the study of Bischoff and Loutan (2004), were in need of qualified interpreters. However, only a tenth of the hospitals had a budget for interpreters. Regardless of factors such as financial or human resources, it is unrealistic to think that the healthcare system can function properly without interpreters (Youdelman, 2008). Adequate communication is not simply desirable but is an essential part of healthcare services (Drennan, 1999). In the next section, I highlight why adequate communication is essential for the provision of healthcare and why I have decided to focus specifically on psychiatric care.

1.2 Telling the clinician what is wrong

Clear communication between the clinician and patient is an obvious requisite for effective healthcare delivery (Breen, 1999). In essence, language is the currency of healthcare. Exchanging information, expressing emotion, instructing patients, and providing health education all occur through the medium of language (Ferguson, 2008). In addition, Woloshin, Bickell, Schwartz, Gany, and Welch (1995) highlight the role played by language in addressing different belief systems. For example, a patient may prefer to use traditional medicine as opposed to Western medicine. The clinician and patient use language to discuss and address such differences in opinion (Woloshin, et al., 1999). Hsieh (2007) notes that it is not only the patients' communicative behaviours, which are critical to the diagnosis and treatment of the patient, but also those of the healthcare worker. Furthermore, the clinicians use language as a means to establish an empathic relationship, which, in itself, may be therapeutic for both parties concerned (Woloshin, et al., 1999).

In many clinical settings, although not ideal, it is possible to treat patients even if there are minimal shared communicative resources (Anthonissen & Meyer, 2008). For example, in general medicine the clinician is able to use blood tests or other means such as brain scans to assist him or her in making a diagnosis. Language services play an even greater role in psychiatric care compared to general or medical healthcare (Searight & Searight, 2009). This is because in mental health and psychiatric care, language is the primary diagnostic tool, and

is one of the central instruments through which patients voice their symptoms (Westermeyer & Janca, 1997). Let me give a few examples, provided by Sadock and Sadock (2003), of the basic uses of language as diagnostic tool within psychiatry. Although the clinician is able to assess the patient's appearance through observation, it is helpful for the clinician to be able to ask the patient about his or her appearance. For example, should the patient appear to dress inappropriately it would be helpful for the clinician to be able to ask the patient: *How would you describe how you look today?* Similarly, the psychiatrist would need to ask the patient certain questions in order to have a better understanding of the patient's mood and affect (i.e. the patient's present emotional responsiveness) (Sadock & Sadock, 2003). Sadock and Sadock (2003) also mention other aspects that are impossible to assess without communication, such as the patient's thought process and content. Both thought process and content are assessed through the patient's speech characteristics. For example, it is possible to identify a disturbance in thought process through word salad (i.e. an incoherent mixture of words and phrases). The presentation of disturbances in thought content can be assessed by asking the patient for example: *Are there things you do over and over, in a repetitive manner?* Furthermore, through communication the clinician is able to assess whether the patient knows where he or she is (orientation); test the patient's memory; and whether the patient has insight into his or her illness (Sadock & Sadock, 2003). In the next section, I refer to the impact of language barriers in medical and psychiatric care.

1.3 When there are no words to explain

As already alluded to in section 1.1, language inaccessibility and the lack of official interpreters have major implications for providing good quality healthcare (Schlemmer & Mash, 2006). Various studies in both medical healthcare and to a lesser extent in psychiatric care have focused on the impact of language barriers. Studies conducted in the medical sciences found that language barriers are likely to lead to:

- Patients delaying their treatment:

  A study conducted in the United Kingdom, found that due to language barriers members of ethnic minority groups did not access healthcare services until their health problems became serious and life threatening (Gerish et al., 2004).
- Compromised patient safety:

Language barriers may compromise patients 'safety since patients facing language barriers are less likely to receive an accurate diagnosis, follow the clinician's advice and adhere to any medication regimen (Flores, 2006; Moreno, Tarn, & Morales, 2009). The impact on patient-safety has also been found when looking at adverse events. Adverse events are any unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient (Divi, Koss, Schmaltz, & Loeb, 2007). Divi, et al. (2007), conducted a study in the United States and found that the Limited English Proficiency (LEP) patients, who participated in their study, are more likely to experience adverse events due to communication failure compared to first-language English speaking patients.

- Increased healthcare costs:

  The improvement of language access for patients may lower the cost of medical care in the end since interpreting services improved patients' utilization of preventive and primary care services, like follow-up visits and medications that may reduce costs for patients (Jacobs, Shepard, Suaya, & Stone, 2004).

- Tension amongst staff and between staff and patients:

  Other studies in the medical context concentrated on the impact of language barriers on hospital staff and patients' attitudes towards one another. The study of Schlemmer and Mash (2006), as referred to previously, found that healthcare providers were resentful towards patients who were unable to speak English or Afrikaans. On the other hand, patients felt that the clinicians did not care about them. Furthermore, in the study conducted by Schlemmer and Mash (2006), healthcare workers reported that they felt frustrated due to the lack of readily available interpreters. They explained that it was time consuming to find an available interpreter and the time spent to find someone interfered with their work performance (Schlemmer & Mash, 2006).

Studies conducted in the field of psychiatry and mental healthcare have found that language barriers lead to:

- Over-diagnosis and inaccurate diagnosis:

  Language barriers between the healthcare worker and patient increase the risk of misinterpretation of language and symptoms and in effect increase the risk of over-diagnosis or inaccurate diagnosis (Rousseau, Measham, & Moro, 2010). The studies

conducted by Flores (2006), and Marcos, Urcuyo, Kesselman, and Alpert (1973) found that language barriers often lead to patients receiving a diagnosis of severe psychopathology. In the late 1990's, Drennan (1999) investigated interpreting practices at one of the major public psychiatric hospitals in the Western Cape and found that due to the lack of professional interpreter posts, misunderstandings over patients' diagnosis and treatment occurred regularly.

- Psychological distress:

  The personal and sensitive nature of issues discussed during psychiatric interviews could be a source of distress. In 2006, I conducted my master's thesis (Kilian, 2007) on interpreting practices in another psychiatric hospital in the Western Cape. In my master's thesis, ad hoc interpreters felt that patients' stories affected and distressed them.

- Concerns over patient - confidentiality:

  In the local study conducted by Smith (2011), interpreters reported that they discussed patients' stories with their colleagues since it served as a coping mechanism, helping them to deal with sensitive information they had to interpret during interpreter-mediated psychiatric interviews (Smith, 2011). This is a breach of an essential part of ethical care – patient confidentiality.

Central to the abovementioned consequences, associated with language barriers and interpreter services in healthcare, is the issue of 'ethics of care'. In order to understand how interpreter services relate to the provision of ethical patient care, I explain in the section below the meaning of 'ethics of care' in the context of this study.

1.4 The ethics of care

It is not satisfactory to provide care without paying attention to the provision of 'good' care. In order to truly understand the impact of language barriers on patient care I will refer to the work of Tronto (2010). Tronto writes about the ethics of care and describes signs of 'good' patient care. According to Tronto (2010), the best forms of institutional care are those provided by practitioners who are highly deliberate and explicit about how to best meet the needs of those they serve. Tronto explains that the following contribute to institutions providing good care: the recognition of and debate on relations of power within and outside

the organisation, and agreement on common purpose; paying attention to human activities as particular and admitting of other possible ways of doing them, and recognising that diverse humans have diverse preferences about how needs might be met; and an awareness and discussion of the ends and purpose of care (Tronto, 2010).

Tronto (2010) regards the signs mentioned below as indicators of 'bad' care:

- When patients are perceived as the vulnerable and dependant members of society. Institutions should never forget that all people require care throughout our lives. Hospitals should adopt a perspective that recognises that all human beings with different capacities and needs require care at different points in their lives (Tronto, 2010).
- When institutions do not pay attention to who is responsible for determining the needs of those who require care. It is highly problematic if the healthcare worker and patient have different perspectives on what is needed. Healthcare workers may have their own agendas in determining others' needs. Furthermore, institutions should realise that needs are not fixed and change constantly (Tronto, 2010).
- When institutions perceive healthcare as a commodity or a purchased service and not a process. This creates alienation, since patients are human beings and the relationship between the health professional and patient plays an essential role in the treatment process (Tronto, 2010).
- If patients are not asked for their input regarding the healthcare services they receive. Or - in instances that patients voluntarily voice their opinions their – if suggestions are perceived as a form of resistance or obstruction (Tronto, 2010).
- When the care responsibilities of hospital staff are not explicitly named or described. Failing to do so may result in the work going unnoticed and could lead to the process of naturalising care relations and blaming care givers who may have inadequate resources (Tronto, 2010).
- If healthcare workers perceive organisational requirements as hindrances to, rather than support for care (Tronto, 2010).

So far, I described the broader aspects of language barriers and interpreter services in the context of medical healthcare and psychiatric care. In section 1.5 below, I explain the specific focus and aims of my dissertation.

1.5 My research aims

As I explained above, the aim of this dissertation is to gain a better understanding of language barriers facing isiXhosa-speaking patients in need of psychiatric care. I furthermore, explained that part of the problem is that very few hospitals have official interpreter services to assist isiXhosa patients. However, how does one go about understanding the problem I refer to above? One way is to study conversations between clinicians and patients within a psychiatric institution. Conversations between clinicians and patients take place in various situations and settings. In my study, I focus on conversations, which take place in psychiatric interviews in a particular state psychiatric hospital[2]. The study conducted by Drennan (1999) found that interpreter services were required mostly for psychiatric interviews (81.6%), while ward rounds, family interviews, psychometrics and groups accounted for the rest. Psychiatric interviews form the cornerstone of all other processes involved in patient treatment. The interviews provide clinicians with an opportunity to collect data necessary to understand the patient's problem and decide on medication regimens and other treatments (Sadock & Sadock, 2003).

The initial plan was to focus exclusively on those psychiatric interviews, which were interpreter-mediated. I learned shortly after commencing the study that it was common practice for clinicians and patients to attempt to communicate in the absence of an interpreter (for reasons I explain in Chapter 4). I therefore decided to include psychiatric interviews that were not interpreter-mediated, since I believed that it would allow me to have a more holistic understanding of the role played by the interpreter. Investigating psychiatric interviews conducted without the use of an interpreter, would also allow me have a better understanding of the impact of alternative language practices within the institutional context. Furthermore, the focus of my study is on real-life (actual) psychiatric interviews. This is mainly because the growing body of literature regarding language practices and the impact of language barriers on healthcare delivery is largely based on hearsay information. Very few evidence-

[2] I use a pseudonym for the hospital through out the dissertation due to issues of confidentiality.

based studies on real-life conversations, between patients and clinicians that do not share a first language, have been conducted (Bot, 2005).

There are two ideas central to the research aims of the dissertation. Firstly, this study is not about prescribing what should or should not happen in actual psychiatric interviews. Instead, it is a descriptive study aiming to describe, not prescribe, what happens in conversational encounters during psychiatric interviews. Research focusing on language practices has evolved from the evaluative account of what does or does not fall within acceptable professional standards towards non-judgmental observation of events and detailed description of what actually happens (Mason, 1999). Secondly, allow me to briefly explain what I mean by saying the aim is to gain a better understanding of actual conversations. Inspired by the work of Davidson (2000, 2002), Bot (2005), Wadensjö (1998), Penn and Watermeyer (2012), and many more, I decided to focus on speakers 'actions during actual encounters and how it contributes to the successful achievement of the goals of the psychiatric interview. In the next section, I provide a more detailed description of psychiatric care and the aims of the psychiatric interview.

The aims of the study also point to the contribution this study makes to the field of Community Interpreting research. To my knowledge, this is the first South African study that provides a detailed account of real-life interpreting practices within psychiatric care. My study is unique in that the detailed account of actual practices allows the reader to gain a clear sense of how registrars and patients communicate either without the use of an ad hoc interpreter or with the use of an ad hoc interpreter. The study's focus on detail makes a significant contribution to the small pool of empirical evidence available to those training interpreters and clinicians working within medical and psychiatric care. The study provides a mouthpiece for registrars, patients and ad hoc interpreters and creates awareness about the daily challenges registrars, patients and interpreters face in terms of language barriers. More specifically, the study makes an important contribution to the field of psychiatry in that it describes in detail the impact that language barriers have on the goals of the psychiatric interview.

1.6 Psychiatric care and the psychiatric interview

1.6.1 One flew over the Cuckoo's nest

In the popular novel, *One Flew Over the Cuckoo's Nest* (written by Ken Kesey), the psychiatric hospital is described as a clinical, cold environment in which patients are voiceless. A lot has been done to change this perception of psychiatric care and today a more holistic patient-centered approach is employed. Hale (2007) explains that in current times, and in contrast to the formerly prevalent emphasis on the Western biomedical model, mental healthcare practitioners are now more critical of their own communicative behaviours and emphasize the importance of being responsive to the patients' psychosocial issues and cultural backgrounds in the diagnostic treatment process (Hale, 2007). In order to provide holistic treatment, hospital treatment characteristically involves a multidisciplinary group of mental health professionals. Each team member addresses different elements of the patient's difficulty. Sadock and Sadock (2003) provide the following description of each team member's responsibility: the psychiatrist is responsible for making a diagnosis and prescribing medication. The nurse is responsible for the patient's personal care. The psychologist is responsible for the diagnostic assessment of the patient's cognitive strengths and weaknesses and for psychotherapy. The social worker is mainly responsible for psycho-educating the patient and his or her family. The occupational therapist assists the patient to function independently in various aspects of his or her life (Sadock & Sadock, 2003).

1.6.2 The psychiatric interview

Psychiatric interviews have two major technical goals: recognition of the psychological determinants of behavior, and symptom classification (Sadock & Sadock, 2003). The psychiatrist classifies patients' complaints and dysfunctions according to specific diagnostic categories. In order to make a diagnosis the psychiatrist will enquire about patient symptoms, course of illness, family history, personality, and developmental history. Since psychiatric patients often find it difficult to describe their experiences, psychiatrists also have to obtain information from other sources, such as family members (Sadock & Sadock, 2003). Many factors influence both the content and the process of psychiatric interviews. The content of an interview refers literally to what is said between psychiatrist and patient. The process of the interview refers to what occurs non-verbally between the psychiatrist and patient. For example, patients may use body language to express feelings they cannot express verbally.

Some of the factors affecting the content and process of interviews include the use of an interpreter, note taking, and the patient's illness itself. Other factors include interviewers' styles, experiences, and theoretical orientations. Even the timing of interjections such as *uh huh* can influence when patients speak and whether they follow leads and cues provided by the psychiatrist (Sadock & Sadock, 2003).

The psychiatrist's ability to establish rapport with his or her patient is fundamental to any psychiatric interview. Sadock and Sadock (2003) define the term rapport as the spontaneous, conscious feeling of responsiveness that promotes the development of a constructive therapeutic relationship. Psychiatrists often use their own empathic responses to facilitate the development of rapport. The development of rapport can be organized into six categories: putting patients and interviewers at ease; discovering patients' pain and expressing compassion; evaluating patients' insight and becoming an ally; showing expertise; establishing authority as clinicians; and balancing the roles of empathic listener, expert, and authority (Sadock & Sadock, 2003).

1.6.2.1 The structure of psychiatric interviews

The following four segments characterize psychiatric interviews (Sadock & Sadock, 2003):

- Segment 1 (The beginning of the interview): The start of the interview has an impact on the remainder of the interview. Patients often feel anxious, intimidated and vulnerable during their first encounter with the clinician. Clinicians who are able to establish rapport, put the patient at ease, and show respect during the beginning of the interview are more likely to have a productive interview and acquire the necessary information to make an accurate diagnosis. It is important for clinicians to introduce themselves and make sure that they know the patient's name. Patients also have a right to know the position and professional status of the clinician and others involved in their care (Sadock & Sadock, 2003).
- Segment 2 (Asking about the patient's problems): After the introduction, the clinician will ask the patient to talk about the reasons for him or her seeking psychiatric treatment. Allowing the patient to use his or her own words without being too direct conveys to the patient that the clinician is interested in listening to the patient's complaints. Patients are unlikely to speak freely unless they have privacy and are sure that their conversations are

confidential. Clinicians should ensure that they attend to factors such as privacy and a lack of interruptions (Sadock & Sadock, 2003).

- Segment 3 (The interview proper): In the interview proper, clinicians discover in detail the patient's presenting problems. It is important that to do this in a systematic manner that facilitates the identification of aspects associated with the patient's problems in the context of an ongoing empathic working alliance with patients (Sadock & Sadock, 2003).
- Segment 4 (The end of the interview): Clinicians want patients to leave an interview feeling that they are understood and respected. At the end of the interview, the patient should feel that he or she conveyed all the important information to an informed and empathic clinician. Towards the end of the interview, clinicians should give patients the opportunity to ask any additional questions. Clinicians should also thank patients for sharing the necessary information and let patients know that the information conveyed has been helpful in clarifying the next steps (Sadock & Sadock, 2003).

1.6.2.2 Common techniques associated with psychiatric interviews

Sadock and Sadock (2003) refer to the following common techniques employed by clinicians during psychiatric interviews:

- Open-ended and close-ended questions: Interviewing involves a fine balance between allowing the patient's story to unfold spontaneously and obtaining the necessary data for diagnosis and treatment. In the ideal interview, the clinician begins with broad open-ended questioning, continues by becoming specific, and closes with detailed direct questioning. The early part of the interview is generally the most open-ended, in that clinicians allow patients to speak as much as possible about their experiences in their own words. An example of an open-ended question is: *"Can you tell me more about that?"* (Sadock & Sadock, 2003, p. 8). Open-ended questions are also used as verification of understanding (Penn & Watermeyer, 2009). For example, clinicians may want to verify whether patients understand the treatment plan. A close-ended, or directive, question is one that asks for specific information and allows a patient few options in answering (Sadock & Sadock, 2003). An example of a close-ended question is: "*Who accompanied you to the day clinic?"* Sadock and Sadock (2003) explain that too many close-ended questions, especially in the early part of the interview, can restrict patient responses. Sometimes directive questions are necessary

to obtain important data, but when they are used too often, a patient may think that information is only to be disclosed in response to direct questioning by the clinician. Close-ended questions can be effective in generating specific and quick responses about a clearly delineated topic. They are effective in eliciting information about the absence or presence of certain symptoms such as auditory hallucinations. Close-ended questions are also effective in assessing such factors as the frequency, severity, and duration of symptoms (Sadock & Sadock, 2003).

- Reflection: In the technique of reflection, a clinician repeats to a patient, in a supportive manner, something that the patient has said. The goal of reflection is twofold: to assure the clinician that he or she has correctly understood what the patient is trying to say and to let the patient know that the clinician understands what he or she said. It is an empathic response meant to let the patient know that the clinician is both listening to the patient's concerns and understanding them. Reflection is not an exact repetition of what the patient has said, but rather a paraphrase that indicates the clinician has understood the essential meaning. For example, when a patient talks about his or her fears about the informing other people about his or her status, the clinician could say: "*It seems that you are concerned with becoming a burden to your family"* (Sadock & Sadock, 2003, p. 9)).
- Facilitation: Doctors help patients continue engaging in the interview by providing both verbal and nonverbal cues that encourage patients to keep talking. For example, the clinician could nod his head; or lean forward in the chair and say "*uh-huh"* or "*mm"* (Sadock & Sadock, 2003, p. 9).
- Silence: In the clinician-patient relationship, however, silence may be constructive and in certain situations may allow patients to contemplate, to cry, or just to sit in an accepting, supportive environment in which the clinician makes it clear that it is not always necessary to talk all the time (Sadock & Sadock, 2003).
- Confrontation: The technique of confrontation allows the clinician to point out to a patient something that the clinician thinks the patient is not paying attention to, is missing, or is in some way denying. It is important for the clinician not to confront the patient in a way that makes him or her hostile and defensive. The aim of confrontation is to help patients face whatever they need to face in a direct but respectful way. For example, a clinician could confront a patient, who made a suicidal gesture in the

presence of the clinician by saying: *What you have done may not have killed you, but it is telling me that you are in serious trouble right now and you need help so that you don't try to commit suicide again* (Sadock & Sadock, 2003, p. 9).

- Clarification: In clarification, clinicians attempt to get details from patients about what they have already said. For example, if a patient told the clinician that he or she was feeling depressed, the clinician could ask the patient: *When do you feel most depressed?* (Sadock & Sadock, 2003, p.9).
- Interpretation: Clinicians mostly use the technique of interpretation when they state something about a patient's behaviour or thinking that the patient may not be aware of (Sadock & Sadock, 2003).
- Summation: Periodically during the interview, a clinician can take a moment and briefly summarize what a patient has said thus far. Doing so assures both the patient and clinician that they have shared understanding of what the patient has actually conveyed. For example, the clinician may say: "*Ok, I just want to make sure that I've got everything right up to this point"* (Sadock & Sadock, 2003, p. 9).
- Explanation: Doctors should explain treatment plans to patients in easily understandable language and allow patients to respond and ask questions (Sadock & Sadock, 2003).
- Transition: The idea of transition allows clinicians to convey the idea that enough information has been obtained on one subject; the clinician's words encourage patients to continue on to another subject. For example, the clinician could say: "*You've given me a good sense of that particular time in your life. Perhaps now you can tell me more about an even earlier time in your life"* (Sadock & Sadock, 2003, p. 9).
- Positive reinforcement: The technique of positive reinforcement allows patients to feel comfortable telling a clinician anything. Encouraging a patient to feel that the clinician is not upset by whatever the patient has to say facilitates an open exchange (Sadock & Sadock, 2003).
- Reassurance: Truthful reassurance of a patient can lead to increased trust and compliance and can be experienced as an empathic response of a concerned physician (Sadock & Sadock, 2003).

- Advice: In many situations, it is not only acceptable but also desirable for clinicians to give patients advice (Sadock & Sadock, 2003).

As I explained earlier, the primary focus of this dissertation is interpreter-mediated encounters and in the next section, I refer to the 'profession' of interpreting within healthcare services, such as psychiatric hospitals.

1.7 What is Community Interpreting?

Hale (2007) explains that interpreting within public service settings, such as hospitals, fall within the category of Community Interpreting. Although, Community Interpreting is perceived as a branch of the interpreting profession (still in its infancy), it is an area of interpreting in its own right (Hale, 2007). Community Interpreting takes the interpreter into the most private spheres of human life. It does not take place at negotiations about major international political decisions or conferences on recent scientific discoveries; it takes place in settings where the most intimate and significant issues of everyday life are discussed, such as in a clinician's surgery, a social worker's office, a police station (Bot, 2005; Hale, 2007). As Mason (1999) explains, the defining characteristic of Community Interpreting is that a limited number of people communicate through an interpreter in spontaneous face-to-face interaction (Mason, 1999). Community Interpreting is usually done in the consecutive and not in the simultaneous mode (Bot, 2005). Hale (2007) explains that simultaneous mode is used in conference interpreting. In simultaneous mode, the interpreter listens to the speaker through headphones and begins interpreting a few seconds after the commencement of each utterance. However, in the consecutive mode, the interpreter interprets a dialogue between people who speak different languages. The interpreting is done after each conversational turn. Each turn is relatively short, and is generally determined by the previous turn (Hale, 2007).

Unlike Conference Interpreting, Community Interpreting has a relatively low status. This is perhaps due to its association with refugees and immigrants who are perceived to have low social status (Hale, 2007). Many refugees and immigrants require interpreter services due to globalization and the increasingly high levels of immigration in many countries around the world (Hale, 2007). The low status of Community Interpreting may also be due to the following factors: the disorganized and unstructured state of the industry; the fact that informal or ad hoc interpreters are frequently used; the absence of mandatory university

education or officially recognized courses for community interpreters; the lack of a strong professional identity; and the general unawareness of the complexity of the task of interpreting (Bot, 2005; Hale, 2007).

One way to change the status is to professionalize Community Interpreting. Professionalizing Community Interpreting would imply that an attempt is made at having the profession of Community Interpreting recognized, with training courses, professional registration and a professional code of ethics (Bot, 2005). As Bot (2005) rightly points out professionalizing Community Interpreting would also mean that the users of interpreting services are aware of the fact that interpreting is a profession and cannot be done adequately by just anyone who is more or less bilingual (Bot, 2005). Professionalizing Community Interpreting will imply that public services, such as healthcare institutions, which simply employ anyone who speaks a fragment of the patient's language, will have to take a critical look at their language policies and practices. Next, I turn the reader's attention to the outline of the chapters in my dissertation and I provide a brief description of each chapter.

1.8 Outline of chapters

The rest of the dissertation is divided into the following chapters:

- In Chapter 2 (*Understanding Community Interpreting research with a particular interest in psychiatric care*), I provide a concise overview of prominent studies (globally and locally) within the field of Community Interpreting research. Next, six specific themes are discussed. The first theme (see section 2.2) refers to a major shift (from a monological to a dialogical perspective) in the way researchers approach interpreter-mediated conversations in real-life. The second theme (see section 2.3) relates to factors guiding speakers' actions during conversations as well as interpreter models. The third theme (see section 2.4) relates to interpreters' competency and interpreting techniques. As part of the fourth theme (see section 2.5), I refer to different perspectives on what constitutes an accurate interpretation. The fifth theme (see section 2.6) relates to the important role played by trust in interpreter-mediated encounters. Finally, the sixth theme (see section 2.7) refers to the demands and psychological impact associated with the role of the interpreter.

- In the beginning of Chapter 3 (*The use of methods to understand language barriers*), I explain the overarching approach (i.e. a post-structuralist approach) used in this study (see section 3.1). Thereafter, I discuss the multidimensional research design (which includes ethnography, discourse analysis, conversation analysis and videography) used in my study (see section 3.2). In section 3.3, I describe the use of video recordings in social sciences and the video-analysis process. As part of section 3.3, I also explain how I went about analyzing the video recordings I made, as well as the semi-structured interviews. Next (see section 3.4), I explain the ethical aspects associated with the study. In section 3.5, I explain the practicalities involved in gaining access into the 'world' of the institution. In the section (see section 3.6) thereafter, I refer to the sampling methods I used as well as the nature of the data I collected. In section 3.7, I describe the research participants who participated in my study. In section 3.8, I refer to the room space and seating positions of participants during the video-recorded psychiatric interviews.
- Chapter 4 (*Psychiatric not interpreter-mediated)*) deals with data emanating from psychiatric interviews that were not interpreter-mediated.
- Chapter 5 (*Interpreter-mediated psychiatric interviews*) deals with psychiatric interviews that were interpreter-mediated.
- In Chapter 6 (*A case study*), I present a case study, which allows the reader to have a contextualized understanding of interpreter-mediated encounters.
- In Chapter 7 (*Understanding the study findings*), I firstly discuss the findings in relation to the goals of the psychiatric interview (see sections 5.1-5.6). Following this, I discuss the impact of language practices on healthcare providers, users and ad hoc interpreters. In addition, I refer to the role played by language and race in post-apartheid South Africa (see section 5.7).
- In Chapter 8 (*Concluding Remarks)*, the focus is on the implications of the study findings and how to address the issues highlighted in the discussion chapter, as well as the study's limitations.

CHAPTER 2: UNDERSTANDING COMMUNITY INTERPRETING RESEARCH IN HEALTHCARE AND MENTAL HEALTHCARE

2.1 Introduction

Community Interpreting as a research subject, in the context of healthcare came to the attention of the scientific community during the early 1990's. Ever since the 90's, there has been growing interest in this topic. This is mainly due to globalization and increasingly mobile populations, as well the greater emphasis placed on human rights in recent years (Leanza, 2010). Healthcare workers increasingly face situations where they encounter multilingual and ethnically diverse patients, prompting scholars to study Community Interpreting (Leanza, 2010). Many of the studies, which I refer to throughout this dissertation, were conducted in developed countries with an increasing number of immigrants and refugees, such as the United States, Europe, Australia and New Zealand. The issue of linguistic diversity is no less important in developing countries, but there is very little literature on provisioning for adequate linguistic access in such contexts. The reason for this is unclear and complex. It might be due to the limited financial resources available for research in this area, particularly when developing countries, such as South Africa, face many other problems such as high levels of poverty and HIV/AIDS.

Previous Community Interpreting research studies from the medical sciences focused on the following issues:

- The accuracy of the interpreters' rendition and the nature of errors. Researchers studied translations in order to identify omissions and clinical significant additions (Pöchhacker & Shlesinger, 2005).
- The impact of interpreting practices on quality of care, and patient satisfaction (Pöchhacker & Shlesinger, 2005).
- The different interpreter models and how interpreters understand their roles (Hsieh, 2006, 2007, 2008).

Studies conducted in psychiatric care settings focus on similar issues as those addressed within the medical sciences. Important Community Interpreting research studies conducted in the field of mental health and psychiatry focuses on the following issues:

- Interpreter training and the impact it has on patient diagnosis (Westermeyer, 1999). Westermeyer (1990) explains that the goal of psychiatric interviews is to allow

patients to endorse questions about symptoms that are present. Alternatively, not to endorse questions about symptoms that are absent. A question, for example about auditory hallucinations, illustrates the crucial role played by interpreters in this regard. A competent interpreter would be cautious about the question *"Do you hear voices?"* since this could also refer to the voices of other people present in the same room as the patient (Westermeyer, 1990, p.746). A better way to phrase the question is *"Do you hear voices that no one else hears?"* (Westermeyer, 1990, p.746).

- Interpreters' movement between interpreter roles within the same encounters and sometimes even within the same turn (Bot, 2005).
- The neglected role of language in the mental healthcare context (Drennan & Swartz, 1999, 2002). The work of Drennan and Swartz (2002) played a crucial role in creating cognizance about language barriers particularly during the immediate years post-apartheid.

Unfortunately, most research studies conducted in both medical settings and psychiatric care do not pay attention to the patient's perceptions regarding the use of interpreter services. Studies focus on the perceptions of healthcare workers and interpreters, failing to take into account patients' opinions regarding interpreting practices (Schuster, 2010).

From here on, I turn the reader's attention to six broad themes (as referred to in section 1.8) that are central to the aims of this dissertation. I will briefly introduce the reader to each theme prior to a more detailed discussion thereof. The first theme that I address refers to the recent shift in the way researchers and academics study conversations in real-life. Traditionally actual conversations were analysed in the same way as written text. In other words, analysts did not take into account issues such as the context in which the conversations took place (Wandesjö, 1998). Researchers, such as Wandesjö (1998), argue that conversations in real-life do not occur in a vacuum. Instead speakers, influenced by various factors, work towards achieving mutual understanding within a particular context. This shift in approach means that researchers no longer only focus on identifying interpreting errors by comparing the source (i.e. the original utterance) and target 'text' (i.e. the translated utterance). Instead, contemporary Community Interpreting research studies include in their focus gaining a better understanding of whether the use of an interpreter contributes to the successful achievement of the goals of the conversation (Davidson, 2000, 2002). Speakers'

understanding of the goals of the conversation, as well as their perception of their roles and that of the other speaker(s), guides their actions during conversations (Davidson, 2000, 2002). As part of the second theme, I discuss the possible factors guiding speakers' actions. For example, interpreter models and speakers expectations of each other explain to some extent why speakers behave and act in a certain manner (Davidson, 2000, 2002). The third theme relates to interpreter competency. Interpreter training plays an essential role in providing 'good' patient care and this theme is of particular importance, since very few institutions offer official training courses for community interpreters. As part of the third theme, I discuss interpreters' use of a direct versus indirect interpreting approach, as well as those factors that are likely to influence interpreters' choice of approach. In the next section (the fourth theme), I address the question of accuracy (i.e. "*What is an accurate interpretation?"*) and the issue of inaccuracy or communication problems. The fifth theme relates to the role played by trust in the interpreter-mediated encounter. In other words, I explore the different reasons for patients and clinicians trusting or mistrusting the interpreter. In addition, I explore the interpreter's trust in the patient and the impact that the clinician's trust have on the role, which the interpreter assumes. In the last part of this chapter, I pay attention to the challenges associated with the role of interpreter (i.e. the sixth theme). The role of the interpreter (particularly that of the ad hoc interpreter) is demanding and may have an adverse psychological impact on interpreters. As mentioned previously, many interpreters fulfill the role of interpreter in addition to their official work. This in itself is very demanding. Furthermore, interpreters frequently have to interpret patients' stories of abuse and neglect. This type of information is difficult to take in and interpreters often do not have the necessary support to assist them in coping with patients' stories.

2.2 A new way of understanding conversations in real life

The work of Wandesjö (1998) greatly influenced my approach to understanding interpreter-mediated encounters and I refer to Wandesjö's work for most part of this section. As explained above, traditionally analysts study interpreted dialogue in the same way as they study the translations of written text. In other words, analysts focus on how accurate the translated utterance corresponds with the original utterance (Wandesjö, 1998). All information that the primary speaker explicitly expresses in his or her turn, including the style and form in which he or she expresses the information, the interpreter has to provide in his or

her rendition of the primary speaker's turn. Furthermore, Wandesjö explains that from this traditional perspective, the meaning of words and utterances is a direct result of the speaker's intentions or strategies alone, while co-present people are merely recipients (without any influence) of the units of information prepared by the speaker. It is as if the individual speaker is detached from his or her interactional context. In the traditional, monological perspective, the interpreter only speaks during every second turn, which is immediately at the end of the primary speaker's turn (Wandesjö, 1998). More specifically, the interpreter's utterances are (and should be) second versions of the preceding utterances, recorded in another language (Davidson, 2002). Wandesjö (1998) deviates from this view by proposing a dialogical perspective on interpreting and uses the term 'dialogue interpreting'. From this perspective, an utterance is a link in a chain of utterances, seen as a thread in a net of intertwined communicative behaviour. Meaning results from joint efforts between the people involved. The meanings of an original utterance will depend on factors such as: how the people present react to it; on preceding and following sequences of talk; and on non-verbal communicative behavior and paralinguistic features (for example eye contact or body language) defined by the situation. The meanings of an utterance depend on the participants' mutual expectations, physical circumstances and artifacts (Wandesjö, 1998).

Building on the work of Wandesjö, Davidson (2000, 2002) argues that instead of focusing on the correspondence between the primary speaker's utterance and the interpreter's rendition of the utterance, researchers should focus on whether the interpreter contributes to the interactional goals of the conversation. For example, researchers should focus on understanding whether the interpreter assists the patient in conveying his or her complaint and whether the interpreter furthers the clinician's understanding of the patient's complaint (Davidson, 2000, 2002). Van De Mieroop, Bevilacqua, and Hove (2012) conducted a study in an old age home and analysed a conversation between a psychologist, patient and interpreter. In the study conducted by Van De Mieroop et al. (2012), the interpreter's actions negatively influenced the patient's score on the Mini-Mental State Examination[3]. The interpreter made

[3] The Mini-Mental State Examination is a test designed to distinguish between signs of dementia, psychosis, and affective disorders.

additions and changed the format of the mini mental interview. This influenced particularly those questions testing memory and literacy. For example one of the questions requires the patient to spell a particular word backwards. The interpreter in this case hinted that the patient still needs to name one more vowel. This facilitated the patient's response and ultimately influenced the patient's score on the mini mental test (Van De Mieroop et al., 2012).

As Davidson (2002) explains, the interpreter can only truly understand what is being said during the interpreter-mediated conversation when he or she understands first why something is being said (i.e. the goals of the conversation). However, a better understanding of the impact speakers' actions have on the goals of the conversation requires an informed understanding of those factors guiding speakers' actions (Davidson, 2002). In the next section, I explore in more detail specific influences and factors, which guide speakers' action during actual conversations.

2.3 Factors guiding speakers' actions

This section focuses largely on factors guiding interpreters and clinicians' actions during interpreter-mediated encounters. Although it is recognized that all three parties within the interpreter-mediated encounter are actively involved in the co-construction of meaning (Van De Mieroop, et al. 2012), very few studies focus on what guides patients' actions during interpreter-mediated encounters (Schuster, 2010). However, at the end of this section I discuss two important South African studies (Schneider, 2010; Watermeyer, 2011), which explain to some extent patients' actions within healthcare settings and during interpreter-mediated conversations.

The interpreter, clinician, and patient's communicative actions closely relate to their perceptions about their own individual roles and the roles each party should play within the interpreter-mediated encounter (Hsieh, 2008). There are different schools of thought particularly about the role of the interpreter. In general, interpreters and clinicians favour either the translation machine model or the mediator model. Bot (2005) explains that the two models are on the opposite sides of the spectrum. On the one end of the spectrum is the translation machine model. According to this model, the interpreter merely acts as translator or language 'tool'. On the other end of the spectrum is the mediator model, and this model

regards the interpreter as an active participant and mediator. The problem is that often speakers have different ideas about what each party's role entails during conversations (Bot, 2005). Healthcare workers and interpreters in many settings have been developing, independently of each other, their ideas about how to work in the interpreter-mediated encounter. There is little joint development of theory or ideas of 'best practice' and / or training. It is therefore not uncommon for each party to have a different perspective of the role that each should play within the encounter, a perspective that may be incompatible with that of the other party (Bot, 2005). The lack of consensus amongst scholars, healthcare practitioners, and healthcare users regarding the various models is due partly to the lack of extensive and systematic research investigating what the various approaches actually consist of and how they compare in real-life practices (Bot, 2005).

In the section below, I provide a more detailed description of both the abovementioned models. In addition, I refer to another model, the bilingual worker model, which prescribes that the interpreter act as a junior clinician who interviews the patient alone (Westermeyer, 1990). I was unable to find any research that study the use of this model in real-life encounters, hence the information I provide on this model is limited.

2.3.1 Interpreter-models

2.3.1.1 The translation machine model

According to the translator model, also referred to as the black box model, the interpreter is perceived as a language 'tool' and is someone who simply takes messages from one person and passes them on to another, without intervening between the patient and the clinician (Westermeyer, 1990). According to Davidson (2002) this model perceives interpreter-mediated interactions as versions of same-language discourse. The interpreter is not allowed to engage meaningfully during the conversations and is not seen as a "real" speaker. The model prescribes that the interpreter translates without any specific introduction to the communicative situation at hand. Working in this model means that no attention is paid to differences in attitude, behavioural norms or conversational techniques between various settings (Davidson, 2002). The interpreter shows no emotions or judgments about the content of the conversation. Primary speakers can make it easier for the interpreter to work as a translation-machine by putting an effort into formulating short and grammatical phrases, by

facing and looking at each other, addressing each other and, in general, by paying little attention to the interpreter (Bot, 2005). In the study conducted by Hsieh (2008), the majority interpreters explained that clinicians expected them to play the role of 'translation-machine'. Bot (2005) suggests clinicians' preference for the translation-machine model is because professional interpreter training programmes teach interpreters that this model is the 'ideal' model (Bot, 2005).

When working within this model the following rules apply:

- The clinician is in charge of the interpreter-mediated encounter, and is responsible for introducing the speakers to each other and regulates turn taking (i.e. when someone gets a turn to speak) (Bot, 2005).
- The black box model requires that the interpreter provide an equivalent translation, including false starts, slips of the tongue etc. The interpreter is furthermore required to use a direct form of translation. In other words, keeping the perspective of the primary speakers (i.e. using the first person singular) is most important (Bot, 2005).
- As mere translator, the interpreter is limited to second turns. For example, the clinician will ask a question, and this will immediately be followed by a translation of the question by the interpreter, which in turn is immediately followed by the patient's response and this is then translated by the interpreter (Van De Mieroop, et al. 2012).
- The interpreter will not ask 'unprompted' questions - except to clarify when he or she did not hear or understand what was said (Bot, 2005).
- The interpreter will not intervene when there is a misunderstanding due to a lack of cultural information (Bot, 2005).

Four main arguments are made in support of the translation-machine model. Firstly, it is regarded as the best model to use when the nature of the situation requires precise translations and no deviations from the original text, such as in situations like child abuse and neglect where legal implications are involved (Hatton & Webb, 1993). Secondly, it is regarded as the ideal for professional-persons-as-interviewers, such as research interviewers and clinicians, with whom the relationship formed is usually of short duration, with intensive questioning periods in which accurate information must be elicited (Bloom, Hanson, Frires, & South, 1966). It is perceived to facilitate the rapid development of conversational rhythm. As

explained above the interpreter is limited to second turns which allows for less interruption and in turn facilitates pace and rhythm (Searight & Searight, 2009). Thirdly, it is argued that this model reinforces the provider-patient relationship since it requires interpreters to adopt a first-person singular interpreting style and involves intentionally avoiding eye contact with the clinician and patient when interpreting (Hsieh, 2008). In other words, the aim of this model is to render the interpreter almost invisible. In the study conducted by Hsieh (2008), interpreters reported that by avoiding eye contact with the clinician and patient they would be perceived as less visible. Fourthly, because the translation machine model prescribes that interpreters provide a word-for-word interpretation, it is argued that this model is less likely to lead to the omission of information (Bot, 2005).

Those opposed to this model argue that the model is unrealistic and impacts negatively on job satisfaction and enjoyment (Levin, 2005). Hsieh (2008) found that interpreters felt conflicted about adopting the role of translation machine, since they felt the urge to act as patient advocate. Levin (2005) found that clinicians at a children's hospital in South Africa tended to adopt the black box model when using nurses as interpreters. Doctors tended to impose this role on the nurses, which led to nurses feeling they were merely being used as language vehicles. However, Levin (2005) found that at the Khayelitsha (an area that consists of formal and informal housing in the Western Cape) clinic, clinicians perceived interpreters as being part of the medical team. The nurses acting as ad hoc interpreters appreciated their being perceived in such a way – as part of diverse work responsibilities, and expressed trust, satisfaction and job enjoyment with regard to their role of interpreter (Levin, 2005). In a training programme at the University of Minnesota, Westermeyer (1990) found that psychiatric residents and staff members increasingly felt that it is unrealistic to expect interpreters to work as mere translators (i.e. 'language tools') in the psychiatric interview. Interpreters shared these feelings and felt that it was impossible to act as merely translators, since the role of interpreter cannot be reduced to language tool (Westermeyer, 1990).

2.3.1.2 The mediator model

According to the mediator or mediator model, the clinician and the interpreter operate as colleagues in gaining a common understanding of the patients' diagnoses (Swartz & Turner, 2006). Bot (2005) refers to a similar model called the interactive model and in this section I

explain Bot's model in more detail. The interactive model is characterized by the recognition that the clinician and interpreter are present as persons, albeit in their different professional roles. Clinicians search for a good match between a specific patient and a specific interpreter and will try to book this specific interpreter for the following sessions with the patient. They also pay attention to the issue of 'trust' both in relationship to the clinician and the interpreter. The interpreter is there as a person with a name. When a 'new' interpreter gets involved in a treatment, the clinician may brief the interpreter about the previous sessions by to help him or her understand the ongoing therapeutic process. The interpreter is there to translate the words that are being uttered, but it has been recognized that the interpreter, by being present, exerts some influence on the conversation. This influence can be put to use to facilitate the communicative process. For example, through his attitude, the interpreter has an influence in discouraging or encouraging the patient to speak freely about what is important to him. 'Empathy' from the side of both the clinician and the interpreter is a prerequisite for therapeutic communication. Social interaction amongst the various participants, outside the session, is not always a boundary violation, and could even be useful in the development of the therapeutic relationship (see section 2.5.1). There is recognition for the clinician being the 'chair' of a session. However, he or she can sometimes and to some extent delegate this 'chairmanship' (I discuss the issue of 'chairmanship' in more detail in section 2.3.4). The complexity of the concept 'equivalent translation' is recognized and it is accepted that not all translations will be 'equivalent'. In a trustful relationship, 'transparency' is important but not an absolute prerequisite for open communication. In the mediator model there is emphasis on the interpreter as a person and thus on the importance of engaging the same interpreter throughout a treatment. The interpreter should also be informed in advance about the nature of the consultation and the interpreter and clinician should have discussions post-session (Bot, 2005).

In practice, it seems that particularly untrained interpreters are more likely to employ the mediator model. Bischoff, Kurth and Henley (2012) found that interpreters perceived themselves as the patients' closest partners in the healthcare service. Interpreters reported that their presence was a comfort to patients and helped them feel less anxious. Hsieh (2008) found that interpreters perceived themselves as advocates responsible for empowering patients who cannot obtain fair and equal healthcare services. According to Hsieh (2008),

interpreters employ two different advocate styles. The first style is that of overt advocate: the interpreter pursues information, offers answers, and seeks services for the patient without consulting with the patient. Interpreters particularly felt it appropriate to take on this role during provider-patient conflict. The second style is that of covert advocate where the aim is to promote self-advocacy to the patient, through improving patients' health literacy. This role also involves informing patients about how to request proper services or information without the clinician's knowledge. In general, interpreters assume this role outside the presence of the clinician, for example during times that patients and interpreters are alone. This role could also imply that interpreters help patients to be competent participants in the provider-patient interactions. For example, interpreters may assist patients to find information in a more effective and appropriate way by elaborating on a speaker's comment to improve a patient's ability to request services and to understand medical procedures, as well as engage in effective provider-patient interactions (Hsieh, 2008).

Some academics refer to specific challenges (listed below) associated with the mediator model, such as the following.

- Within this model, the interpreter may repeatedly interrupt the interview and attempt to control the interview. Such unwarranted intervention might otherwise result in misdirection of the interview (Hsieh, 2007; Putsch, 1985).
- As team members the interpreter and clinician may discuss matters during the interpreter-mediated encounter that are not conveyed to the patient, and this may cause the patient to feel excluded (Bot, 2005).
- The interpreter can become too involved and roles can become blurred, which results in situations in which the clinician is no longer part of the conversation (Bot, 2005).
- Drennan and Swartz (2002) argue this model can be problematic when roles are not explicitly discussed. They warn that there need to be clear guidelines regarding the circumstances under which the clinical responsibilities are assigned to the interpreter and how the clinician should retain overall accountability (Drennan & Swartz, 2002).

2.3.1.3 The 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, and the clinician has no contact with the patient (Westermeyer, 1990). The clinician relinquishes his or her list of questions to the interpreter and lets the interpreter make the contact, build rapport, motivate client co-operation, and ask and record the questions and answers (Bloom, et al., 1966). Westermeyer (1990) points out that this model is problematic on many levels. It could lead to a lower level of care if the interpreter has to perform clinical tasks that he or she is not trained to perform. In instances that the interpreter does not have official training it could lead to ethical and legal problems (Westermeyer, 1990).

A description of the various interpreter models raises the question: *Is it truly a matter of choice?* In other words, while acting as interpreter does the interpreter make a conscious choice to play the role of either mediator or 'translation machine'. In the next section I address this question.

2.3.2 Is it a matter of choice?

Wandesjö (1998) explains that interpreters cannot avoid being both a translators and mediator. Pöchhacker and Kadric (1999) found that the interpreter could even move between the two roles within the same turn. Pöchhacker and Kadric (1999) conducted a study in an ear, nose and throat department of a hospital in Vienna and analysed a voice therapy session involving two speech clinicians, a 10-year old boy (the patient), and hospital cleaner acting as unprofessional interpreter. They found that in many instances the interpreter played a more reserved role, at times she would even step out of the role of interpreter by not rendering utterances. However, in other instances the interpreter was prepared to go beyond providing renditions on request and made direct contributions to the communicative content of the interaction (Pöchhacker & Kadric, 1999).

Bolden (2000) argues that interpreters in real life encounters are speaking agents who are engaged in the process of making meaningful utterances. Bolden (2000) explains that the interpreter's actions are aimed at eliciting an intended response from, or to have an intended effect upon the other speakers. Interpreters' actions in making sense of utterances manifest as a choice between several alternatives available to them at any particular time within the frame of ongoing activity. These alternatives, ranging from being a 'translating machine' to having

an independent interactional position (i.e. the mediator role); embody interpreters' moment-by-moment decisions about what role will be the most appropriate in a particular interactional environment. The interpreters' communicative behaviour and actions are therefore not static, since each moment within the interpreter-mediated encounter is unique (Bolden, 2000).

Davidson (2000, 2002) argues that interpreters are not, and cannot merely be language tools because they are faced with the reality of language in equivalency. Furthermore, linguistic systems are not the same in how they convey information contextually, and because interpreters are themselves social agents and participants in the discourse (Davidson, 2000, 2002).

According to Bot (2005), the best of both models are most appropriate for real life interpreter-mediated encounters. Bot argues that the interpreter as mere translation tool denies the presence of the interpreter. This denies the inevitable influence of the interpreter on the content, the structure and the organization of the session. A liberal version of the mediator model is also not a model to aim for. In this model, the interpreter has so much responsibility that in the end the dialogue dominated by the interpreter while the clinician loses touch with what is going on and is largely excluded from the dialogue. Bot (2005) therefore concludes that a restrictive version of the mediator model of interpreting is ideal. This allows for the use of some techniques associated with the translator model (i.e. brief turns, no overlapping talk, the clinician as chair), as well as techniques associated with the mediator model. Techniques associated with the mediator model include the use of recycling[4] (used mainly by the clinician), clarifying questions (used mainly by the interpreter) and feedback (used mainly by the patient and clinician) (Bot, 2005). In the next section, I refer to the work of some researchers who explore clinicians' perceived expectations of the interpreter's role.

[4] The speaker repeats his or her question or use slightly different words and usually precedes this by a summary of what he or she has just heard (Bot, 2005).

2.3.3 Clinicians' expectations of the interpreter

As mentioned in section 2.3.1.1, Hsieh (2008) found that healthcare providers reported that they expected interpreters to provide literal, neutral, faithful information (i.e. as the translator model prescribes). Bischoff, et al. (2012) found that clinicians who are not used to working with interpreters were more likely to demand that interpreters act as translators and provide word-for-word translations.

Hsieh, Ju, and Kong (2009) found that healthcare providers contradicted themselves, since on the one hand they wanted the interpreter to act as a translator, while on the other hand they viewed interpreters as colleagues who are members of the healthcare team. Hsieh et al. (2009) argue that the emphasis on the team made some providers expect interpreters to ally with them. The notion of team member and alliance contradicts the neutral performance that is emphasized by the translator role. In the study conducted by Hsieh et al. (2009), clinicians also aligned themselves with interpreters, noting that they both shared similar a goal (i.e. patient care). They trusted interpreters' ability to make active judgements to fulfil the goals of the team. In other words, deviation from the translator role is accepted and valued when it accomplishes the team's objectives. Clinicians emphasized that interpreters should however not overstep their role boundaries and overtake the providers' control over the healthcare services. Clinicians therefore wanted interpreters to play an active role within certain role boundaries. Clinicians also stated that some interpreters are welcomed into a more active role because of their medical expertise and training. From this perspective not all interpreters are endowed with the same set of professional boundaries. In short, interpreters' role boundaries can vary drastically depending on the tasks, clinical speciality, and the providers' knowledge of their background. Having control over the medical encounter is critical to providers as they feel the need to be in charge of the interpreter-mediated interactions (Hsieh et al., 2009). I discuss the issue of control and the management of the interpreter-mediated encounter in more detail in the next section.

2.3.4 Managing the interpreter-mediated encounter

As I referred to above, each model prescribes who between the clinician and interpreter should manage the interpreter-mediated encounter. Hsieh et al. (2010) argues that ideally the interpreter should be in charge of cultural and linguistic aspects and the clinician in charge of

medical or clinical aspects. It is best to have the linguistically and culturally knowledgeable interpreter and the medically knowledgeable physician exercise their expertise in the corresponding area. The problem is that what is medical, psychiatric social, cultural and linguistic are not always obvious (Hsieh et al., 2009). Similarly, Bot (2005) explains that the interpreter should mainly be in charge of the turn taking process and making sure that the participants do not talk at the same time. According to Bot (2005), this does not imply that the clinician cannot play a role in this regard, simply because he or she does not understand what the patient is saying. Although, the clinician only has limited use of linguistic ways to regulate turn transfer (for example through grammar, content, and intonation), he or she may use alternative techniques, such as gestures, gaze, overlapping speech and silent moments, to assist the interpreter in managing turn taking. Furthermore, Bot (2005) warns that it is important that the interpreter and clinician do not compete with each other in regulating turn taking.

In addition to turn taking, interpreters also seem to manage other aspects associated with the interpreter-mediated encounter. In the study conducted by Hsieh (2008), interpreters reported that they manage the interpreter-mediated encounter through the following mechanisms:

- Conserving resources: One way in which interpreters conserve medical resources include acting as co-diagnostician. By assuming this role, interpreters may help providers to identify the patient's problem more effectively, and so, conserve resources. Interpreters often work with the same patients during different appointments and consequently acquire knowledge of the patient. During sessions, interpreters might verify information that they already know to save time and only interpret messages that they were not able to verify. Interpreters mentioned that after the provider leaves the room, patients might ask questions to verify their understanding of the diagnosis or medication. The interpreter would then confirm information that had already been discussed during the encounter with the clinician and seek the provider's clarification when needed. Interpreters also explained that they might act as backup providing variable services when needed. Many interpreters talked about how clinicians' communicative behaviours reflected their lack of time or cultural sensitivity to provide optimal care. Interpreters explained that it was therefore not uncommon for them to have patients discussing their emotional and social stress

with the interpreter (outside the presence of the provider). Interpreters at times might provide empathy, counselling, and comfort to patients (Hsieh, 2008).

- Regulating appropriate, ethical and relevant performances: Hsieh (2008) suggests that when assuming the role of manager, interpreters do not side with any speaker but evaluate whether the information is appropriate and ethical to the provider-patient interaction, and choose their communicative strategies accordingly. For example, providers at times may become irritated and express their frustration through their tone of voice. One way of handling the matter is to point out the inappropriate behaviour of the patient or provider and specify what is appropriate and acceptable in provider-patient encounters (Hsieh, 2008).
- Managing the optimal exchange of information: Hsieh's (2008) found that interpreters manage information in three ways. Firstly, interpreters modify information to improve the providers' and the patients' understanding. For example, some words in the source language do not have equivalent counterparts in the target language. Secondly, the interpreter might modify information for cultural reasons. For example, certain comments might be considered inappropriate or offensive in another culture. However, this is not the same as the cultural broker role, since the cultural broker provides others with the cultural framework to understand the communication, while the role of managing information does not necessarily involve that the interpreter make cultural issues comprehensible to other speakers. Thirdly, interpreters manage both the content and the flow of information. Interpreters therefore screen the relevance of information. For example, interpreters mentioned that they do not interpret comments not directed to the patient (Hsieh, 2008).

Pöchhacker and Kadric (1999) found that when the interpreter inappropriately takes charge of the interpreter-mediated encounter, this might have a detrimental impact on the goals of the conversation. In the study conducted by Pöchhacker and Kadric (1999), the interpreter without the knowledge of the clinician used his or her own explanations or definition of words. In instances that the patient did not provide an immediate response, the interpreter expanded his or her rendition of the clinician's words by providing the patient with various options. The interpreter assumed responsibility for the patient's answers. In some instances, the interpreter dismissed the patient's negative answers and insisted that the patient give a

positive answer. Furthermore, the interpreter provided the patient with reassurance. This could be problematic (Pöchhacker & Kadric, 1999). For example, it would be problematic if the interpreter's reassurance gives the patient false hope about his or her prognosis.

Davidson (2000) found that due to time constraints the interpreter and patient often waited together for the arrival of the clinician. In the study conducted by Davidson (2000), the interpreter and patient became acquainted and established a relationship during the time they waited together for the clinician. Presumably, due to this initial contact, the interpreter tended to dominate the interview, and rather than maintaining parallel and related conversations, the interpreter only occasionally informed the patient and clinician of the other's responses. The interpreter only took on the role of interpreter when the patient and clinician explicitly made it clear that they want the interpreter to interpret by telling him or her explicitly to do so. Particularly when the patient made a request for interpretation, this was not always granted.

The limited and in some instances non-existent contact between the patient and clinician, for obvious reasons has a negative impact on the doctor-patient relationship. Furthermore in some instances interpreters answered questions on behalf of clinicians (without the clinician's knowledge of the patient's questions). The significance of this is that patients are receiving answers from their interpreter and not from their physician. Furthermore, the clinicians have no idea that their patients are asking questions at all, which increases the likelihood that ethnic minority patients are seen as passive. It also prevents the clinician from following up on difficult questions that may display a deep misunderstanding, on the part of the patient, as to what the diagnosis or plan of treatment involve. Davidson (2000) found that in instances, in which the interpreter inappropriately took charge of the conversation, most of the patient's complaints were left undiagnosed and untreated. This was mainly because the interpreter did not share the patient's complaints with the clinician. Davidson (2000) found that filtering patients' utterances, screening them for relevance to the physician's questions and deleting patients' utterance to protect the clinician and the institution from the patient's critique occasionally took place. In Davidson's (2000) opinion, instead of acting as advocates for interpreted patients, interpreters were acting, at least in part, as informational gatekeepers who keep the interview 'on track' and the physician on schedule. Instead of focusing on the patient's needs interpreters frequently engaged in furthering the physician's perceived

agenda. This happened not only because of time pressures, but because hospital-based interpreters are members of the hospital community where they work and interact daily; they are institutional insiders and perceive themselves as such (Davidson, 2000). In the next section, I refer to two studies, which focus on how the patient actively negotiates care and how the patient involves the interpreter during the interpreter-mediated encounter.

2.3.5 Patient tactics

Prior to a more detailed description of patient actions during conversations, I would like to turn the reader's attention to the study of Schneider et al., (2010). The research conducted by Schneider et al. (2010) studied patient tactics in negotiating healthcare and found that patients are creative and active agents operating within the constraints and possibilities of the healthcare environment. Patients' actions are oriented to two main goals: obtaining care and preserving their sense of self and dignity. This is not surprising considering that the healthcare environment is one of mass processing and depersonalisation. One of the key tactics employed by patients was forming alliances and making connections with members of staff. In other words, patients who 'connected' with staff were more likely to have their needs met (Schneider et al., 2010).

Watermeyer (2011) makes a significant contribution to our understanding of patients' wants and needs within the interpreter-mediated encounter. Video-recordings of interpreter-mediated encounters between pharmacists and first-language Setswana (i.e. one of the official languages of South Africa) speakers were analysed. Patients displayed a need to control the involvement of the interpreter. At times patients spoke directly to the pharmacist, in broken English. At other times, patients explicitly asked the interpreter to assist. Watermeyer (2011) found that often the patient (and not the pharmacist) invited the interpreter's assistance. This illustrates patients' need to control the involvement of interpreters and that clinicians should allow patients to decide if, and at what point during the conversation, they require the interpreter's assistance (Watermeyer, 2011). In section 2.4, I refer to the importance of interpreter competence and training, as well as the techniques interpreters use.

2.4 Competency and techniques

2.4.1 Competency and training

Many scholars (Bloom et al., 1966; Buwalda, 2007; Diaz-Duque, 1982; Putsch, 1985) make important arguments when it comes to the essential role played by interpreter training. Diaz-Duque (1982) argues that bilingualism alone does not qualify someone to be an interpreter. healthcare workers often employ individuals to act as interpreters, partly because they assume that a person's bilingualism automatically qualifies him or her to be an interpreter (Diaz-Duque, 1982). However, the ability to act as interpreter requires more than simply speaking more than one language. On a very basic level, interpreters should have linguistic training in order to act as interpreters. On a technical level, interpreters, within the interpreter-mediated encounter, should be able to understand the question and the meaning of the question. Interpreters require training in order to ask questions skillfully and report the patient's response back to the clinician (Bloom et al., 1966). Putsch (1985) points out that interpreters working within psychiatry require linguistic training in order to effectively describe and explain terms, ideas and processes that may lie outside the linguistic systems of patients. On another level, interpreters require cultural competence. Linguistic competence implies but does not guarantee cultural competence (Schwartz, Rodriguez, Santiago-Rivera, Arredondo, & Field, 2010). In addition, interpreters should know how to foster a doctor-patient relationship. Insensitive interpreters may negatively influence patients' perceptions of how friendly, concerned and respectful clinicians are towards them (Baker, Hayes, Fortier, & Puebla, 1998).

More specifically, Buwalda (2007) indicates that interpreters in the mental health system should ideally:

- be fluent in two languages (the interpreter must have the ability to understand, speak and write in both languages);
- be able to interpret accurately;
- 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 healthcare 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).

Not only is the interpreter's training is of importance; healthcare workers' training in interpreter-use is equally important. Gerrish, Chau, Sobowale, and Birks (2004) found that even though healthcare workers had interpreter services aiding them, they rarely employed the use of interpreters. This was partly due to their lack of knowledge in working effectively with interpreters and because they were unsure about the preparations interpreters had received in fulfilling their role. A study conducted by Stolk et al. (1998) found that training in interpreter use was effective in improving communication between patients and healthcare workers in an acute inpatient facility.

In addition to the interpreter's competencies, the clinician requires some level of linguistic competence (Bloom, et al., 1966). The clinician should at least have basic knowledge of the patient's language. It has been found that knowledge of even a few words or phrases of the patient's language can be very helpful and very meaningful to the patient. This simple knowledge can affect the general mood of the patient. The clinician can use his knowledge to some extent to check the interpreter's rendition of the patient's turn (Bloom, et al., 1966). Tribe and Lane (2009) argue that training in linguistic competence will assist clinicians in understanding that each language has its own grammatical structures and traditions.

Something, which may take only a few words to say in one language, may take several sentences to be interpreted accurately. If the interpreter appears to be saying a lot more or less, than you are, this may merely be a reflection of the different language structures (Tribe & Lane, 2009). The clinician should also have training in cultural competence. Although it is unrealistic to expect clinicians to be experts in every culture, they should at least be comfortable with, informed about, and appreciative of the cultures they encounter (Bussema & Nemec, 2006). In the context of mental health, cultural competence is a multidimensional construct that requires awareness of beliefs and attitudes, knowledge, and skills regarding one's own worldview, a client's worldview, and appropriate intervention strategies (Schwartz, et al., 2010). Cultural differences exist in beliefs about the meaning of mental illness, in how symptoms are expressed, and in what constitutes safe and effective treatment (Bussema & Nemec, 2006). Cultural competence means that clinicians will be cognizant of non-verbal communication that may contain cultural variations (Tribe & Lane, 2009).

Furthermore, clinicians should create an environment where the interpreter feels able to ask for clarification if he or she does not understand a term or question. Patients may initially feel uncomfortable with an interpreter being present, perhaps because they are concerned about confidentiality and information reaching other members of their community or simply embarrassed about not being proficient in English. Researchers suggest that clinicians try to avoid discussing with the interpreter any issues that do not require interpretation such as whether they are free to make the next appointment or related issues. This can make the patient feel uncomfortable and excluded (Tribe & Lane, 2009). It is also important that the matter of roles is discussed and negotiated prior to the interpreter-mediated encounter. How the questions are to be asked, how special terms are to be interpreted, pacing of the interview, ways of simplifying expressions or using cultural terms if necessary – all these and other practical issues must be worked out in advance of the interview (Bloom et al., 1966).

2.4.2 Techniques: Direct versus Indirect Interpreting Approach

Interpreters have two interpreting approaches they can use during the interpreter-mediated encounter, namely a direct or indirect interpreting approach. A direct approach implies that the interpreter interprets every turn in the first person, allowing the patient and clinician to communicate directly (Hale, 2011). An indirect approach involves interpreting in the third

person, summarising what the patient and clinician are saying and rendering only what the interpreter considers relevant (Hale, 2011). Van De Mieroop (2012) found that even when interpreters claim to use a direct interpreting approach, in practice they regularly use an indirect interpreting approach (i.e. using the third person). There are different views regarding the reasons behind interpreter's use of direct versus indirect approach. Below, I refer to factors that are likely to influence interpreter's choice of approach as well as a shift in approach.

It seems that training plays an important in interpreters' choice of approach. Bischoff et al. (2012) found that inexperienced interpreters employed a direct approach, while more experienced interpreters, especially when working with more experienced clinicians, were more likely to employ an indirect approach. Hale's (2011) findings seem to contradict that of Bischoff et al (2012). Hale conducted a study in Australia and found that the majority of interpreters (86.2%), participating in a survey, reported using the direct approach. Only one (untrained) respondent reported using an indirect approach and 12.6% (5 trained and 11 untrained) stated that they used a combination of both. No trained interpreter used the mediated approach consistently. It is my opinion that the discrepancy in findings may be due to the fact that almost all the interpreters who participated in Hale's study were accredited interpreters. The authorities who accredited the interpreters may favour the use of a direct interpreting approach. As mentioned previously, professional training programmes are likely to favour the translation machine model, which prescribe that interpreters use a direct approach (Bot, 2005).

The clinician's choice of direct or indirect interpreting approach when addressing the patient may influence interpreter's choice of approach (Van De Mieroop, 2012). In the study conducted by Van De Mieroop (2012), interpreters used the third person (i.e. he or she says) in their interpretations of both the patient and clinician's turns. Interestingly enough, interpreters used the third person more frequently to interpret the clinician's turns compared to the patient's turns. According to Van De Mieroop (2012), this was because clinicians were more likely to refer to patients in the third person. Not surprisingly, patients more frequently used a personal approach to answer questions related to their health (Van De Mieroop, 2012).

Furthermore, interpreters may also change interpreting approach when they want to avoid being embarrassed (Dubslaff & Martinsen, 2005). For example, in the study conducted by Dubslaff and Martinsen (2005), the clinician said that the patient's test results showed that the patient had an increased risk for heart disease and therefore one had to do something about the matter. Instead of using the indirect approach used by the clinician, the interpreter chose to use a more direct and personal approach to deliver the above message. The interpreter informed the patient that he had a higher percentage of risk for a disease in his or her heart. Not only did the interpreter use a direct approach, but he or she also omitted the part where the clinician mentions that something can be done about the patient's health risk. The patient was understandably upset by the news and asked where in the heart the disease can be found. The interpreter in turn responded by using indirect speech (he or she says) to translate the patient's question to the clinician. The authors argue that the interpreter's switch in style (from direct to indirect) is indicative of the interpreter's realization that he or she caused the patient to panic and that he or she wants to shift the responsibility away from himself or herself. The interpreter's use of the direct approach in this instance could also reflect his or her identification with the patient. Interpreters often perceive the use of a direct interpreting style as indicative of the interpreter's solidarity with the patient (Dubslaff & Martinsen, 2005). Interpreters may also change from a direct interpreting approach to an indirect approach when delivering bad news to the patient about his or her health. Van De Mieroop (2012) explains that interpreters use the third person when delivering bad news to distance themselves from the bad news. As I explained in section 2.3.1.1, according to the translation machine model, the use of the first person and a direct interpreting approach is associated with an accurate interpretation. In the next section, I explore the views of those ascribing to the translation machine model as well as more liberal views on the notion of accuracy.

2.5 Accuracy and communication problems

2.5.1 The issue of accuracy

Hale (2007), argues that those in favour of the translation machine model believe that translations should be literal in order to be accurate and that the interpreter's interpretation of the primary speaker's words should be equivalent at all levels of the language hierarchy

(lexical, syntactic, semantic and pragmatic). However, providing equivalence at all these levels is unachievable (Hale, 2007).

Bot (2005) formulated her own criteria to understand aspects related to equivalence in her study of interpreter-mediated psychotherapeutic conversations. Bot used the criterion therapeutic equivalence to study accuracy. In other words, an interpretation is equivalent if the interpreter's turn can be placed in the same therapeutic category as the original turn. For example, if the aim of the clinician's original utterance was to confront the patient, then the interpreter's rendition of this utterance should also confront the patient. The second criterion, perspective of person entails that the interpreter uses the first person singular if this was used by the clinician or patient in the original utterance. The third criterion namely, information equivalence refers to the content of what is said. This implies that all the information contained within the original utterance should be reflected in the rendition. Bot (2005) used this set of criteria to analyse interpreter-mediated psychotherapeutic conversations and found that interpreters often omit utterances in which the clinician express a relationship between himself and the patient. Confrontations and interpretations were also often changed into a different type of intervention (Bot, 2005).

Unlike Bot (2005), the work of Penn and Watermeyer (2012) seems to suggest that the omission of information or content is not necessarily an indication of accuracy. They found that uninterpreted information could have a positive impact on the conversational goals. In the study conducted by Penn and Watermeyer (2012), side-conversations (i.e. conversations between the interpreter and patient, which remain uninterpreted in the immediate interactional context) play an essential role in interpreter-mediated encounters in HIV/AIDS clinics. Side-conversations were seen to align the interpreter and the patient or offer guidance. It also provided important diagnostic information. (Penn & Watermeyer, 2012).

As Penn and Watermeyer (2012), Hale (2007) and Wandesjö (1998) favour a more liberal understanding of accuracy. Hale (2007) proposes that equivalence is viewed from a pragmatic perspective. This involves understanding the meaning of an utterance beyond the literal meaning of the words, understanding the speaker's intentions in context, taking into account the participants and the situation, and then assessing the likely reaction of the listeners to the utterance. It also involves understanding the appropriateness of the utterance

according to different cultural conventions that are linked to the languages in question. It should be acknowledged that the interpreter's understanding of the source or original turn is based on his or her subjective understanding of the turn. It is to the subjective interpretation of the source utterance that an interpreter has an obligation to be faithful (Hale, 2007).

Wandesjö (1998) explains that researchers should explore what people present and what is the adequate way to act given the current situation. People convey meaning through joint efforts between the people present in the conversation. Hence, the meanings of an original utterance will depend on how the people present react to it, on preceding and following sequences of talk, on non-verbal communicative behaviour and extra-linguistic features (Wandesjö, 1998). The issue of accuracy is complex, but some scholars argue that there are clear warning signs that those working with interpreters should be aware of, as well as specific ways to address inaccuracy. In the next section, I explore these warning signs and 'corrective' methods in more detail.

2.5.2 Warning signs and corrective methods

In section 2.4.2, I referred to the impact the interpreter's fear of embarrassment had on his or her choice of interpreting approach. Relating to this issue is the issue of potential loss of face, which is one of the main causes of miscommunication (Cambridge, 1999). Everyone wants to preserve his or her public self-image. The question of loss of face and identification with one or other of the parties is particularly relevant in a clinical setting where the danger is that an untrained interpreter may filter out utterances seen as showing a particular ethnic group in a bad light. Cambridge (1999) use the following example to illustrate the potential impact loss of face could have during interpreter-mediated encounters. The interpreter, embarrassed by the patient using treatment 'prescribed' by a traditional healer, may omit this information. Unaware that the patient is taking traditional medicine, the clinician prescribes medicine that in combination with the traditional medicine may have an undesirable pharmacological effect (Cambridge, 1999).

In Bot's (2005) study, clinicians (and occasionally patients) who noticed divergent renditions frequently used recycling as a corrective method. In other words, the clinician repeats his or her question or use slightly different words and usually precedes this by a summary of what he or she has just heard. Clinicians also used feedback as a corrective technique; however,

this technique was problematic in interpreter-mediated encounters. Bot (2005) explains that this is because the relation in time and space between an utterance and the feedback about this utterance was easily lost. Feedback was effective if a primary speaker does not have multiple turns and if he or she keeps his or her turns short. A third corrective technique was the use of clarifying questions. In the study conducted by Bot (2005), this technique was mostly used by the interpreter. Bot (2005) furthermore found that even though an interpreter was present, communicative breakdown occurred in various sessions. Communicative breakdown was always accompanied by an additional problem, both in the management of the session (overlapping speech, long turns), and in the translation (many divergent translations). Interestingly, in the study by Bot (2005) breakdowns did not occur in those conversations in which there were few divergent translations, no overlapping speech, no long (multiple) turns, and in which corrective techniques were used.

According to Hale (2007), the following will minimize the potential for misunderstanding and facilitate the comprehension process. At the discourse-internal level, the interpreter should have a thorough knowledge of the two languages involved. The speaker should have a coherent discourse style, a willingness to be understood, and use unambiguous expression. At the discourse-external level, the interpreter should have an understanding of the discourse roles in the interaction; the social roles attributed to the participants; the context of the situation; the setting; the relevant cultures; knowledge of the subject matter; and a common or shared knowledge with the speakers. In addition, the speakers should have an understanding of the interpreter's role, and an understanding of the interpreter's needs (Hale, 2007). In the next section, I highlight the role played by trust in the interpreter-mediated encounter.

2.6 The role played by trust in the interpreter-mediated encounter

An open and trusting interpersonal relationship is a prerequisite for effective communication (Robb & Greenhalgh, 2006). In the interpreter-mediated encounter, trust seems to play an important role on many levels.

Robb and Greenhalgh (2006) investigated patients' trust in the interpreter. They analysed issues of trust in the narratives of interpreted consultations in a primary healthcare facility in the United Kingdom (UK). The study findings suggest that the interpreter's perceived

personal qualities (gentle, caring, empathetic, and a respectful and non-judgmental attitude); and continuity of positive encounters over time contributed to patients' trust in the interpreter. Trust in the interpreter was also closely linked to a positive evaluation of the interpreter's professional qualities such as linguistic skill; confidentiality; and commitment to addressing patients' health or health-related problems. Robb and Greenhalgh (2006) argue that this indicates that a kind and friendly interpreter will not be trusted if the interpreter did not also have the necessary professional skills as described above. Another potential block to voluntary trust was the nature of the health problem. Some issues were considered too private and intimate to be revealed to strangers, especially those from the same community. Sexual problems (especially HIV/AIDS), mental health problems, domestic violence, and issues about bringing up children were all considered problematic areas to talk about in the presence of an interpreter. Patients also mentioned that they were unlikely to trust an interpreter that was not on their 'side'. Patients expected the interpreter to take and advance their 'side' in a power struggle with the clinician, and were disappointed if this did not occur (Robb, & Greenhalgh, 2006).

In the study conducted by Hsieh (2008), it was found that in those instances where interpreters did not trust patients, they tended to align explicitly with the healthcare institution and speak with the institution's voice. However, when they felt that the patient could be trusted interpreters spoke with a different voice.

Furthermore, interpreters are more likely to switch from the role of translator to that of mediator when there is sufficient mutual trust between clinicians and interpreters. Interpreters are also more likely to assume the role of mediator if they work with the same clinician over a longer period (Bischoff, et al., 2012). This could also be because clinicians who are aware of interpreters' strengths and weaknesses may be more likely to trust interpreters and implicitly encourage them to take on more responsibilities within the interpreter-mediated encounter (Bischoff, et al., 2012). In the next section, I explore some of the demands and challenges associated with the role of the interpreter, as well as interpreters' coping mechanisms.

2.7 The challenges associated with the role of interpreter

The focus of this section is mainly on the adverse psychological impact interpreting has on interpreters. The reason is that the majority of interpreters in South Africa are untrained and fulfills the role of interpreter in addition to their official work. Dual work roles are potentially stressful due to the pressures they add. Furthermore, psychiatric care deals not only with psychiatric disorders, which are in and of themselves complex, but also with sensitive issues likely to accompany them, such as abuse, rape, family violence, abandonment and HIV/AIDS. It is not fair to expect ad hoc interpreters, who do not have the necessary training, skills and support, to interpret sensitive patient information.

2.7.1 Conflicting expectations and unrealistic demands

In addition to dual work roles, stressors such as conflicting expectations are associated with the role of the interpreter. As mentioned briefly before, interpreters are generally expected to act as language instruments. However, clinicians proclaim that they are in favour of the translator role, when at the same time they expect interpreters to play a more interactive role (Hsieh et al., 2010). As Hsieh et al. (2010), explains interpreters are often aware of these conflicting expectations.

Another potential source of stress relates to the pressures created by dual work roles. In the South African context bilingual individuals acting as interpreters, fulfill the role of interpreter in addition to their official work roles. Ad hoc interpreters do not usually receive payment for their additional work. Dual work roles are likely to lead to job conflicts, with employees concomitantly regarding interpreting as an unpaid burden (Putsch, 1985).

Furthermore, the role of interpreter can be very demanding. A patient who is unable to access services due to his or her lack of familiarity with the English language would be more likely to try and make the most of having access to an interpreter 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 (Lipton, Arends, Bastian, & Wright, 2002). In addition to these stressors, it is also challenging to work with patients due to other reasons, which I explore in the next section.

2.7.2 Patients' stories

Interpreters, particularly within psychiatry, work in situations that expose them to both physical and psychological harm (Lipton et al., 2002). Patients may also 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 experience the emotional impact of the words they translate (Hsieh, 2006). As mentioned previously, the role of interpreter also includes conveying bad news. For example, informing a patient that he or she has cancer, HIV or a sexually transmitted disease is an unpleasant task that can involve touching on taboo areas (Hobson, 1996). Interpreters may also be unable to integrate information that they find distressing (Lipton et al., 2002). Unfortunately, very few studies focus on the impact the abovementioned could have on interpreters. This 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). Perceiving the interpreter as language instrument who does not get emotionally involved, implies that the interpreter should not be affected by the information they translate (Wandesjö, 1998).

The literature indicates that interpreters may be particularly vulnerable to the emotional impact of their work because they often have a shared cultural and racial background with the client, which leads to identification and in some instances vicarious traumatisation (Splevins, Cohen, Joseph, Murray, & Bowley, 2010). In the study conducted by Splevins, et al. (2010), the vicarious experiences of interpreters working in a therapeutic setting with asylum seekers and refugees were explored. The interpreters described feeling a strong sense of empathy with their clients. However, this fast became a process whereby participants felt that they were feeling the same emotions as their clients. Interpreters felt that it was important and unavoidable to bring emotional aspects of the self into the session to engage the client. The lack of role clarity, combined with mixed beliefs about the professional-personal balance, appeared to relate to interpreters sharing the feelings of their clients and becoming enmeshed. Interpreters described a pattern whereby the initial distress, which was linked to becoming emotionally involved with clients and being shocked by client's stories, was so overwhelming that they consciously decided that they needed to develop some copings strategies to protect their own wellbeing. Interpreters relied on a combination of external

support and personal coping techniques. Participants relied on their family and friends to support them, or they turned to their employers for support, requesting counseling, debriefing before and after sessions, and peer supervision (Splevins, et al., 2010). In another study (Lipton et al., 2002), interpreters were 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 known to them (Lipton et al., 2002). In the study conducted by Lipton et al. (2002) interpreters reported that they often experience disruptions both in their family life and in terms of their own perceptions of personal safety.

Lipton et al. (2002) found that interpreters used the following dysfunctional coping strategies: 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 how to implement healthy coping strategies for dealing with very sensitive material that is potentially psychologically damaging (Lipton et al., 2002).
Interpreters require on-going training and support to assist them to retain the information that they interpret (Tribe & Raval, 2003). Understandably, in light of the above, interpreters should not only be required to have language skills, but also have the ability to deal with emotionally challenging material, while maintaining appropriate boundaries in relation to patients (Tribe & Raval, 2003). Interpreters require on-going support and supervision in order to facilitate maintenance of their own mental health (Lipton et al., 2002).

In this chapter, I focused on six themes, which allowed the reader to have a better understanding of the role(s) of the interpreter, factors guiding speakers' actions, the importance of training, different interpreting techniques, the issue of accuracy and equivalence, the role played by trust, and the challenges associated with the role of interpreter. In the following chapter, I focus on the methods used to collect and understand the data (see Chapter 3).

CHAPTER 3: THE USE OF METHODS TO UNDERSTAND LANGUAGE BARRIERS

3.1 Investigating language barriers in the mental healthcare context

As mentioned in preceding chapters I decided to address the issue of language barriers within psychiatric care by studying conversations between registrars and patients within a particular psychiatric institution. The conversations consisted of interpreter-mediated psychiatric interviews as well as psychiatric interviews conducted without the use of an interpreter. The psychiatric institution, St. James hospital is one of the three major public psychiatric hospitals in the Western Cape. I selected this particular hospital due to its location. The hospital is located in the Cape Town Metropole and serves patients speaking Afrikaans, English and isiXhosa. Although the majority of patients are Afrikaans-speaking, there is an increasing demand from isiXhosa-speaking patients for psychiatric services. There are many informal communities located close to the hospital and the majority of residents from these communities are isiXhosa-speaking. Most residents living in these poverty-stricken informal communities are unable to afford private healthcare. The Western Cape receives many migrants from the Eastern Cape and is expected to experience continued increases of isiXhosa-speakers from the Eastern Cape (The presidency, 2008).

I decided to focus on one hospital since the aim of this study is not to provide a generalized description of what happens in psychiatric institutions across the board. Instead, the aim is to describe what happens in the abovementioned encounters.

In order to describe what happens in practice I made video-recordings of the psychiatric interviews. In addition, semi-structured interviews were conducted with registrars, interpreters and patients. The semi-structured interviews were audio-recorded and the aim was to discuss various issues related to the dissertation topic with the research participants. The different methods employed in this study (i.e. video-recorded sessions of actual psychiatric interviews and audio-recorded semi-structured interviews) are complementary (as will be explained in more detail later in this chapter). The mixed-method approach allows for a more holistic understanding of actual practices within the particular psychiatric institution. More recently, there has been a growing resistance in qualitative research to employing a single methodological strategy to analyze the data set of an entire study (Denzin & Lincoln,

2005). There is a need for the reevaluation of analytic strategies that avoid a type of fragmented reductionism (Atkinson & Delamont, 2005). It is not productive for researchers to represent the social world primarily or exclusively through the lens of just one analytic strategy or data type. Most Community Interpreting research combines aspects of different methodological and theoretical frameworks. This allows researchers to employ only those methodologies and frameworks that are useful to the aims of the research project (Hale, 2007).

Prior to a more detailed description of the processes involved in the collection of the data, I would like to turn the reader's attention to the theoretical assumptions that underpin these processes and that influenced me – the researcher.

3.2 The hybrid network that I find myself in: a theoretical overview

In this study, I subscribed to a post-structuralist approach, which locates the gendered, culturally situated researcher at the centre of his or her research. This approach encourages the researcher to acknowledge the influence that he or she has on the data collection process and the interpretation of the study results (Denzin & Lincoln, 2005). In my case, my childhood experiences of Black languages as well as my 'relationship' with Afrikaans have influenced me in many ways and undoubtedly influenced my choice in research topic and the way I interpreted the study findings. However, in addition to personal influences my choices as a researcher are also influenced by previous research, paradigms and methods. Denzin and Lincoln (2005) explain that researchers are guided by certain principles. The principles combine beliefs about ontology, epistemology and methodology. The net that contains the researcher's epistemological, ontological, and methodological ideas is referred to as a paradigm, or interpretive framework (Denzin & Lincoln, 2005) or, as I refer to it, 'a hybrid network'.

In the context of this study, a post-structuralist approach forms the outer layer of the hybrid network. A post-structural approach is critical in nature and asks why and how knowledge is produced, and in whose interest (Swartz, 1998). This approach allows researchers to have critical conversations about language, democracy, race, gender, class, globalization, freedom, and community. Researchers using a critical approach are constantly challenging the

distinction between the 'real' and that which is constructed, understanding that all events and understandings are mediated and made real through interactional and material practices, through discourse, conversation, writing, and narrative (Denzin & Lincoln, 2005).

Influenced by this critical approach, I decided on a specific research design. A research design describes a flexible set of guidelines that connect the researcher's approach or interpretive framework with methods for collecting and analyzing the data. The research design involves a clear focus on the research question, the purposes of the study, what information will most appropriately answer specific research questions, and which strategies are most effective for obtaining it (Denzin & Lincoln, 2005). I employed a multi-dimensional research design consisting of four interconnected layers that include the following:

- ethnographic approach;
- discourse analytical approach;
- conversation analysis; and
- video-analysis.

3.2.1 An ethnographic approach

In the context of this study, an ethnographic approach implies a cultural interpretation and rich description of everyday life and practices within a particular setting. An ethnographic approach focuses on how meaning is created through social interaction within a particular setting (Holstein & Gubrium, 2005). Ethnographic studies consider how meaning is created within conversations in these settings. They combine attention to how social order is built up in everyday communication with detailed descriptions of place settings. Ethnographic studies are highly descriptive of everyday life within settings, and include extracted dialogue as well as ethnographic accounts (i.e. a rich description of the researcher's observations) of interaction being used to convey meaning (Holstein & Gubrium, 2005).

Traditionally, anthropologists used an ethnographic approach to study indigenous people. This was particularly the case in colonial times, when the anthropologist made detailed notes of his or her 'objective' observations of the indigenous people in their 'natural habitat'. The anthropologist's detailed notes would only benefit him or her and the colonial regimes who wanted to use the ethnographic information to control the indigenous people (Denzin & Lincoln, 2005). Today, not only anthropologists, but also professionals from various

disciplines, such as psychology and linguistics, have employed an ethnographic approach to study various research topics. However, contemporary ethnographers reject the traditional notion of the purely 'objective' researcher. Furthermore, contemporary ethnographers are critical of who will gain from the research and of the researcher's influence on the research process and data collected. As Angrosino (2005) explains, the researcher's actions, relationships, and emotions while in the field play a central role in contemporary ethnographies. This is in contrast to traditional ethnographies, which reserved any mention of the researcher's role and influence to the foreword and acknowledgment sections.

In my study, I used one contemporary ethnographic approach namely, 'embedded ethnography' (Lewis & Rusell, 2011). Embedded ethnography requires the researcher to submerge him or herself fully in the chosen field of study, learning the day-to-day and the ordinary aspects of social and cultural life by 'being there'. The researcher has to allow him or herself to experience the mundane and sacred, overt and nuanced aspects of socio-cultural life through observations, encounters and conversations. Embedded research implies that the researcher is responsive to working with collaborators, and adaptive to the requirements of ethics and other forms of research regulation (Lewis & Rusell, 2011). Lewis and Rusell (2011) argue that embedded ethnography is characterized by the fact that the researcher is on the one hand perceived as part of world of the research participants. The research participants are the researcher's collaborators. At the same time, the researcher is required to remind the participants of his or her independence and role as researcher. Instead of only using the organization and research participants for the purpose of the research study, the researcher is obligated to use the knowledge he or she acquired during the data collection process, to give back to the organization. This involves giving formative advice to the organization and its participants even if the news is uncomfortable to hear. Embedded ethnography allows the researcher to experience the 'worldview' of the organization, its members and their partners, but also requires the researcher to assess that experience in the light of academic knowledge and give the resulting insights back to the organization critically and formatively. Although the researcher allows him or herself to immerse him or herself in the inside world of the organization, he or she also has an outsider's perspective. In part, this is a product of the insider-outsider dynamic of participant observation, but where the ethnographer traditionally stood in-between her research 'subjects' and the ethnographic product, now he or she must

stand among a multiple set of collaborators, contexts and dissemination demands (Lewis & Rusell, 2011).

According to Hale (2007), researchers frequently use an ethnographic approach to conduct studies on language practices in hospitals. The aims of such ethnographic studies are to gain a better understanding of the interpreted situation; discover how the different participants in interpreted exchanges interact and behave; and explore participants' expectations of each other. Ethnographic studies in Community Interpreting can also be very useful as a way to elicit the views, concerns and needs of the different parties involved in the interpreted encounter (Hale, 2007). Below, I focus on the method, Discourse Analysis, which closely to the method of Ethnography (Atkinson & Delamont, 2005).

3.2.2 Discourse Analytical Approach

Discourse Analysis (DA) should not be intellectually divorced from ethnography (Atkinson & Delamont, 2005). Broadly speaking, a discourse analytical approach is a generic term for any approach used to study discourse, and involves using transcriptions of naturally occurring speech for data (Hale, 2007). Discourse analytical studies emphasize the structure of talk itself and examine the conversational mechanisms through which meaning emerges (Holstein & Gubrium, 2005). As explained by Drennan and Swartz (2002), from a discourse analytical perspective language is perceived as a medium through which various 'realities' are communicated. Mazur (2004) explains that when people use language they are acting through words, i.e. they are interacting with one another. This interaction can take many forms such as turn taking in conversation, agreeing and disagreeing, questioning and answering, opening and closing conversation, preparing to engage in and enter conversation, attacking or defending, and persuading or explaining (Mazur, 2004).

Various methods fall under the umbrella of Discourse Analysis. Hale (2007), refers to four discourse analytical methods that researchers use in the field of Community Interpreting research. The four approaches are: Conversation Analysis (CA); Interactional Sociolinguistics (IS); Ethnography of Communication**;** and Critical Discourse Analysis (CDA). Below the different methods are described based on the definitions provided by Hale (2007).

- Conversation Analysis (CA) represents the detailed, micro-analysis of linguistic features and turns in conversation. It aims to understand the structure and meaning of conversation through transcripts of conversations. CA concentrates on talk in interaction in the form of spoken conversation. It aims to determine the patterns and the order produced by individuals in everyday talk. It attempts to discover the taken-for-granted rules of conversation, to see how people interact with one another and make sense of the world. Furthermore, it is concerned with the micro-analysis of certain stages of interactions (Hale, 2007).
- Ethnography of communication analyses language and text in the context of culture. It seeks to describe modes of speech according to the ways in which they construct and reflect social life within particular speech communities. Researchers use this method to study communicative patterns as part of cultural knowledge and behaviour. The ethnography of communication is concerned with what speakers need to know and do in order to communicate appropriately within a particular speech community. It involves knowing not only the language code but also what to say to whom, and how to say it in a culturally appropriately way in any given situation. Further, it involves the social and cultural knowledge speakers are presumed to have which enables them to use and interpret linguistic form. Communicative competence extends to both knowledge and expectation of who may or may not speak in certain settings, when to speak and when to remain silent, to whom one may speak, how one may talk to persons of different statuses and roles, what non-verbal behaviours are appropriate in various contexts, what the routines for turn taking are in conversation, how to ask for and give information, how to request, how to offer or decline and the like – in short, everything involving the use of language and other communicative modalities in particular social settings (Hale, 2007).
- Interactional Sociolinguistics (IS) has its roots in the ethnography of communication, and analysts using this approach typically focus on linguistic and cultural diversity in communication, and how this affects the relationships between different groups in society. IS draws heavily on CA techniques in its micro-analytical approach to interactions but unlike CA, an IS analysis explicitly recognizes the wider sociocultural context's impact on interactions (Hale, 2007).

- Critical Discourse Analysis aims to reveal connections between language, power and ideology, and critical discourse analysts aim to describe the way power and dominance are produced and reproduced in social practice through the discourse structures of generally unremarkable interactions. At its core, one finds investigations of the enactment, exploitation, and abuse of social power in everyday interactions. CDA is concerned with social problems, not with language use per se, but with the linguistic character of social and cultural processes and structures. It analyses both power inherent in discourse and the power exerted over discourse. One basic difference between CDA and other forms of DA is the definition of discourse itself. Within linguistics, this term usually refers to a connected unit of language beyond a single sentence. In CDA, however, discourse means different ways of structuring areas of knowledge and social practices and systems of rules implicated in specific kinds of power relations. These researchers suggest that interpreters can help achieve this social goal by deviating from their strict role of interpreter and adopting the role of advocate (Hale, 2007).

Although approaches such as Ethnography of Communication and Interactional Sociolinguistics (emerging from the work of John Gumperz) play an important role in the analysis of conversations. I primarily used Conversation Analysis (CA) for the purpose of my study. This is because I am first and foremost interested in providing a detailed description of conversations and practices embedded within the hospital context. The power and cultural inferences that one could make based on speakers' actions are not part of the main focus of the study. In addition, the basic theoretical assumptions (see section 3.2.3.1) of CA, illustrate why this approach is most suitable for my study about language practices and real-life conversations.

3.2.3 Conversation Analysis

Peräkylä (2005) explains three basic assumptions about CA, which allows the reader to understand the theoretical foundation of this approach. After a description of the theoretical foundation of CA, I explain the specific version of CA, which is applicable to my study.

3.2.3.1 The basic theoretical assumptions of CA

Peräkylä (2005) provides a description of the theoretical foundation of CA in terms of three basic assumptions:

- Talk is action: Talk is primarily a means for human action. Talk as action, is intertwined with other means of action such as gaze and gesture. Some CA studies focus on the organization of actions that are recognizable as distinct actions. For example, CA studies focus on actions such as openings and closings of conversations or the delivering of bad news. CA studies have also shown that some actions are typical in certain institutional environments. For example, diagnostic sessions or medical consultations are typical of healthcare institutions. Furthermore, certain aspects such as turn taking repair, and general ways in which sequences of action are built make talk possible (Peräkylä, 2005).
- Action is structurally organized: Conversation Analysts perceive talk as actions, which are thoroughly structured and organized. Speakers have to orient themselves to rules and structures that make their actions possible. These rules and structures essentially focus on the relations between actions. Single acts are parts of larger, structurally organized entities, namely sequences. The most basic and important sequence is called an adjacency pair. An adjacency pair is a sequence of two actions in which the first action (first pair part), performed by one speaker, invites a particular type of second action (second pair part) to be performed by another speaker. Examples include question-answer, greeting-greeting, request-grant/refusal, and invitation-acceptance/declination. Adjacency pairs serve as a core around which larger sequences are built. A pre-expansion can precede an adjacency pair. For example, the first speaker first asks about the other speaker's plans for the evening and only thereafter, the first speaker invites the other speaker for supper. There are also insert expansions and these involve actions that occur between the first and the second pair parts. For example, a clinician asks a patient whether he would be interested in participating in a research study. Before responding, the patient requests more information about the research study. In post-expansion, the speakers produce actions that follow from the basic adjacency pair. For example, the clinician asks the patient whether he or she regularly takes his or her medicine and in response, the patient indicates that he or she takes the medicine. After the patient's response, the

clinician says “thank you” to close a sequence of a question and an answer (Peräkylä, 2005).

- Talk creates and maintains the intersubjective reality: Critics of CA argue that this approach focuses too much on the organisation of talk and neglects the meaning conveyed through talk. Peräkylä (2005) argues that is a flawed argument arising from the impression created by the technical exactness of CA studies. According to Peräkylä (2005), CA studies examine the meaning and reason behind speakers’ actions within a particular conversation and that CA accesses the construction of meaning within real time. CA focuses on meanings and understandings that are made public through speakers’ actions and remains critical of speakers’ intrapsychological experience and the impact this has on their actions. CA studies focus on the current speaker’s understanding of the preceding turn. This is because any turn of talk is shaped by the previous turn; it also displays its speaker’s understanding of that previous turn. Furthermore, CA studies focus on the conversational goals of an encounter. For example, in general the goal of a medical consultation is to diagnose and treat patients. The speakers’ understanding of the institutional context and the goals of the conversation guide their actions (Peräkylä, 2005).

Researchers use different ‘versions’ of CA depending on their study aims. The approach, Conventional CA is most suitable for the purpose of my study for reasons I explain in the next section.

3.2.3.2 Different versions of CA

Previously, I explained that the purpose of this study is to describe what happens in practice. In line with the aim to ‘describe’ practices, I have opted for a particular application of CA, namely a conventional and not a directed or summative application. In essence, a conventional approach allows for a detailed description of actual practices (Hsieh & Shannon, 2005). A basic description of each approach (as provided by Hsieh and Shannon) and its application will provide for a more informed understanding of why the conventional approach is most suitable for the purpose of this study:

- Conventional CA is generally used with a study design whose aim is to describe a phenomenon. This type of design is usually appropriate when existing theory or

research literature on a phenomenon is limited. Researchers avoid using preconceived categories, instead allowing the categories and names for categories to flow from the data. Researchers immerse themselves in the data to allow new insights to emerge. The data analysis starts with reading all data repeatedly to achieve immersion and obtain a sense of the entire body of data. Thereafter, the researchers read the data word by word to derive codes. The codes come directly from the text and thereafter the researcher sort the codes into categories based on how different codes are related and linked. With a conventional approach to CA, relevant theories or other research findings are addressed in the discussion section of the study. The advantage of this approach is that the researcher is less likely to form a biased interpretation of the data. The disadvantage is that this method can easily be confused with methods such as grounded theory or phenomenology. These methods share a similar initial analytical approach but go beyond Conventional CA to develop theory or a nuanced understanding of the lived experience (Hsieh & Shannon, 2005).

- Directed CA is used when existing theory or prior research exists about a phenomenon that is incomplete or would benefit from further description. The goal of this approach is therefore to validate or extend conceptually a theoretical framework or theory. Existing theory or previous research can provide predictions about the variables of interest or about the relationships among variables, thus helping to determine the initial coding scheme or relationships between codes. Content analysis using a directed approach is guided by a more structured process than in a conventional approach. Data analysis involves creating a preconceived list of codes, based on existing theory or prior research, and the coding process is informed by this list. The theory or prior research used will guide the discussion of findings. The advantage of this approach is that existing theory can be supported or extended. The disadvantage of this approach is that although researchers approach the data with an informed understanding there is nonetheless, strong bias (Hsieh & Shannon, 2005).
- Summative CA involves mainly identifying and quantifying certain words or content in text with the purpose of understanding the contextual use of the words or content. This quantification is an attempt not to infer meaning but, rather, to explore usage. This approach goes beyond mere word counts to include latent content analysis. Latent content analysis refers to the process of interpretation of content. In this

analysis, the focus is on discovering underlying meanings of words or the content. The data analysis starts with searches for occurrences of the identified words by hand or by computer. Word frequency counts for each identified term are calculated, with source or speaker also identified. With this approach, researchers try to explore word usage or discover the range of meanings that a word can have in normal use. The advantage is that it is an unobtrusive and nonreactive way to study the phenomenon of interest. It provides basic insights into how words are actually used. The disadvantage is that findings from this approach are limited by their inattention to the broader meanings present in the data (Hsieh & Shannon, 2005).

In the next section, I refer to the use of video in the context of social science as well as the methods used to analyse video data.

3.3 Specific methods used in this study

3.3.1 The use of video

I have made two main arguments so far. Firstly, the objective researcher employing an ethnographic approach is something of the past. Secondly, it is possible to draw upon contextual factors when applying conversation analysis, without transforming the data into something that it never was. These two points are captured by the use of video analysis, which as a method relates closely to ethnography and conversation analysis. I describe the method and emergence of video analysis below and start with a description of video data within the context of social science.

The increasing popularity of video data within social science gave rise to video analysis (Knoblauch, 2012). Video data in the context of social science refers firstly to video recordings of social interactions (ranging from human interaction with humans, to humans interaction with animals) (Knoblauch, 2012). In the context of social science, video analysis is characterized by the fact that it is the researchers themselves who are recording the video in the field. Secondly, video data refers to data consisting of social interaction in natural settings. In other words, researchers do not try to create the situations they study but attempt to record interactions where and how they are happening. Video recordings and analyses of

'natural' social interactions demand that researchers go to where the action is (Knoblauch, 2012).

What are the advantages? Video captures a version of an event as it happens. It enables researchers to observe real life practices allowing the researcher to be in more direct contact with the subject he or she is investigating (Peräkylä, 2005). Heath, Hindmarsh, and Luff, (2010) argue that the use of video recordings allows the researcher to observe non-linguistic features that are essential for a conversational analytic approach. It provides opportunities to record aspects of social activities in real-time: talk, visible conduct, and the use of tools, technologies, objects and artefacts. Video-data can be preserved and used for repeated scrutiny. Unlike other forms of social scientific data, there are opportunities to play back in order to re-evaluate aspects such as gaze or body language. This allows for multiple takes on the data – to explore different issues on different occasions, or to consider the same issue from multiple standpoints. The video data allows the researcher to consider the resources that participants use to make sense of, and participate in, the conduct of others. Video can also enable the analyst to consider the ways in which different aspects of the setting feature in the unfolding organisation of conduct. These aspects include not only the talk of participants, but their visible conduct, whether in terms of gaze, gesture, facial expression, or bodily language. Furthermore, video data enable the analyst to consider how objects, artefacts, texts, tools and technologies feature impact on the action and activity under scrutiny (Heath, et al., 2010).

What are the challenges? Heath, et al. (2010) explain that despite the growing interest in using videos for research it remains neglected particularly in ethnography. This might be because video-based, qualitative research could pose a number of important practical, ethical, methodological and analytic challenges. Yet few guidelines exist on how to address these challenges. Even before any research is undertaken difficulties may arise. Ethics committees can become concerned at simply the suggestion that cameras and microphones will be used to record naturally occurring activities. This is perhaps due to research participants being more identifiable in video material than in audio-recordings. The most significant challenge associated with video recordings of everyday activities is that it does not necessarily resonate with the theories, concepts and themes that inform dominant approaches to research in the social sciences. Consequently (unlike field observations, in-depth interviews and focus

groups), it proves difficult to link video-based research to more conventional approaches within the social sciences (Heath, et al., 2010). In the following section, I describe the method of video analysis.

3.3.2 The method of Video Analysis

Knoblauch (2012) explain that video analysis does not apply preconceived categories and codes to the data. The aim is rather to document the ways in which certain actions are relevant for the participants in a situation. Speakers' actions may be meaningful, but the analysis should describe how it is significant in relation to the activities at hand. The method of video analysis regards interaction as consisting of talk, positions, and bodily orientations. While talking is a central resource for gaining shared understanding, a variety of body positions, movements and gestures, directions of gaze, handling of material objects and technological apparatus, as well as space, all constitute powerful resources that are used to gain a shared understanding (Knoblauch, 2012). Video analysis allows one to explore these resources used by speakers to show their position within the social interaction, their understanding of the situation, and their affiliation with other speakers (Fele, 2012).

Researchers trained in Conversation Analysis have chiefly influenced the methodology of video analysis. Sequential analysis used in CA is the methodological cornerstone of the emerging video interaction analysis (Knoblauch, 2012). According to Knoblauch and Schnettler (2012), video analysis should be considered a hermeneutical activity. They explain that actions and interactions are not only to be observed – rather, actions are guided by meanings any observer must try to account for, not only in principle but also in each instance. This basic principle of the interpretive paradigm distinguishes it from other methodological approaches dealing with video data. Other methods used to analyse video material, involve the application of pre-established codes. In comparison, the method of video analysis does not include the use of pre-established codes. Instead, it starts from the assumption that action can only be explained if we understand its meaning. This method allows researchers to distinguish between the meanings actors link to their actions and the ways in which observers conceive of these meanings and conceptualise them scientifically. Any scientific understanding has to be grounded in everyday-life understanding. In other words, scientific constructs do not have meaning if it is isolated from actions in everyday life. Social scientific

analysis and its specific categories (such as turns, sequences, etc.) rests on the hermeneutic assumption that analysts dispose of knowledge of the culture in which the actions occur and make use of this knowledge in order to understand what is going on (Knoblauch & Schnettler, 2012).

As mentioned previously video data in social sciences implies that, the researcher is responsible for video-recording social interaction. Knoblauch and Schnettler (2012) explain that the researcher's living presence and experience of the encounter they film is of great importance once the researcher starts the analysis of the video data. The researcher's ability to make sense of the video material can be without first-hand ethnographic knowledge. The use of ethnography allows the researchers to get a sense of the typical meanings of the actions they are observing, and it assists them in recovering the contexts of the action. Video recordings focus on the particulars of situated performance as it occurs naturally in everyday social interaction. It is by way of ethnography that the situated meaning of actions as constructed can be understood (Knoblauch & Schnettler, 2012). In section 3.3.3, I describe in more detail the way in which I analysed the video-data.

3.3.3 Analysing my video-recordings

My approach to analyzing the transcriptions of the video-recordings was exploratory in nature since my aim was to describe practices and behaviour as they happened in real life, and I therefore did not approach the data with predefined categories (unlike my approach to the semi-structured interviews) or themes in mind. However, two studies conducted respectively by Friedland and Penn (2003), and Bot (2005) - both of which analysed actual interpreter-mediated encounters, influenced my approach to the analysis of the data.

3.3.3.1. Techniques used by Friedland and Penn

Friedland and Penn (2003) used CA to explore potential facilitators and inhibitors that occurred during an interpreter – mediated interview and in this section, I will refer to their work. A facilitator is any action or strategy adopted by any of the participants to: achieve the clinical goals of the interview; improve flow of content; and provide a dynamic of trust and empathy. A facilitator makes an overall positive contribution to the purpose of the interview.

An inhibitor is any action or strategy that has a negative impact on the three factors mentioned above. Friedland and Penn (2003) provided the following examples of facilitators:

- The clinician establishes roles and routines at the start of the interpreter-mediated interview. The clinician explains the purpose of the interview and negotiates the rules of the interview with the patient and the interpreter.
- The clinician gives autonomy to the interpreter as an active partner, not just a translator or language instrument. This involves leaving it up to the interpreter to decide how he or she wants to phrase his or her words.
- The interpreter ensures that all participants are included, and takes the initiative to probe without direct prompting from the clinician.
- The interpreter is flexible and moves between his or her role as an interpreter and information gatherer.
- The use of interview techniques, such as requests for elaboration, summarizing or paraphrasing, and expansion of talk for clarification purposes.
- The tolerance of silences, this involves allowing the patient to think, without rushing him or her or prompting an answer.
- The elimination of jargon so that the patient can better understand the question asked.
- The use of repetition to slow the tempo of the interview. In addition, the use of repetition facilitates input, and allows for repair and modification.
- Familiarity and cooperation between the clinician and interpreter.
- The interpreter's knowledge on the topics being probed.
- The rapidity of turns reflecting an efficient information flow. For example, the clinician gives the interpreter key words or asks a short question, and the interpreter elaborates on these in the patient's language.

Friedland and Penn (2003) provided the following examples of inhibitors:

- The clinician and patient have different agendas. For example, the clinician (depending on the type of interview) is interested in collecting clinical information. However, the patient provides detail not related to his or her clinical problem.
- Instances where participants are interrupted or where overlaps of speech occurred leading to a breakdown in communication.
- Long and complicated repair trajectories, which may lead to misunderstandings.

- Mistranslations, which prevent the transmission of accurate and essential clinical information.

3.3.3.2. Techniques used by Bot

Bot (2005) employed more complex techniques compared to those used by Friedland and Penn (2003). Bot's techniques are based on CA as well as on her own theoretical framework and concepts. Bot (2005) used the theme 'management of the session' to analyse turn taking and overlapping speech. This allowed Bot (2005) to identify how speakers organize turn taking and turn transfer and to identify who amongst the three speakers are in charge of these processes. In addition, Bot used the theme 'interpretation techniques' to identify how information and therapeutic perspective are preserved.

In my approach to the data, I studied similar themes as those investigated by Bot (2005), including overlap in speech, interruptions and the management of turn taking. However, unlike Bot, I did not score the frequency of these elements to provide a numerical overview thereof. The reason being partly that I found Bot's presentation of techniques confusing, and I felt that providing a numerical analysis of the data would divert focus away from other issues such as context and cultural influences. I used different methods to analyse the semi-structured interviews and in the next section, I explain how I went about analyzing the interviews.

3.3.4 Analysing my semi-structured interviews

The analysis of semi-structured interviews allows the researcher to reach areas of reality that would otherwise remain inaccessible, such as participants' subjective attitudes (Peräkylä, 2005).

The semi-structured interviews were analysed only after my initial analysis of the video-recordings. This was because I anticipated that the video-recordings would raise issues that I was unaware of and which I could then explore in more detail during the semi-structured interviews. Being unaware of the issues emerging from the video-recordings could have prevented me from identifying these issues or related issues when analysing the semi-structured interviews.

I used Content Analysis (also called Thematic Analysis) to identify themes emerging from the data. 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, 2005; Weber, 1985). Informed by the video-recordings I approached the interviews with a predetermined list of themes, this technique known as selective coding.

Developing a set of rules helps the researcher ensure that he or she consistently codes throughout the textual analysis (Bless, Higson-Smith, & Kagee, 2006). The predetermined set of codes was used to selectively code words, phrases or paragraphs that represented the pre-determined set of codes. In addition, I used open coding and this involved coding words, phrases, or paragraphs not included in the predetermined set of codes. Doing so allowed me to incorporate important codes into the coding process that could have significant bearings on the results (Bless et al., 2006). Data associated with each code were grouped codes into categories by finding patterns, similarities and differences between the codes. I grouped codes that related to the same theme together and codes did not overlap. The supervisor reviewed the codes and categories, this is aimed at reaching intercoder agreement, increasing the reliability and validity of the data.

Now that I have explained the more theoretical aspects associated with the data collection and analysis processes, I turn the reader's attention to the practical aspects. In the next section, I refer to the ethical aspects of the study.

3.4 Ethical considerations

This study (Ref no: N09/05/162) has been approved by the Committee for Human Research at Stellenbosch University. In addition, board of the hospital approved the study. I provided the institution with annual written updates regarding the data collection.

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 that there would be no negative consequences should they choose not to participate in the study. They were assured that their anonymity would be protected (this included not using participants' real names), and that any information that they disclosed would be treated as confidential. All the above-mentioned

information regarding confidentiality was also explained in the consent forms that participants were required to sign.

It was decided that the video-recordings would be seen by me, the supervisors of this study, and the individual who assisted the researcher in transcribing the video data. The video recordings are safely stored and only I have access to them. After completion of the dissertation, I will destroy the video-recordings. Even after I obtained ethical clearance, I still had to find a way into the institution and in the next section; I explain how I went about gaining access.

3.5. Gaining access into the 'world' of the institution

It is one thing to have a data collection plan in place and something else to execute the plan. Although, I obtained ethical clearance to collect data at St. James Hospital, this did not provide me with a way into the 'world' of the hospital. Successful data collection, in my opinion, can only be obtained if the hospital personnel have an understanding of the nature of the study and the potential impact it could have on the daily functioning of the hospital wards. Therefore, my supervisor, Prof. Leslie Swartz, and I approached a senior psychiatrist, whom my supervisor is acquainted with, working at the hospital in question. During our meeting with the particular psychiatrist I discussed the aims of the research project and my wish to collect data at the hospital. The senior psychiatrist was of the opinion that our research was of great importance and gave me the contact details of two registrars[5] working at the females only ward that he was in charge of. I contacted the two registrars and met with them to explain the nature of the research project and to ask them if they would be interested in participating in my study. Both of them were interested in participating and they also gave me the contact details of registrars at some of the other hospital wards. Meetings were arranged with the registrars at the other wards and they agreed to participate in my study. The registrars also introduced me to ward personnel and I was able to inform them about the study, since it was important for me not to disrupt the wards' daily functioning.

[5] Also known as psychiatrists in training, and referred to as 'residents' in countries like the United States.

Together with the registrars it was decided that they would contact me a day in advance to inform me if they had a patient booked that met the study's inclusion criteria. Needless to say, in reality things were more complicated and as a result I contacted the registrars every second day to find out whether they had any patients booked. Sometimes I was notified a day in advance, other times I was informed of a patient a few hours in advance. My initial contact with the registrars allowed me 'a foot in the door' - allowing me to recruit research participants for both the video-recordings as well as the audio-taped interviews. Below, I discuss my sampling methods and the data collection aspects in more detail.

3.6 Sampling and data collection

Purposive and snowball sampling were used to recruit research participants. Purposive sampling was used since it was essential to recruit participants who were involved in multilingual psychiatric interviews. I decided not use a sampling method such as targeted sampling. The reason is that my initial arrangement with the hospital was that I was going to conduct research at only one of the wards. The research participants that I recruited from the ward brought me into contact with other potential participants (snowball sampling) from a few of the other wards. The hospital gave me additional permission to recruit from these wards. However in light of the sensitivity of the study topic and in honour of the initial arrangement I had with the hospital, I did not ask for further permission to recruit from all the hospital wards. As noted the registrars informed me when they had a patient booked for a diagnostic consultation. The registrars were therefore responsible for booking their patients and interpreters. I was therefore not directly involved in the recruitment of the participants that were part of the video-recorded psychiatric interviews. However, I was responsible for the recruitment of the registrars as explained above as well as the participants that took part in the semi-structured interviews.

I video-recorded 25 psychiatric interviews at St. James hospital. Thirteen of the 25 psychiatric interviews were interpreter-mediated and interpreters assisted the registrars to communicate in isiXhosa with their patients. The remaining 12 psychiatric interviews were not interpreter-mediated. Furthermore, four of the 12 psychiatric interviews were conducted in isiXhosa, while eight of the 12 psychiatric interviews were conducted in English. The video-recordings took place at three of the hospital wards. The specific details regarding the

setting will be explained in the Results Chapter. The video-recordings varied from approximately a few minutes to an hour.

After the video-recorded psychiatric interviews those involved were asked if they would be interested in participating in semi-structured interviews. In total 23 semi-structured interviews were conducted and the interviews varied from approximately 15 minutes to an hour and half. All the registrars and interpreters who were involved in the video-recordings of the psychiatric interviews participated in the semi-structured interviews. However, only a few (four) patients participated in the semi-structured interviews. It should be noted that I only approached these four patients due to the following reasons: during some of the sessions patients had difficulty communicating with registrars since they were experiencing auditory and visual hallucinations at the time of the consultation. Some patients became very emotional and I did not want to add to their burden by asking them to participate in my study while they were clearly overwhelmed.

In additional to the interpreters that were involved in the psychiatric interviews that I video-recorded, other interpreters working at the hospital participated in the semi-structured interviews. As mentioned previously, this was not part of the initial data collection plan. I asked the registrars and those interpreters who had participated in the video-recordings whether they knew of other interpreters working at other wards. A student enrolled in the programme in MA Clinical Psychology, at the University of Stellenbosch, assisted me in recruiting and interviewing these interpreters. Furthermore, since I am not able to communicate with the patients in their first language, my mother-tongue isiXhosa-speaking colleague was assigned to interviewing the patients. Since my isiXhosa colleague was not present at the time of the video-recordings, appointments were scheduled with patients at another time. In some instances, before they could be interviewed, patients were discharged or moved without my knowledge. Prior to directly approaching patients (who participated in the video-recorded psychiatric interviews), I firstly asked the registrar looking after the patient whether he or she would mind if we ask the patient to participate in the semi-structured interviews. My reason for doing this was that it was still the registrar's patient and I had no authority over the patient. None of the registrars rejected my requests. In those psychiatric interviews that were not interpreter-mediated, I directly asked the patient whether

he or she would be interested in participating. In interpreter-mediated encounters, I asked the interpreter to ask the patient in the patient's first language whether he or she would be willing to participate. Although all four patients, who were approached, agreed to participate I still felt that it was necessary for my isiXhosa-speaking colleague to ask patients in their first language whether they really were interested in participating in the study.

The audiotaped interviews and the video-recordings were transcribed verbatim. I was responsible for the transcriptions of the video-recordings of the diagnostic sessions that did not involve the use of an interpreter. As a first-language Afrikaans-speaker, I translated the Afrikaans parts of the interviews into English. A bilingual, first language isiXhosa-speaker, who is also a part-time translator, was responsible for the transcriptions of the interpreter-mediated sessions. The translator also translated the isiXhosa sections of the transcriptions into English. Once the translator's transcriptions had been completed, I reviewed the accuracy of the transcription, particularly those parts of the sessions that were originally in English or Afrikaans. Two senior lectures in isiXhosa, one working at the University of Cape Town, and another at the Department of African Languages at Stellenbosch University, reviewed the English translations of the isiXhosa dialogue. These experts also served as my co-supervisors. In the last section of this chapter, I describe my participant sampling in more detail.

3.7 Research participants

In the 12 psychiatric interviews, which did not involve an interpreter, the patients were all male and all the registrars were female. It was my understanding that all the patients were first language isiXhosa-speakers. The registrar, who conducted four of the psychiatric interviews in isiXhosa, was bilingual in isiZulu (her first language) and isiXhosa (her second language).

In 11 of the 13 interpreter-mediated psychiatric interviews, the registrars were female and in two psychiatric interviews, a male registrar was present. All the interpreters used in the interpreter-mediated psychiatric interviews were female. In the 13 interpreter-mediated psychiatric interviews, six patients were female and seven patients were male. In 11 of the 13 interpreter-mediated psychiatric interviews, healthcare workers acted as interpreters and in

two interviews female household aides acted as interpreters. I use the term 'healthcare worker' because I do not want to specify the specific occupations of the healthcare workers. The reason for this is that at the time of data collection, there were only a few isiXhosa-speaking healthcare staff employed within certain occupational categories and mentioning their occupations could compromise their anonymity. I will however mention that none of the interpreters (involved in the psychiatric interviews) were registrars or psychiatrists in their official capacities. As with the psychiatric interviews (which did not involve the use of an interpreter), it was my understanding that in the interpreter-mediated psychiatric interviews all the patients were first language isiXhosa-speakers.

I assigned specific 'symbols' to each participant quoted to make it easier for the reader to follow the quotes of a particular patient, interpreter, or registrar throughout the chapter. I gave the eight registrars the first 8 letters of the alphabet (i.e. Dr.A-H) and the 11 interpreters the last 11 letters of the alphabet (i.e. Interpreter P-Z). I gave the patients numbers ranging from 1-21 (i.e. Patient 1-21). In Table 1 and 2, I present a summary of the abovementioned information.

In total 23 participants participated in the semi-structured interviews. The participants consisted of 11 ad hoc interpreters (all female), eight registrars (seven out of the eight participants were female), and four patients (two were female and two male). Seven of the 11 interpreters were officially employed as household aides, and four of the 11 interpreters were employed as healthcare workers.

3.8 Room space and seating position

The psychiatric interviews, which I video-recorded, took place either in the consultation room or in the meeting room. The consultation room (used in eight out of the 13 video-recorded sessions) was a small room with a desk and two or three chairs. The meeting room, in comparison (used in five out of the 13 video-recorded sessions), was a large room with many chairs and a small desk in the corner of the room. My understanding was that the registrar's choice was dependent on availability. In other words, if the meeting room was occupied, the small consultation room would be used or vice versa. However, it is likely that some of the registrars may have chosen the more spacious meeting room due to my presence. Although I

asked registrars to go about their 'business' (i.e. consulting patients) as they normally would, registrars perhaps felt that a fourth person with a camera required more room space. In the majority of cases (10 out of the 13 video-recorded sessions), the patient sat in the center with the registrar and interpreter on either side of the patient. In all the sessions, the three parties sat in a half circle formation. In almost all the psychiatric interviews, which that took place in the small consultation room, except for one, the three parties would sit in close proximity to one another. In the sessions held in the meeting room, the three parties sat further apart from one another. This is probably due to the greater space. In some instances, the patient leaned towards to the interpreter and in the majority instances, the patient sat closer to the interpreter than to the registrar.

In the next chapter, I provide a detailed description of the ways in which the patients, registrars and interpreters interacted and shared information during the psychiatric interviews. In addition, I refer to the discussions I had with research participants during the audio-recorded semi-structured interviews.

Table 1 *Summary of Psychiatric Interviews (Not Interpreter-mediated)*

Psychiatric Interviews (not interpreter-mediated)	**Registrar**	**Patient**
1.Interview (Vid.857)	Female Registrar (Dr.G)	Male Patient (P3)
2.Interview (Vid.553)	Female Registrar (Dr.A)	Male Patient (P4)
3.Interview (Vid.738)	Female Registrar (Dr.A)	Male Patient (P5)
4.Interview (Vid.748)	Female Registrar (Dr.A)	Male Patient (P6)
5.Interview (Vid.804)	Female Registrar (Dr.A)	Male Patient (P7)
6.Interview (Vid.621)	Female Registrar (Dr.D)	Male Patient (P8)
7.Interview (Vid.348)	Female Registrar (Dr.F)	Male Patient (P3)
8.Interview (Vid.007)	Female Registrar (Dr.F)	Male Patient (P14)
9.Interview (Vid.735)	Female Registrar (Dr.F)	Male Patient (P15)
10.Interview (Vid.112)	Female Registrar (Dr.F)	Male Patient (P16)
11.Interview (Vid.902)	Female Registrar (Dr.F)	Male Patient (P17)
12.Interview (Vid.426)	Female Registrar (Dr.H)	Male Patient (P18)

Table 2 *Summary of Interpreter-mediated Psychiatric Interviews*

Interpreter-mediated psychiatric interview	**Registrar**	**Patient**	**Interpreter**
1.Interview (Vid.702)	Female Registrar (Dr.B)	Female Patient (P1)	Female Household Aide (Interpreter R)
2.Interview (Vid.807)	Male Registrar (Dr.D)	Female Patient (P2)	Female Healthcare Worker(Interpreter Y)
3.Interview (Vid.452)	Female Registrar (Dr.F)	Male Patient (P8)	Female Healthcare Worker (Interpreter Z)
4.Interview (Vid.650)	Female Registrar (Dr.F)	Male Patient (P9)	Female Healthcare Worker (Interpreter Z)
5.Interview (Vid.248)	Female Registrar (Dr.F)	Male Patient (P10)	Female Healthcare Worker (Interpreter Z)
6.Interview (Vid.850)	Female Registrar (Dr.E)	Female Patient (P11)	Female Healthcare Worker(Interpreter Y)
7.Interview (Vid.454)	Female Registrar (Dr.E)	Female Patient (P12)	Female Healthcare Worker(Interpreter Y)
8.Interview (Vid.132)	Female Registrar (Dr.E)	Female Patient (P13)	Female Healthcare Worker(Interpreter Y)
9.Interview (Vid.649)	Male Registrar (Dr.C)	Female Patient (P19)	Female Household Aide (Interpreter V)

Table 2 (Continued).

Interpreter-mediated psychiatric interview	**Registrar**	Patient	Interpreter
10.Interview (Vid.845)	Female Registrar (Dr.D)	Male Patient (P20)	Female Healthcare Worker (Interpreter P)
11.Interview (Vid.602)	**Female Registrar (Dr.D)**	Male Patient (P8)	Female Healthcare Worker (Interpreter P)
12.Interview (Vid.019)	Female Registrar (Dr.D)	Male Patient (P3)	Female Healthcare Worker (Interpreter P)
13.Interview (Vid.917)	Female Registrar (Dr.D)	Male Patient (P21)	Female Healthcare Worker (Interpreter P)

CHAPTER 4: PSYCHIATRIC INTERVIEWS NOT INTERPRETER-MEDIATED

In this section, I refer to the findings pertaining to the psychiatric interviews that were not interpreter-mediated. To remind the reader, it was common practice for registrars and patients to communicate without the use of an interpreter. In four of the 12 video-recorded psychiatric interviews (not mediated by an interpreter), the patients and registrar communicated in isiXhosa. The registrar (the same registrar was involved in all four interviews) was fluent in isiXhosa. In eight of the 12 psychiatric interviews, the patients and registrars attempted to communicate in English. The registrars were first language English or Afrikaans-speakers and did not speak isiXhosa.

Based on my discussions with the registrars and my observations while collecting data at the various wards it seemed that the registrars decided on the use of an interpreter based on the nurses' recommendations. It is likely that in eight of the psychiatric interviews, the patients and registrars communicated in English, because the registrars were under the impression that the patients were able to speak English. However, it is unclear how the nurses determined that the patients, who participated in the eight psychiatric interviews, were bilingual.

Below, I explain that the patients were in fact not bilingual and seemed to have great difficulty communicating in English. The patients, who participated in the psychiatric interviews conducted in isiXhosa, provided mostly single-worded 'yes' or 'no' or one liner responses to registrars' questions. In comparison, those patients who communicated in isiXhosa provided detailed responses to registrars' questions. For example, in Table 1 (see below), I compare two patients' responses to a similar diagnostic question. It is standard practice for psychiatrists to ask patients about the reasons for their visit to the psychiatrist. This question is normally an open-ended question. For example, the psychiatrist may ask the question in the following format: *What led to your admission to the hospital*? This type of open-ended question allows patients to speak in their own words about their problems (Sadock & Sadock, 2003). In the psychiatric interview conducted in isiXhosa (see Table 3), the registrar asked a similar diagnostic question: *"Phambi kokuba uze apha esibhedlele kwaye kwathini?" (Before you came here to the hospital what happened?)*. As can be seen in Table 3 (see Extract 1), the patient talked in some detail about the events that led to his hospitalization. In the psychiatric interview conducted in English (see Extract 2 of Table 3),

the registrar phrased the diagnostic question as: *"Tell me why did you come to the hospital?"* However, the patient's response in English is not nearly as detailed as that of the patient who communicated in isiXhosa. In Table 4, I present another example of patients' yes and no responses to the registrars' questions. In the psychiatric interview conducted in isiXhosa (see Extract 3 of Table 4), the registrar probed the patient to talk about the voices he was hearing and in response, the patient provides a detailed explanation of the voices he hears. In the psychiatric interview conducted in English (see Extract 4 of Table 4), the registrar asked the patient a similar question, namely: *"The voices are still bothering you?"* The patient's response was *"yes"* and when the registrar probed the patient he was not forthcoming with much information.

Table 3 *Diagnostic Questions about Patients Reasons for Being Admitted to Hospital.*

Psychiatric interview conducted in isiXhosa	**Psychiatric interview conducted in English**
Extract 1: ***Registrar (Dr.A):*** *Phambi kokuba uze apha esibhedlele kwaye kwathini? (Before you came here to the hospital what happened?)* ***Patient 4:*** *Eh..endlini ndiye nda. ukusuka kwethu apho sisakhwela itrain, saza apha esibhedlele, wathi ufuna ukundithengela iisunglasses. (Eh…. at home I. when we left from there, we boarded a train, then we came here to the hospital, he said he wanted to buy me sunglasses.)* ***Registrar (Dr.A):*** *Mm.* ***Patient 4:*** *Ndathi alright xa ezondithengela isunglasses, its fine because nam ndiyazi-need-a iisunglasses. Sasuka khona… (I said alright, if he was going to buy me sunglasses, it's fine because I need sunglasses. Then we left there …)* *(Registrar interjects)* ***Registrar (Dr.A):*** *Nguwe owawucele iisunglasses okanye nguye owathe uzakuthengela? (Is it you who wanted sunglasses or is it him who said he was going to buy for you?)* ***Patient 4:*** *Nguye owathe uzandithengela iisunglasses. (It's him who said he was going to buy me sunglasses.)*	*Extract 2:* ***Registrar (Dr.G):*** *Ok. Um, tell me why did you come to the hospital?* ***Patient 3:*** *I was sick.* ***Registrar (Dr.G):*** *And how were you sick? You say you were sick, what was the problem?* ***Patient 3:*** *I think, I was going to be Jesus.* ***Registrar (Dr.G):*** *Oh, you thought you were going to be Jesus?* ***Patient 3:*** *Yes.* ***Registrar (Dr.G):*** *Ok, and how long did you have that feeling for?* ***Patient 3:*** *For a month.*

Table 3 (Continued).

Psychiatric interview conducted in isiXhosa	Psychiatric interview conducted in English
Registrar (Dr.A): *Mm.* ***Patient 4:*** *Emva koko sahamba saya kwenye ichemist safika kuthiwa zezamalady iisunglasses khona, ukusuka khona sakhwela itaxi saya eSalt River, Salt River wathi masiye ecaweni, ndathi mna laa cawa andiyingeni endingayaziyo. (After that we went to another chemist, there we were told that only ladies' sunglasses were available, from there we took a taxi to Salt River, at Salt River he said we must go to church, and I said I don't go to a church that I'm not familiar with.)* ***Registrar (Dr.A):*** *Ngoba? (Why?)* ***Patient 4:*** *Ngoba kaloku kwathiwa mandingangeni kwicawe ngecawe. (Because it was said I must not attend different churches.)* ***Registrar (Dr.A):*** *Kwakutsho bani? (Who said that?)* ***Patient 4:*** *Kwatshiwo eUniversal. (It was said at the Universal [church].)* ***Registrar (Dr.A):*** *Mm.*	

Table 4 *Diagnostic Questions about Hearing Voices*

Psychiatric interview conducted in isiXhosa	**Psychiatric interview conducted in English**
Extract 3: ***Registrar (Dr.A):*** *Ok so ivoices ezi uzivayo? (Ok, so the voices you are hearing?)* ***Patient 4:*** *Bendingavi voices, bendingavi kwa- voice leyo. (I did not hear voices, I did not hear even one voice.)* ***Registrar (Dr.A):*** *Mh.* ***Patient 4:*** *Bendingavi kwa-voice leyo. (I did not hear even one voice.)* ***Registrar (Dr.A):*** *Mh so ufuna ukubulala umama wakho, kutshiwo? (Mh, so you want to kill your mother, it is said?)* ***Patient 4:*** *Ah-ah, bendingafuni ukumbulala, ndikuxelele nayizolo ndiphuphe ndiza kuhlatywa ngulaa mntu lowa, ebefuna ukundihlaba, andimazi lo mntu. (No, no, I did not want to kill her, I am telling you even yesterday I dreamt of someone who wanted to stab me, he wanted to stab me, I don't know this person.)* ***Registrar (Dr.A):*** *Ngumntu ebefuna ukukuhlaba phi? (It was a person who wanted to stab you where?)*	*Extract 4:* ***Registrar (Dr.D):*** *The voices are still bothering you?* ***Patient 8:*** *Yes.* ***Registrar (Dr.D):*** *Ok, what are they saying?* ***Patient 8:*** *They are saying, I'm not right.* ***Registrar (Dr.D):*** *Ok, are they saying anything else?* ***Patient 8:*** *Yes, they are saying just like that, I'm not right.* ***Registrar (Dr.D):*** *Do they keep on repeating themselves?* ***Patient 8:*** *Yes.* ***Registrar (Dr.D):*** *Is that how they keep you awake?*

Table 4 (Continued).

Psychiatric interview conducted in isiXhosa	Psychiatric interview conducted in English
Patient 4: *Ebefuna ukundihlaba, bendilele, bendilele apha eroom-ini yam. (He wanted to stab me, I was asleep, I was asleep in my room.)* ***Registrar (Dr.A):*** *Mh, mh.* ***Patient 4:*** *Bendiphupha ngoko. (I was dreaming then.)* ***Registrar (Dr.A):*** *Mh, mh.* ***Patient 4:*** *Emini. (In the afternoon.)* ***Registrar (Dr.A):*** *Mh, mh.*	***Patient 8:*** *What, mhu?* ***Registrar (Dr.D):*** *Awake, like you cannot sleep? They are talking all the time?* ***Patient 8:*** *I didn't sleep well.*

One could argue that the vast difference in patients' responses was due to their mental health condition. In other words, those patients who responded in English were too psychotic or ill to communicate with the registrars. However, in light of the additional examples (see Extracts 5-9) I present below, it seems that the reason for patients' consistent restricted responses is more likely due to their limited proficiency in English. For example, responses such as those provided by the patient in Extract 5, suggest that the patient had trouble communicating in English. The registrar asks the patient whether he would be interested in going to a rehabilitation centre. At first, the patient does not respond and later responds by saying *"So, I must go. First, I go?"* See below for the dialogue that arose between the registrar and patient.

Extract 5:

Registrar (Dr.G): *I'm going to speak to the social worker, she's your social worker. And we'll see if we can try and organise something for the rehab centres where you go and stay for a few weeks, normally there is a waiting list. Is that something you would be interested in? Would you go and stay somewhere for a while?*

(No response from patient.)

Registrar (Dr.G): *Or would you rather go to outpatients. Where you are at home, but you go to the group once a week and then you go back home?*

(No response from patient.)

Registrar (Dr.G): *Which one would you prefer?*

Patient 3: *So, I must go. First I go?*

Registrar (Dr.G): *But I think it's important, it's something that you need to do for yourself, because you want to make (inaudible). It's not something I can send you to do, or make you do it. It's something that you need to want to change.*

(No response from patient)

Registrar (Dr.G): *It's something that you need to want to do and then it can work really well.*

(No response from patient.)

Another indicator of patients' limited proficiency in English is that some patients repeated the exact same phrases used by the registrar in a preceding utterance (see Extract 6). This could be indicative of patients' limited vocabulary. See below for the dialogue that arose:

Extract 6:

Registrar (Dr.D): *Are you having difficulty sleeping every night?*

Patient 8: *Yes.*

Registrar (Dr.D): *Or just last night or some nights?*

Patient 8: *Some nights.*

Registrar (Dr.D): *Some nights.*

Patient 8: *Some nights.*

Patients' poor use of grammar (as reflected in Extracts 7-9 below) further supports my argument that LEP patients experienced communication problems. For example, as can be seen in Extract 7, the patient said: *"The small children love me, all them love me",* (instead of saying *"All of them loves me"*). In addition, the patient said: "*Everybody love me",* (instead of saying*: "Everybody loves me"*). See below for the extract in which these sentences occurred.

Extract 7:

Patient 17: *So they think I'm helping police just because people fighting. I just um, I just take my cell phone, I make sure. I'm not phoning police to come.*

Registrar (Dr.F): *Mm, mm, ok.*

Patient 17: *And the children, the small children love me all them love me. If I make so they make so. Everybody love me.*

In another interview (see Extract 8), a patient said: "*I was stop it in April",* (instead of saying: *"I stopped using it in April"*). See below for the extract in which this sentence occurred.

Extract 8:

Registrar (Dr.G): *And were you taking your medication regularly?*

Patient 3: *Yes, I was taking my medication. I was stop it (the medication) in April.*

Lastly, in another psychiatric interview (see Extract 9), a patient said: "*No something wrong. I alright",* (instead of saying: *"Nothing is wrong. I am alright"*). See below for the extract in which this sentence occurred.

Extract 9:

Registrar (Dr.F): *Ok, is there something wrong?*

Patient 14: *No something wrong. I alright.*

The findings strongly suggest that expecting patients to communicate in broken English is unrealistic. Patients' English responses did not have much substance and this is likely to impact on the accuracy of the diagnosis. Furthermore, patients' repeating the registrars' words, begs the question whether patients really understood the questions and whether their answers can be seen as their own. I learned from the audio-recorded discussions that two of the patients reported that in certain instances they did not understand what the registrar was saying. Both patients reported that when they don't understand the registrar, they ask for clarification. However, not one of the patients, during the psychiatric interviews conducted in English, indicated that they did not understand questions, nor did they ask for clarification. There seems to be a discrepancy between patients' comments and what they do in practice. Perhaps patients perceive themselves to be powerful agents within the doctor-patient consultation; however this is not supported by patients' actions during actual psychiatric interviews. Situations such as those I described above, are not only detrimental to the goals of the psychiatric interview, but also creates a system in which patients, who already have less power than clinicians, have even less power since they are forced to communicate in a language that they are not proficient in.

The only facilitative factor (and similarity between the psychiatric interviews conducted in isiXhosa and those conducted in English), was that the patient and registrar made regular eye contact in both the isiXhosa and English psychiatric interviews. This could have a positive effect on the goals of the psychiatric interview. Eye contact is a sign that the listener is paying attention to the speaker. It creates the impression that the registrar hears what the patient is saying. However, the regular eye contact may also be due to factors such as gender. It is common for isiXhosa-speaking patients to avoid eye contact with the clinician due to the clinician's status in the healthcare system. In some African cultures, such as the isiXhosa culture, it is disrespectful to make eye contact with someone in a position of power (Swartz, 1988). In the 12 psychiatric interviews, which were not interpreter-mediated, all the registrars were female and all the patients male. In the majority of cases, the patients referred to the registrars as *'Sister'* (i.e. Nurse) and not *'Doctor'*. It is likely that the patients perceived the registrars not as clinicians, but as nurses and therefore felt more comfortable making regular

eye contact with the ‘registrars’. Nurses generally have less power than clinicians within the institutional hierarchy.

In the next part of this chapter, I focus on the video-recordings of the 13 interpreter-mediated psychiatric interviews.

CHAPTER 5: INTERPRETER-MEDIATED PSYCHIATRIC INTERVIEWS

As referred to in Chapter 3, I used similar categories to those used by Friedland and Penn (2003) to organize the findings pertaining to the interpreter-mediated psychiatric interviews. More specifically, I used the following three categories to categorise the study findings: 'Facilitators', 'Inhibitors', and' Other'. Findings under the category, 'Inhibitors' (section 5.1), refer to those aspects hindering the successful achievement of the goals of the psychiatric interview. For example, under this category, I refer to instances in which interpreters omitted crucial clinical information. This makes it difficult for registrars to make an accurate diagnosis. Facilitators (see section 5.2) in the context of this study refer to those aspects contributing to the goals of the psychiatric interview. Under the category, 'Facilitators', I present examples of how one of the registrar's language skills helped her to corroborate patient information. The category' Other' (see section 5.3), refer to findings such as the management of the interpreter-mediated session, issues related to power, gender and age, etc.

5.1 Inhibitors

5.1.1 Basic interpreter requirements

The ad hoc interpreters, particularly the household aides, had poor language skills. Interpreters' poor language skills were mainly evident in their use of English grammar. See the dialogue (Extract 10), below for one of the household aides' use of grammar:

> *Extract 10:*
>
> ***Interpreter V:*** *She say sometime she feel happy, ne*[6] *and she feel to talk to somebody. When she go to that person and talk about his life.*
>
> ***Registrar (Dr.C):*** *Mm.*
>
> ***Interpreter V:*** *Like she feel like to talk and maybe the stress are going to be done and then people they change what she talk, to say maybe she want to sleep to his father.*

Interpreters explained to me, during the audio discussions, sharing a first language with patients qualified them to act as interpreters. Ten out of the 11 interpreters reported that they are first language (L1) isiXhosa-speakers. One of the participants reported that she is a first

[6] The equivalent of the word 'ne' is 'you see'.

language isiZulu-speaker. Nine of the 11 interpreters reported that they regarded themselves as bilingual and three participants were reportedly multilingual. The majority of participants reported that they were fluent in English and five of the participants reported that Afrikaans was also part of their linguistic repertoire. Interestingly, although interpreters were reportedly bilingual (and some even multilingual), some interpreters seemed uncertain about their language proficiency. For example, the isiZulu-speaking interpreter (who acted as interpreter for the isiXhosa-speaking patients) reported that she was still learning to speak isiXhosa and that at times she was uncertain whether she provided an accurate interpretation. See below for the dialogue that arose:

Extract 11:

Interpreter Z: *Ja, there are sometimes some words that you kind of find in isiXhosa, like the word research. So you have to explain it in a roundabout way.*

Researcher*: And were there any more words like that, that you had to explain in a roundabout way?*

Interpreter Z: *Yes, uh like the word 'researcher'.*

Researcher: *Ok and how did you explain the word to the patient?*

Interpreter Z: *I come up with some word that may make some meaning to the patient. I used the word 'utwaningo' which means like it's sort of a study.*

Researcher: *Ok and any other words?*

Interpreter Z: *But like for me being isiZulu-speaking and interpreting for a isiXhosa-speaking person, there was some words that I was not sure that I am giving the right. Like with this last guy [patient] there was this word, but I can't remember now.*

Researcher: *Ok and if you say that you weren't sure, is it because although isiXhosa and isiZulu are very similar, they are not exactly the same?*

Interpreter Z: *Yes, they are not exactly the same.*

Researcher: *So it is sometimes difficult for you as a isiZulu-speaking person to understand exactly everything in isiXhosa?*

Interpreter Z: *Sometimes yes. Yes, I'm still learning isiXhosa.*

The above findings suggest that the interpreters in fact not meet the most basic interpreter requirement – they were not competent in more than one language. The interpreters'

uncertainty about their own language skills supports my argument that the interpreters were not suitable to act as interpreters.

5.1.2 Uncertainty about the interpreter's role

There seemed to be uncertainty about the role of the interpreter. In my presence, the registrar, patient and interpreter did not discuss the role of the interpreter and the interpreting process would work. The uncertainty and confusion disrupted the flow of the communication. It may also precipitate unwanted frustration and uneasiness amongst the patients, registrars and ad hoc interpreters.

For example, in the beginning of one of the psychiatric interviews the registrar greeted the patient and asked the patient a question. Before the interpreter could interpret the question, the patient asked the interpreter in what language he should respond to the registrar's question. The interpreter explained to the patient that he should speak in the language he felt most comfortable in, after which the patient responded in isiXhosa. Uncertainty about the interpreting process may cause unnecessary tension for some of the patients who, due to their psychiatric conditions, already have to cope with high anxiety levels. The following examples reflect interpreters' uncertainty about their role and the interpreting process. In certain instances, interpreters provided renditions of utterances only when explicitly requested to do this by the registrar or patient. While in other instances during the same psychiatric interview, the interpreters did not wait for a request to provide an interpretation. Extracts 12-13 are examples of this behaviour. In the extract below (Extract 12), the interpreter interjects to provide a rendition without the patient or registrar requesting her to do so.

Extract 12:

Registrar (Dr.C): *Mm, I understand, but I want to know what was difficult, stressful. I get the feeling that you say there wasn't enough support.*

Patient 19: *Mm.*

Registrar (Dr.C): *From your family members.*

Patient 19: *Yes. I didn't sleep.*

Registrar (Dr.C): *Yes, I understand, I*

(Interpreter interjects)

Interpreter V: *Ugqirha ufuna ukubuza - ukuba xa ucinga, ukh'ubone xa ucinga. (The doctor wants to ask you – if when you think, you see when you think.)*

Later in the same psychiatric interview, the registrar explicitly asked the interpreter to assist him (see Extract 13).

Extract 13:

Registrar (Dr.C): *Too much was happening.*

Patient 19: *Yes.*

Registrar (Dr.C): *Your plate was too full. You had to do too many things.*

Patient 19: *Mm, then I say to her no don't want to do the adopted because at Eastern Cape, they are gonna say where are they (the children). And it's a little, little girl so I can't, it's my sister, so.*

Registrar (Dr.C): *Ok. Can you just help me (looking at the interpreter). Specifically what I would like is if you can find out if there was a lot of praying, not sleeping and cleaning at night at strange hours. Feeling that there is too much energy and too much power.*

5.1.3 Overlapping roles

In Chapter 2, I referred to Wadensjo (1998) who argued that communication between people in real life, does not take place in a vacuum. Various factors, outside the immediate interpreter-mediated session, affect the interpreter's rendition of the clinician or patient's turn. In this section, I describe instances in which interpreters, likely due to their official work as healthcare workers and household aides, overstepped the boundaries.

Two of the three interpreters, who were also healthcare workers, at times answered on behalf of the patient. This was likely due to their pre-existing knowledge of the patient, which they probably acquired through their official roles. For example (see Extract 14), one of the interpreters (a healthcare worker) answered on behalf of the patient when the registrar asked the patient what his or her plans were and this seemed to aggrevate the registrar. It might be that the interpreter responded in this way because of her pre-existing knowledge of the patient's plans, which she previously acquired in her capacity as a healthcare worker.

Extract 14:

Registrar (Dr.D): *What is his plans for when he is going to go home?*

Interpreter P: *What did we say? I can't remember. What did we say but*

(Registrar interjects)

Registrar (Dr.D): *No, no, I want to know from him (the patient) what is he planning?*

In other instances (see Extracts 15-16) interpreters, who were also healthcare workers, took on the role of registrar and answered questions on behalf of the registrar and this seemed to frustrate the patient. For example (see Extract 15), in one of the psychiatric interviews the interpreter replied on behalf of the registrar, when the patient asked whether the government could provide her with a loan. The patient urged the interpreter to ask the registrar. See the dialogue below:

Extract 15:

Patient 11: *Ndithi kaloku isicelo, bendinesicelo kugqirha uba ebengenokundibolekela noba yi-loan noba ku-government noba kukubani, bandicelele isicelo, then ndisebenze lo msebenzi wobugqirha ndiwugqibe then ndiyibuyise back imali yabo ke ngoku? (I say my dear; I have a request to the doctor. Can she ask for a loan on my behalf from the government or whoever? They can make a request for me, then after completion of my traditional healer ritual, I can return the money?)*

Interpreter Y: *Abazokwazi. (They won't be able to.)*

Patient 11: *Mxelele kaloku. (Tell her.)*

Registrar (Dr.E): *Wat sê sy? (What is she saying?)*

During the same psychiatric interview, referred to in Extract 15, the registrar told the patient that she had spoken to the patient's brother (see Extract 16). The patient asked what brother she was referring to since the patient did not have a brother. The interpreter then responded, without posing the question to the registrar, that she did not know. The patient once more urged the interpreter to ask the registrar the question. It seems that in this instance the interpreter acted as institutional gatekeeper by denying the patient access to the registrar. See below for the dialogue that arose:

Extract 16:

Patient 11: *Ngowuphi lo brother wam ebethetha naye ndingenabhuti nje mna?(Which brother was it that she spoke with, I don't have a brother.)*

Interpreter Y: *Andiyazi. (I don't know.)*

Patient 11: *Khawumbuze. (Ask her.)*

Registrar (Dr.E): *Wat sê sy? (What is she saying?)*

5.1.4 Insensitivity and a safe environment

Certain interpreter' actions seemed insensitive and not conducive towards an environment in which patients feel encouraged to talk openly about personal matters. For example, in some instances one of the interpreters responded inappropriately to the patient's reference of her father's suicide. During the same psychiatric interview, the interpreter had to ask the patient whether she enjoyed her first sexual encounter. The patient responded by saying that she did not like it. After this response, the interpreter responded by telling the patient not to lie. See below for the dialogue that arose:

Extract 17:

Interpreter Y: *Ubunjani ubuyithanda? (How was it, did you enjoy it?)*

Patient 2: *Hayi bendingayithandi. Bendithyafa. (No, I didn't like it. I was weak.)*

Interpreter Y: *Hayi s'ukuxokisela (with emphasis)! (No, don't lie!)*

The omission of remarks aimed at preparing and comforting patients may create an atmosphere in which patients are discouraged to talk about sensitive personal issues. Some interpreters consistently omitted registrars' sensitive comments directed towards the patient. For example, in one of the sessions the patient conveyed that her father committed suicide. The registrar responded by saying, *"I am sorry to hear that"*, but this was never conveyed to the patient. In another psychiatric interview, the patient seemed embarrassed that she had difficulty recalling information. In response to this, the registrar said: "*That's alright".* However, the interpreter did not convey this to the patient. The same interpreter (mentioned above) also omitted phrases used by the registrar to prepare the patient prior to asking sensitive questions. For example, the registrar would start his question by saying: *"This question may seem odd".* The interpreter would omit this phrase and simply ask the question. See below for the dialogue that arose:

Extract 18:

Registrar (Dr.C): *Uhm, the next question seems odd, but did you have to spend any time in the police cell or*

(Interpreter interjects)

Interpreter Y: *Ubukhe waya ejele? (Did you ever go to jail?)*

Patient 2: *Uba mna? (with surprise) (Who, me?)*

Interpreter Y: *Ewe, zange ukhe wavalelwe? (Yes, have you never been imprisoned?)*

Patient 2: *Yho! Hayi, yho! (with emphais) (Yho! No, yho!)*

5.1.5 Inaccuracy, omissions and additions

It is unrealistic to expect that inaccuracies are always avoidable. The examples I present below, illustrate the affect that inaccuracies may have on the patient and in creating an environment in which the patient feel safe.

In one of the psychiatric interviews, the patient asked why her family did not visit her in hospital. The registrar suggested that perhaps this was due to financial reasons. In her interpretation, the interpreter (instead of using a more indirect approach by suggesting possible reasons) conveys the registrar's suggestions as facts. The interpreter conveys to the patient that her brother informed the registrar that the family does not have money for transport, however when they have money they will visit her. However, the registrar merely suggested that perhaps the family's absence is due to financial reasons. In response, the patient became visibly upset, since she felt that her family could use her grant money to visit her. See below for the dialogue that arose:

Extract 19:

Registrar (Dr.E): *Ok, maar sê vir haar die familie weet sy is hierso. So hulle sal kom sodra die geld seker daar is. (Ok, but tell her that her family is aware that she is here. So, perhaps they will visit as soon as they have money.)*

Interpreter Y: *Uh-uh, uthi ugqirha mandikuxelele uba bayayazi uba ulapha qha babethwa yimali yokukhwela. (Uh-uh, the doctor says I must tell you that they know that you are here but they can't visit because of financial issues. They don't have money for transport.)*

Patient 11: *Ok.*

Registrar (Dr.E): *Ek het met (I)*

(Interpreter interjects)

Interpreter Y: *Xa befumene imali yokukhwela bazowuza. (When they have money for transport they will come.)*

Patient 11: *Ok, ok.*

Interpreter Y: *Ok, sisi. (Ok, sister.)*

Registrar (Dr.E): *Ek het met haar broer gepraat oor die foon, maar hy kon net bietjie (I spoke to her brother over the phone, however he could only talk a little)*

(Patient interjects)

Patient 11: *Bangayopeya beze ngemali yam nje, bangayopeya. (They can go get my grant and come with it.)*

Furthermore, in some instances interpreters provided inaccurate renditions of patients' utterances, which could lead to an inaccurate diagnosis. For example, one of the interpreter's interpretations of the patient's words seems to indicate that the patient may have sleeping problems, because she repeatedly wakes up during the night. However, when looking at original words of the patient, the patient merely mentioned that when she wakes up the other patients are still sleeping. Information about the patient's sleep patterns could provide important diagnostic cues regarding the patient's mental health condition. See below for the dialogue that arose:

Extract 209:

Patient 11: *Ndiyazibona noko, ndiye ndothuke zisalele, ndothuke ekuseni ndifike zisalele. (I see them, when I wake up in the morning they are still asleep. I get startled from sleep and find them still asleep.)*

Interpreter Y: *Sy se sy verskil van hulle, want sy slaap, dan skrik sy wakker, dan slaap sy, dan skrik sy wakker. (She is different to them, because she sleeps, then wakes up and then sleeps and wakes up again.)*

Registrar (Dr.E): *En as sy wakker skrik loop sy rond in die nag? (And when she wakes up in the night does she walk around?)*

Interpreter Y: *Xa wothukayo uyahamba-hamba apha ebusuku okanye? (When you are awake at night, do you walk around or?)*

Patient 11: *Ha-ah ndiye ndothuke ndiphinde ndilale. (No, I just wake up and sleep again.)*

Interpreter Y: *Sy loop nie rond nie, sy slaap weer? (She doesn't walk around, she goes back to sleep?)*

It seemed that some omissions occurred under specific circumstances. Interpreters omitted patients' negative remarks towards the hospital or registrar. For example, one of the patients became irritated and conveyed to the interpreter that she was tired of the hospital. However, the interpreter did not convey this to the registrar. See below for the dialogue that arose:

Extract 21:

Interpreter Y: *Kaloku as long yena ezohambisa umyalezo kusisi wakho. (As long as he is going to pass the message to your sister.)*

Registrar (Dr.E): *Wat sê sy? (What is she saying?)*

Interpreter Y: *Sy sê…(She is saying)*

(Patient interjects)

Patient 11: *Iyandidika into yalapha ke hayi, nxaa! (with emphasis) (It tires me the thing of here!)*

Interpreter Y: *Khawume ndixelele ugqirha uba uthini. (Hang on let me tell the doctor what you are saying.)*

Interpreter Y: *Sy sê Thulakele, hoekom kom hy dan nie, want hy het geld. (She said Thulakele, why is he not visiting her because he has the money.)*

Registrar (Dr.E): *Issit? (Is that so?)*

It also seems that interpreters at times omit information in favour of providing the registrar with a concise response. For example, in one of the psychiatric interviews, the registrar asked whether the patient completed school. The patient replied that she left school in standard four since she fell pregnant. However, the interpreter only conveyed that the patient left school in standard four and did not convey the reason for this. The above examples of omissions, relate to the argument of interpreters acting as gatekeepers, filtering information and omitting information that they regard as inappropriate or irrelevant.

During the semi-structured interviews, registrars reported that they were concerned that interpreters might omit information pertaining to the patient's culture since interpreters are under the impression that it would not make sense to Western healthcare workers. I was

surprised to find that in some instances interpreters conveyed cultural information and acted as cultural brokers. However, in other instances, interpreters omitted cultural terms and references. The reasons behind these actions are unclear. Below, I provide examples of uninterpreted cultural references:

- One of the patients used the word *makoti (meaning 'newly married woman')* when she described that, she believed she would marry her priest. The patient explained that she was convinced that she would be married and bought traditional makoti clothing.
- Another patient was a practicing sangoma and referred to the word *mrhawulweni (a small bag used by traditional healers to keep their money in).*The patient also referred to the use of herbal medicine to cure illnesses such as tuberculosis. The interpreter only interpreted and explained the latter cultural reference. It seems that in this case the interpreter was selective in her interpretation of cultural information.
- In the example below (see Extract 22), the registrar asked the patient when she became mentally ill, the patient responded by saying: *Ndagula ndagula ngentethe ndimncane. (I got the traditional illness when I was young).* The interpreter omits the information pertaining to the patient's explanation of the time that she became a sangoma. This type of information provides valuable information about the patient's understanding of his or her illness and the traditional belief system that the patient ascribes to. However, this crucial information is omitted. See below for the dialogue that arose:

  Extract 22:

  Registrar (Dr.E): *Wanneer het sy vir die eerste keer siek geraak? (When did she fall ill for the first time?)*

  (Interpreter interjects)

  Interpreter Y: *Kungokuba ke ngoku waqala nini ukugula? (When did your sickness first manifest?)*

  Registrar (Dr.E): *Mental illness?*

  Patient 12: *Ugula ndagula ngentethe ndimncane. (I got the traditional sickness when I was young.)*

  Interpreter Y: *OH, USEMNCINCI? (in a raised voice) (OH, YOU WERE STILL YOUNG?)*

  Patient 12: *Andaya esikolweni.Ndagula ngentethe. (I could not go to school. I became sick to be a Sangoma [according to tradition].)*

Interpreter Y: *Ukugula ngengqondo? (Being mentally disturbed?)*

Patient 12: *Ugula ngenqondo ne, ndandinyanga umntana wandiloya. (Being mentally disturbed ne, I was healing a child but he bewitched me.)*

Interpreter Y: *Mh.*

Patient 12: *Omnye umkhwetha. (Another initiate.)*

Registrar (Dr.E): *Wat sê sy? (What is she saying?)*

Interpreter Y: *Kaloku ugqirha ufuna ukuqonda njengokuba ufumana le nkamnkam yakho kagavamen, wena waqala nini kowuphi unyaka ukugula ukuze ufumane le mali? (The doctor would like to know that, since you receive this government grant, when, and in what year, did you get sick because so you could get the disability grant?)*

Patient 12: *Ndaqala ngo 19, 2006. (It started in 19-, 2006.)*

Registrar (Dr.E): *Wat sê sy? (What is she saying?)*

Interpreter Y: *Upeya? (Getting a grant?)*

Patient 12: *Hayi. (No.)*

Interpreter Y: *Ukugula? (Sickness?)*

Patient 12: *Ndandingapeyi imali kadanki. (I was not getting a grant.)*

Registrar (Dr.E):*WAT SE SY? WAT SE SY? (in a raised voice) (WHAT IS SHE SAYING? WHAT IS SHE SAYING?)*

Interpreter Y: *Sy sê 2006, het sy (She said in 2006, she)*

(Registrar interjects)

Registrar (Dr.E): *Begin om (Started to)*

(Interpreter interjects)

Interpreter Y: *Met die grant. (With the grant.)*

Registrar (Dr.E): *Ja. (Yes.)*

Interpreter Y: *Maar nou wil ek weet wanneer het sy begin siek raak. (But now I want to find out when she fell ill.)*

Registrar (Dr.E): *Ja. (Yes.)*

Interpreter Y: *Siende dat sy mos nou die pay kry, watter jaar het sy begin siek raak? (Seeing that she receives pay, what year did she became ill?)*

5.1.6 "It could be those open holes [my insanity] saying so"

The findings I refer to in this section are of great importance, since it illustrates how the use of interpreters could have a major impact on the collection of accurate patient information. It is important for the registrar to be aware of the the patient's insight into his or her condition. Information pertaining to the patient's insight could assist the registrar to evaluate for example, if the patient is in denial about his or her illness, or if he or she is aware of their illness but blames it on others (Denzin & Lincoln, 2005).

Furthermore, interpreters' renditions of patients' words at times suggested that patients are more psychiatrically ill than is conveyed when looking at patients original responses in isiXhosa. More specifically, when looking at the interpreters' renditions of patients' words it seems that the patient has no or very little insight into his or her mental health condition. However, when looking at patients' original words it seems that some of the patients indeed have insight into their conditions.

For example, during one of the psychiatric interviews, the registrar asked the patient why she was in hospital. The patient responds by giving a description of something she saw outside her window on the day she came to the hospital. As part of her response, she states the following: *"Andikho zingqondweni ndiyaziva".* The interpreter's interpretation of these words is *"Something in her head was also not so nice"*. However, the independent translation of these words is *"I noticed that I was losing my mind".* The interpreter's rendition of the original message does not have the same impact. See below for the dialogue that arose:

Extract 23:

Patient 2: *Xa ndisondela kweli planga kugalelwe into engathi si-snuff, like into engathi yi-tea bag seyiqhaqhiwe, qha ayikho ninzi ithiwe shweleshwele, eyi ndahlala ndaqonda ukuba makhe ndihlala apha phantsi ndizulise nje wethu, andikho zingqondweni ndiyaziva, xa ndijonga elaa planga hayi sana eli planga lisenza laa nto. Ndihambe ndiqonde uba ndiya kumama e-4, umama mos (As I was approaching this plank there was something that looked like a snuff on it, it looked like a broken tea bag but there wasn't much of it. I sat down. I thought I should sit down to calm down. I was losing it [becoming confused], and I could feel it as I looked at this plank again it was still doing the same thing. I went to my mother at [number] four, mama mos)*

(Interpreter interjects)

Interpreter Y: *Ok, khawume, khawume. (Ok, wait, wait.)*

Interpreter Y: *Where did I end. The story is long?*

(Interpreter laughing)

Registrar (Dr.C): *I think the last time was that she was feeling weak.*

Interpreter Y: *Yes, and she said and then they came back, when they went back home late that afternoon.*

Registrar (Dr.C): *Uhm.*

Interpreter Y: *When they came at home they were busy cleaning the house and she went outside.*

Registrar (Dr.C): *Uhm.*

Interpreter Y: *When she went outside there she saw a plank there lying outside, and the plank was moving upside down, up and down, up and down. And then she go near to it to have a look and on top of that piece of plank there was a tea bag, a broken tea bag.*

Registrar (Dr.C): *Uhm.*

Interpreter Y: *And then she go back again and then she sat and look at this thing, and then this thing was moving, moving and then she sat. She discovered there that something in her head was also not so nice.*

In another psychiatric interview, the patient explained that she was in love with her priest and she believed they would get married. The interpreter then asked the patient if the patient was in a relationship with the priest after which the patient said: "*There is no relationship, it's in me, inside".* However, the interpreter interpreted these words as *"The man was unaware of this (her feelings towards him)".* The patient's original words have more impact and convey a stronger message of the patient's awareness and insight into her condition. See below for the dialogue that:

Extract 24:

Patient 13: *And izinto ezincinci ke phofu ezinjenge-towels ndanditshilo kubo ndathi sendizithengile, besendizithengile for loo nto. (And the small things like towels, I told them that I have already bought them. I bought them for the occasion.)*

Interpreter Y: *BESELE NIYIQALISILE IAFFAIR (in a raised voice)? (HAD YOU ALREADY STARTED AN AFFAIR?)*

Patient 13: *HAYI, AKUKHO AFFAIR, ILAPHA KUM NGAPHAKATHI (in a raised voice). (THERE IS NO AFFAIR, IT IS HERE INSIDE OF ME.)*

Interpreter Y: *OH ILAPHA KUWE, NGUWE LO MNTU UZIMISELE UKUBA UZA KUBA NGUMAKOTI WALO BHUTI (in a raised voice). (OH, ITS IN YOU, YOU ARE THE PERSON WHO IS COMMITTED TO BEING THE WIFE OF THIS GUY?)*

Patient 13: *Ndim ndodwa lo mntu, ndizimisele, ndizibekele ixesha. (It's me alone, I am committed. I have set aside time.)*

Interpreter Y: *Waske watshata wa-disappointed ke ngoku. (He got married and then you were disappointed.)*

Patient 13: *NDA-DISAPOINTED, UYAZIVA EZI ZINTO ZENZEKA NGONYAKA OMNYE (in a raised voice). (I WAS DISAPPOINTED, DO YOU HEAR THESE THINGS ARE HAPPENING IN ONE YEAR.)*

Interpreter Y: *Hayi, ungumntu kaloku. (No, because you are a person.)*

Patient 13: *Ewe. (Yes.)*

Interpreter Y: *Wagula emveni ke ngoku emveni koko? (You became sick after that?)*

Patient 13: *Ndaba njalo ke ngoku, ukusukela ngoko ke ngoku ndaqalela ngoko ke. (I was now like that, ever since that incident, I started then [to be sick].)*

Interpreter Y: *Nee ek verstaan nou hoe sy gevoel het. Sy't nou verlief geraak op hierdie man, maar die man was mos nou onwetend van haar. En sy het vir haarself gesê sy gaan sy makoti raak en sy't beginnne goed koop. Soos die handoeke en daai wat Makoti's gebruik. (I understand how she felt. She fell in love with this man, but the man was unaware of her. She told herself that she was going to be a makoti and she started buying things, like towels and things that the Makoti's use.)*

Registrar (Dr.E): *Mm.*

Interpreter Y: *Al daai goed het sy bymekaar gemaak en gekoop en vir haar gekry, want sy gaan met hierdie man trou. (She collected and bought all those things for her, because she was going to marry this man.)*

(Registrar interjects.)

Registrar (Dr.E): *Wat? (What?)*

(Interpreter interjects)

Interpreter Y: *En toe trou hy en toe is sy so teleurgesteld. (And then he got married and she was so disappointed.)*

In yet another psychiatric interview, the registrar asked the patient why she had told another registrar that people were jealous of her. The patient responded by saying that she cannot remember saying this, however perhaps she said this due to her insanity. The interpreter did not convey the latter part and only conveyed that the patient cannot remember saying that people were jealous of her. See below for the dialogue that arose:

Extract 25:

Registrar (Dr.B): *Sy het voorheen vir die ander dokter gesê die mense by die huis is jaloers op haar en dit is hoekom sy hier is. Dink sy nogsteeds so? (Previously she told the other doctor that the people at home were jealous of her and that's the reason why she is here. Does she still think this?)*

Interpreter R: *Uthi komnye ugqirha ubuthethe naye uthe abantu bane-jelasi ngawe (She said, from one of the doctors you spoke with, you said people are jealous of you)*

(Patient interjects)

Patient 1: *Hayi andiyikhumbuli ndithetha nge-jelasi andiyikhumbuli loo nto. (No, I don't remember speaking about jealousy. No, I don't remember that.)*

Interpreter R: *Sy sê sy onthou niks van daai nie. (She said she does not remember any of that.)*

Patient 1: *Inoba yiloo mingxunya evulekileyo itshoyo. (It could be those open holes [my insanity] saying so.)*

Interpreter R: *Sy sê sy het nie gese die mense is jaloers op haar nie. Sy het nie dit gesê nie. (She said she never said that people were jealous of her. She never said that.)*

In the examples below, I present instances in which the interpreters (instead of omitting information) made their own additions. These additions seem to suggest that patients are more ill than what might be the case:

- The patient conveyed that she was happy. However, the interpreter's rendition of this is that the patient said she is *"Very happy"*. The patient never said that she was 'very'

happy. Excessive happiness could imply, for instance, that the patient has manic features. See below for the dialogue that arose:

Extract 26:

Registrar (Dr.E): *Ek sien sy is nou hartseer, maar vanoggend toe sy opgestaan het, was sy gelukkig toe? (I see that she is sad at the moment, but when she woke up this morning was she feeling happy?)*

Interpreter Y: *Uthi ugqirha uyakubona ngoku unenyembezi, ekuseni ngoku ubuvuka ubunjani? (The doctor said, she sees that you are in tears, in the morning how did you feel?)*

Patient 11: *Bendiright. (I was right.)*

Interpreter Y: *Sy sê sy was oraairt gewees. (She said she was alright.)*

Registrar (Dr.E): *Was sy bietjie gelukkig of baie gelukkig? (Was she somewhat happy or very happy?)*

Interpreter Y: *Ubuphume uvuya kakhulu okanye ubunjani ekuseni? (Were you very happy or how did you feel in the morning?)*

Patient 11: *Ndiphume ndivuya. (I was happy.)*

Interpreter Y: *Oh, baie gelukkig. (Oh, very happy.)*

Registrar (Dr.E): *Issit. Hoekom is sy dan so gelukkig? (Is that so. Why is she so happy?)*

- The patient gave a description of the events, which occurred on the day she went to hospital. The patient described the presence of a woman in her home who left the house when a pastor prayed for the patient. The interpreter conveyed to the registrar that the patient thinks, *"This lady is busy with her"* (i.e. bewitching her) and that the patient referred to muthi-practices (this generally involves the use of traditional medicine prepared by traditional healers or sangomas). However, the patient did not mention bewitchment or muthi-practices. See below for the dialogue that arose:

  Extract 27:

  Patient 2: *Ndanxiba wabe sefika utat'umfundisi kwabe kungeniswa icawe pha ekhaya kwathandwa kwathandazwa, kwathandazwa, laa mama thina into esiyiqapheleyo, lo bendimbambile ngoku bendingathi ndiyatshowukhwa khange afune ukuhlala, uye wathi uyobeka imbiza, wafika kwakhe wavala, wakroba ngeefestile. (I dressed up and then the pastor arrived at my place and started a church service at home. We prayed*

and prayed and we noticed that, that woman, who I had touched earlier when it felt like I was being choked, didn't want to stay. She said its time for her to cook, and she went home, closed the doors and peeped through windows.)

Interpreter Y: *So ke ngoku lilonke ukrokrela yena? (So you are suspecting her?)*

(No response from patient)

Interpreter Y: *Ukrokrela yena? (Are you suspecting her?)*

Patient 2: *Ha-ah-na andimkrokreli. (No, I'm not suspecting her.)*

Interpreter Y: *Uhm, so that after that*

(Patient interjects)

Patient 2: *Ngoomheza bam andikrokreli yena. (They are my neighbours I don't suspect her.)*

Interpreter Y: *After that they get other people to pray in their house.*

Registrar (Dr.C): *Uhm.*

Interpreter Y: *But that lady who took her to that person didn't want to come into their house.*

Registrar (Dr.C)*: Uhm.*

Patient 2: *And ebusuku andilali ndiyabethwa zinto endingazaziyo. (And I don't sleep at night, some things that I do not know are beating me.)*

Interpreter Y: *So she thinks it's that lady who is busy with her.*

Registrar (Dr.C): *I see.*

Interpreter Y: *About muthi stuff.*

5.1.7 Time constraints

Below, I present examples of instances in which time constraints seemed to affect the quality of patient information collected. In three of the sessions, the registrar and interpreter were pressurized for time. In one of these sessions, the registrar told the interpreter: *"We should hurry up"* and in a raised voice repeatedly asked the interpreter what the patient was saying. It seemed that in response, the interpreter attempted to get the patient to give a concise response instead of a more detailed one. When the patient tried (the interpreter interjected) to explain her story was detailed and that she did not want to leave out information, the interpreter reacted by saying: *"Oh God"*. Later during the psychiatric interview the

interpreter told the patient to only answer questions provided by the registrar (i.e. and not wonder off the point) due to time constraints. See below for the dialogue that arose:

Extract 28:

Interpreter Y: *Waphila ngantoni? Umbuzo wam waphila ngantoni? (What healed you? My question is what healed you?)*

Patient 13: *Sendisitsho kaloku sisi, ndaye (I was saying sister, I)*

(Interpreter interjects)

Interpreter Y: *Ngoku phambi kokuba ufike apha, ubuphinde wagula mos emveni kwexesha nhe? Ubuphinde wagula ngoku ubusebenzisa iipilisi. (Now, before you arrived here, you became sick after some time? You became sick again while using pills.)*

Patient 13: *Sisi eyam ingulo inde, ndaphinda ndaya eSan Marco*[7]*. (Sister my illness is long. I went to San Marco again.)*

Interpreter Y: *Oh Thixo! (with emphasis) (Oh God!)*

Patient 13: *Ndayolala eSan Marco, uyakhumbula? (I went to sleep at San Marco, do you remember)?*

Interpreter Y: *Ndiyabuza, phendula umbuzo wam qha. (I'm asking a question, answer my question only.)*

Later during the same psychiatric interview…

Interpreter Y: *UThemba, wambetha ngesandla okanye ngenduku? (Did you beat Themba with your hand or a stick?)*

Patient 13: *UThemba pha entungweni. (Themba in the roof.)*

Interpreter Y: *Mama phendula umbuzo (in a raised voice). (Mama answer the question.)*

Patient 13: *Ndambetha. (I beat him.)*

Interpreter Y: *Phendula umbuzo. (Answer the question.)*

Patient 13: *Ndambetha ndamkrwitsha. (I beat and strangled him.)*

[7] The name San Marco is a pseudonym for another psychiatric hospital in the Western Cape.

Interpreter Y: *Ndithe kuwe uza kuphendula umbuzo obuzwe ngugqirha qha, otherwise soze sigqibe. (I said to you, you will only answer questions that are being asked by the doctor otherwise we won't finish.)*

5.1.8 Doctor-patient relationship

It seemed that the alliance between the patient and interpreter excluded the registrars. For example, as can be seen in the dialogue below, at times the interpreter and patient laughed at something the patient said in isiXhosa, while the registrar was excluded from this.

Extract 29:

Interpreter Y: *Wena, uziva njani ngobomi bakho? (How do you feel about your life?)*

Patient 2: *Ndibe nendlu entle, nditshate, ndihlale endlini enkulu. (I must have a beautiful house, get married and stay in a big house.)*

(Patient and interpreter laughing.)

Registrar (Dr.C): *And now?*

It was my impression that the registrars actively tried to establish a relationship with the patients and used various creative strategies to facilitate this process. For example, registrars made sensitive comments, but as previously mentioned, the interpreters omitted many of these remarks. Registrars, particularly during the beginning of the sessions addressed the patients directly, using the second person. As mentioned when spoken to directly patients were also more likely to make eye contact with the registrar. One of the registrars used humour in response to the patient saying that she did not always want to wash the dishes at home. The registrar remarked that he also does not like to wash dishes and this invoked laughter. It also seemed to lighten the patient's somber mood.

During the semi-structured audio-interviews, the majority of registrars said that they felt that the presence of the interpreter made them feel alienated. They felt excluded from the conversations, between the patient and interpreter that occurred during the psychiatric interviews. According to the registrars, the patients placed more trust in the interpreter who shared a language and culture with them. This created a kinship between the interpreter and patient which the registrar could not penetrate. See below for the statement made by one of the registrars regarding the abovementioned:

Extract 30:

Registrar (Dr.C): *Well for instance the patient, because the translator is speaking her mother tongue she, or there is a tendency for her (the patient) to trust or believe the translator and place more trust with her. And she can be more comfortable with that person. So at times I felt that I was a party to their discussion, although I am leading this discussion technically. So there is a small bit of alienation there as an interviewer that I feel that I am a bit removed there.*

One of the registrars felt that she did not share the same connection with isiXhosa-speaking patients compared to her English and Afrikaans-speaking patients, simply because she was unable to communicate with them on a regular basis. The registrar explained that often when she walked past patients in the wards, they would have a casual conversation. This strengthened the relationship she had with her patients. However, with the isiXhosa-speaking patients she did not always have the time to find an interpreter for the purpose of having a casual conversation. This seems to suggest that isiXhosa-speaking patients do not receive the same level of patient care. See below for the registrar's quote:

Extract 31:

Registrar (Dr.B): *Baie keer gaan jy agter toe en gesels sommer met die pasiënte in die verbygaan soos: "Hallo hoe gaan dit vandag". En ons het glad nie daai basiese opleiding in isiXhosa om enigsins met hulle te kommunikeer nie. So jy skeep hulle amper `n bietjie af omdat jy nie altyd die tyd het om `n tolk te kry en daai klein geselsies te maak nie. So definitief, die band tussen jou en die pasiënt is nie so goed soos wat, wat dit sou wees as jy in hulle moeder taal kan gesels nie. (Very often you go to the back and chat with the patients when you walk by them, like: "Hallo, how are you today". And we don't have training in basic isiXhosa to be able to communicate with patients. So you almost neglect them in a certain sense since you don't always have the time to find an interpreter to assist when makings small talk with the patients. So, definitely the connection between you and the patient is not as good as it could be when you are able to talk in the patient's mother tongue.)*

5.2 Facilitators

5.2.1 Eye contact

To some extent the registrar, patient and interpreter portrayed the same behaviour when it came to eye contact. In other words, whenever one person spoke directly to the other person they would make direct eye contact. For example, the registrar and interpreter made eye contact whenever they spoke to one another. The same applied to when the interpreter and patient spoke to one another. Interestingly, the majority of patients only made brief eye contact with the registrar whenever the registrar spoke to them or when they spoke to the registrar.

However, the registrars attempted to make regular eye contact with the patient not only during the times they spoke to the patient, but also when the interpreter spoke to the patient or when the patient spoke to the interpreter. The interpreters would also look at the patient whenever the registrar spoke to the patient. The majority of patients, on the contrary, did not make any eye contact with the registrar in those instances that they were not 'required' to speak to the registrar, i.e. when the registrar did not address them directly. The majority of registrars only addressed patients directly during the beginning and at the end of the sessions. In the beginning of the sessions, the registrars directly addressed patients when introducing themselves and when they asked short, simplistic questions, such as "*How did you sleep?"* or *"How are you doing?"*. At the end of the sessions, registrars would directly address patients when thanking the patients for their time. The findings suggest that the registrars used eye contact as a means to connect and communicate with their patients in the absence of a common language.

5.2.2 Basic knowledge of one another's language

Although the registrars were fluent in English and Afrikaans, one of the registrars seemed to have limited proficiency in isiXhosa. This registrar spoke in isiXhosa when greeting the patients during the beginning of the psychiatric interviews. She used isiXhosa comments, such as *"Thula, thula, sisi"(i.e. "Hush, hush sister")* to comfort patients when they became emotional. This registrar also used her knowledge of isiXhosa to verify and check the interpreter's interpretation of the patients' utterances. This illustrates how essential it is for registrars to have at least some basic knowledge of the patient's language.

During the audio-recorded semi-structured interviews, my colleagues and I learned that three of the four patients were first language isiXhosa-speakers and one was a first language isiSotho-speaker. The isiSotho-speaking patient had to communicate in isiXhosa with the interpreter. It was also not clear whether the interpreter and registrar were aware of this, since this was not raised during the psychiatric interview (which I recorded). Only during the semi-structured interview the patient informed my colleague that he was a first-language isiSotho-speaker. All the patients, except for one, reported that they had a limited proficiency in English. Regardless of their limited proficiency in English, patients used their language skills to communicate and interact with registrars, even if only to thank the registrars at the end of the session. Perhaps this was patients' way to negotiate some power within the triadic psychiatric interview. Also, whenever the registrars greeted the patients in English, the patients responded in English. However, as soon as the registrars asked questions, which were more complex, most patients were unable to answer these questions in English. For an example of this, see Extract 32.

Extract 32:

Registrar (Dr.E): *Slaap jy lekker? (Are you sleeping well?)*

Patient 11: *Ja. (Yes.)*

Registrar (Dr.E): *Slaap jy net soveel soos die ander pasiënte of minder of meer? (Are you sleeping as much as the other patients or less or more?)*

Patient 11: *Andazi uthini. (I don't understand what she is saying.)*

One of the few patients, who had some command of Afrikaans, used her knowledge of the language to correct the interpreter's interpretation of her words. See below (Extract 33) for an example of the patient correcting the interpreter:

Extract 33:

Interpreter Y: *Sy bly met haar kind, haar suster en haar suster se kind. (She stays with her child, her sister and her sister's child.)*

Registrar (Dr.E): *Ok, en hoe oud is haar kind? (Ok, and how old is her child?)*

Patient 13: *HA-AH, SISI MAMELA (with a raised voice). Ndithi ndihlala nosister wam, nentombi kasister wam. (NO, NO, SISTER LISTEN. I am saying, I am staying with my sister, and my sister's daughter.)*

5.2.3 Bilingual healthcare worker

The interpreters who were also healthcare workers were able to provide important additional information regarding the patient's condition. For example, during one of the psychiatric interviews, the registrar asked the patient about her appetite. The interpreter informed the registrar that when she came on duty she was informed by the nurses that the patient vomited the day before. In addition, one of the other interpreters (a healthcare worker) noticed a change in the patient's mood. The interpreter informed the registrar of her concerns about the patient's change in mood. Registrars also seemed to rely on interpreters' status as healthcare workers. For example, one registrar asked the interpreter whether she could arrange for the patient to attend an organisation for substance abuse. Furthermore, the registrars were also more likely to ask interpreters, who were also healthcare workers, compared to the household aides, for their opinions about the patient's condition. In some instance (as I referred to above), interpreters official roles as healthcare workers provided valuable patient information that the registrar might otherwise not have known. During the semi-structured interviews one of the registrars expressed the need for interpreters to acquire the necessary skills to be able to evaluate patients' thought processes. See below for the registrar's quote:

Extract 34:

Registrar (Dr.D): *Ek voel `n mens moet besluit wie is watse rol. En ek dink nie die tolk moet die rol van dokter vervul nie, maar ek dink ook nie die dokter moet die rol van die tolk vervul nie. Ek dink mens moet vooraf baie mooi besluit hoe gaan mens dit doen, hoe gaan die sisteem werk, terwyl die dokter wil partykeer hoor wat is die gedagte proses van die pasiënt en dit is `n geweldige probleem as daar swak kommunikasie is vir `n dokter om te evalueer wat is die gedagte proses van die pasient. Hoe sit die pasiënt sy sinne aanmekaar. Jy weet waste abstrak idees is daar, dit is iets wat die tolk sal moet terugvoering gee aan die dokter. En dit is nie noodwendig iets wat mens in `n vraag aan `n pasiënt kan stel nie. Die tolk gaan moet se hierdie is die gedagteprossese wat ek by hierdie pasient sien. En dit is iets wat ons vir ons tolke gaan moet leer om te evalueer. (I feel you have to decide who will play what role. I don't think the interpreter should fulfil the role of the doctor, but I also don't think the doctor should play the role of the interpreter. I think you have think carefully about how you will go about it beforehand and how the system will work. The doctor sometimes wants to hear what the patient's though processes are. And it is a major difficulty for the doctor to evaluate the patient's thought processes when there is poor communication. How does the patient formulate his*

sentences. You know, what abstract ideas can be identified. This is something that the interpreter will be required to report back on. And this is not necessarily something that you can get by simply asking the patient. The interpreter should inform the doctor that this is the patient's thought processes that I was able to identify. And this is something that we should teach interpreters to evaluate.)

The fact that the registrars requested and welcomed interpreters input during the psychiatric interviews, seems to suggest that although the registrars more frequently requested the input of the interpreters who were also healthcare workers, they also bestowed a lot of trust in the interpreters (regardless of their occupations). As one of the registrars explicitly told the interpreter (who informed the registrar that the patient misspelled a word in isiXhosa): *"Ok, I wouldn't know. I trust you."*

5.2.4 Cultural broker

As referred to earlier in this chapter, at times interpreters acted as cultural brokers. In other words, interpreters explained to the registrars some of the patients' cultural references. For example, one of the male patients mentioned during a prior psychiatric interview to the registrar that he had not yet undergone the initiation process. The initiation process is in essence a process that young boys undergo to become men. It is their rite of passage into adulthood and involves circumcision. During the psychiatric interview, the registrar asked the interpreter whether the patient's preoccupation with his genitals is perhaps because the patient has yet to undergo initiation. The interpreter explained to the registrar that normally men at the age of 18 years would go for initiation and that it is unusual in cultural terms for a man at the age of 23 years (i.e. the patient's age) not to have taken part in the initiation process. The interpreter also contextualized the initiation process, by explaining to the registrar the costs involved in the initiation process. Another interpreter explained to the registrar the term *gooi-gooi* (i.e. a community-based savings club) that the patient referred to in her response.

During the semi-structured interviews, all the interpreters reported that culture plays a role when it comes to interpreting. The majority referred to the ancestors and *amafufunyana*[8], and the prominent role they play in patients' stories. See below for the dialogue that arose:

Extract 35:

Researcher: *Do think that culture plays a role during the interpreting session?*

Registrar (Dr.C): *Ja like sometimes it can be because the patient he can talk things like amamfufunyana, the ancestors, okay that man want me to go for sangomas, I'm not crazy because they called me. It's a calling. And I can explain now. Okay she said no it's not so sick it's a calling, it's a culture. All those things. Hmmm*

One of the interpreters (a healthcare worker) explained that in the isiXhosa culture there is a certain way to handle a situation in which someone else was saddened. As an example, the interpreter referred to one of the psychiatric interviews in which she assisted as an interpreter in which the patient cried when talking about the death of her father. The interpreter explained that in the isiXhosa culture she had to comfort the patient and explain to the patient that everything happens for a reason.

5.3 Other

5.3.1 The lack of professional interpreter services

The findings suggest that the lack of professional interpreter-services is forcing the registrars into a position that they are not comfortable with and is likely to affect the quality of the clinical data collected. Registrars felt uncomfortable asking security guards, household aides and healthcare workers to act as interpreters, since interpreting interfered with ad hoc interpreters' official work. However, registrars felt that they had no choice but to rely on the ad hoc interpreters. One of the registrars reported that because she felt uncomfortable using ad hoc interpreters, she tried to get the psychiatric interview over as soon as possible. Although, only one of the registrars reported this, it is probable that the other registrars also haste through the psychiatric interviews. See the registrar's response below:

Extract 36:

[8] *A type of spirit possession occurring amongst isiZulu and Xhosa-speakers (Swartz, 1998).*

> ***Registrar (Dr.F):*** *Well, first of all because we don't have interpreters I had to ask somebody and put them out. And ask them to do stuff they don't really want to do. So it's something that can be quite unpleasant. You know I (inaudible) want to get the interview over as quickly as I can. It's also frustrating because the interpreter changes all the time. You don't know if they know anything about psychiatry, so. And obviously the way people talk is also quite important for your mental state exam. So it's all kind of frustrating and unsatisfying in general. You know, so it's not pleasant for the patient either. You know, if they know it's perfunctory and they can't get their point across. And I never love these kinds of things but you have to deal with it.*

The findings also suggest that the lack of professional interpreters places ad hoc interpreters in a role that they do not feel comfortable with. Some of the registrars were of the opinion that certain ad hoc interpreters disliked the patients and did not understand what the patients were saying. Interpreters' attitudes toward patients may have a negative impact on the communicative atmosphere – creating what may be perceived to be a hostile environment in which patients feel discouraged to talk about personal matters. See the registrar's response below:

> *Extract 37:*
>
> ***Registrar (Dr.F):*** *Like when some of the security guards are asked to do it. These people aren't really interested in psychiatry and I can tell quite clearly that they dislike patients. So the time is against them, they don't really want to speak to the guy. The guy makes no sense to them. So they are just like: "Agh, I don't know what to say." You know, you just sometimes get those sessions where you feel you know, you might have not bothered, because whatever the patient was understanding from what you were saying, and what you heard the patient said, was just a disaster.*

The lack of official interpreter services seems to have a major impact on patients' access to quality healthcare. A few registrars reported that patients who were not proficient in English or Afrikaans did not receive the same level of care as other patients. This suggests that not all patients receive the same access to quality healthcare and that some patients are discriminated against. One of the registrars explained that isiXhosa-speaking patients who were unable to

speak English or Afrikaans had no one to talk to when the isiXhosa-speaking staff was off duty, or when no other isiXhosa-speaking patients were admitted to a particular ward. The particular registrar was concerned that in such cases isiXhosa-speaking patients was admitted for long periods of time, and that patients felt they were not heard. The interpreters's comments support the registrar's opinion. See the registrar's response below:

Extract 38:

Registrar (Dr.E): *Kry vir ons tolke. Ek dink ons isiXhosa pasiënte lei daaronder veral omdat by St. James is daar nie baie pasiënte, nou is die pasiënt soms die enigste een wat isiXhosa praat en dan kan sy met niemand rerig in die saal gesels nie. Of dalk het die pasiënt selfs fisiese klagtes, maar sy kan dit nie vir ons sê nie. En net die feit dat jy weet jy word gehoor maak baie keer dat die pasiënt minder aggressief of gefrustreerd raak. En op die ou einde bly hulle dalk langer. (Find interpreters for us. I think that our isiXhosa patients are suffering because of this, especially since there are not many isiXhosa patients at St.James. What you have now is that if the patient is the only one that can speak isiXhosa and then she has no one on the ward to talk to. Or maybe the patient has physical complaints however she is unable to communicate this to us. And the fact that you are being heard, in many instances, makes the patient less aggressive or frustrated. And at the end of the day they might stay longer.)*

During the semi-structured interviews, interpreters clearly felt a personal responsibility towards the patient and felt that the role of interpreter enabled them to give back to their people (i.e. isiXhosa-speakers). Some interpreters explained that patients were relieved when someone who was isiXhosa-speaking came on duty. One of the interpreters reported that patients became irritated and aggressive when they were unable to communicate with the registrars. See below for the dialogue that arose:

Extract 39:

Researcher: *Okay, um are you financially rewarded for your work as an interpreter?*

Interpreter U: *No.*

Researcher: *And how does that make you feel?*

Interpreter U: *Well I didn't worry about it because I just felt I am giving back to my community and erh, um because I could help somebody else who doesn't understand and, erh, most of the time you know when the patients are being spoken to and they don't understand what is being said to them they take it the wrong way you know so if they do understand they are calm but the minute a person speaks another language which they don't understand sometimes you could see that they get jittery and some of them will shout or some will get aggressive, you know, but when they understand, they, they are calm you know. They will talk to you nicely, you know. So I, I didn't really mind doing it, Hmm.*

The personal responsibility interpreters reportedly felt towards patients suggests that they perceived themselves as the patient's keeper and advocate. Some of the interpreters, who were also household aides, reported that they interacted on a daily basis with the patients while cleaning the wards. Their regular interaction with patients gave them the opportunity to get to know patients on a personal level. One of the interpreters (household aide) reported that due to their regular interaction with the patients they had a better understanding of the patients and their problems. See below for the dialogue that arose:

Extract 40:

Researcher: *Okay, so the first question I'd like to ask you is are you employed as an official or an unofficial interpreter here at St. James?*

Interpreter S: *Erh I'm employed as an unofficial interpreter because my job is a household aid. But as a household aid in St. James,I, the doctors have difficulties with the African patients because some of the African patients, they don't understand English and then sometimes they don't understand the doctors so now even the doctors they ask us as employees of St. James hospital who are working together with the patient which us as the cleaners we better understand the patients because we are in the same environment and then each and every day we know this patient if the patient is discharged then he is coming back and he is coming again and then we do understand and then sometimes the patients each and every time they go back they discharge outside St. James hospital and within 2 months then patient is coming back and then we do a conversation with the patients. Why you are here? Last month you were discharged. And then the patient, they give us a lot of information. No I am sick*

because of this and this and that outside or maybe I didn't take my tablets and then alter if the doctor he want to talk to the patient and then we will be on the side of the patient what was wrong outside then we interpret for doctor, you see.

All the interpreters felt that they shared a strong emotional connection with the patients. One of the interpreters (a household aide) explained that when patients are initially admitted they are scared and anxious. As household aides, it was their responsibility to comfort patients and reassure them that they have nothing to fear. The household aides felt that it was their responsibility to explain to patients that the hospital is a place of safety and they will be discharged as soon as they are well. One of the interpreters (a household aide) reported that she went out of her way to help patients. The interpreter explained to me that sometimes she offered a patient (that she thought was lonely) a sandwich. She would also give the patient tobacco if the patient requested her to do so. Alternatively, she would try to get the patient to engage with her by asking him or her help her fold the laundry, since this created an opportunity for them to interact. See below for the dialogue that arose:

Extract 410:

Researcher: *So hoe meer jy vir hulle verduidelik hoekom jy hier is en hoekom jy vir hulle die vrae vra – dan praat hulle meer? (So the more you explain to them why they are here, and why you are asking them [questions], the more they talk?)*

Interpreter R: *Mm. Hulle voel oop en free om te praat. Die meeste pasiënte hulle kom so bang-bang sien. Dis deel van die pasiënt se siekte. En hulle voel hulle is alleen hierso. Dan praat ons met hulle en sê: "Nee jy is veilig hierso, jy kom rus hierso en as jy gesond gaan jy huistoe en jou mense kan vir jou kom besoek. So moenie bang wees nie." En hoe meer ons so vir hulle tolk, hoe meer raak hulle vry. Hulle raak so baie lief vir my en erg oor my. Partykeer sê hulle: "Sisi bring vir my twak môre. Dan sê ek ok ek bring vir jou twak more. Of miskien ek werk mos in die kombuis, dan vat ek `n broodjie daar en gaan gee vir die pasiënt. Dan vat ek dit vir daai een wat so stil en lonely sit daar, dan gee ek dit vir die pasiënt en sê eet. En maybe ek sien die pasient raak beter, dan sê ek vir hom: "Kom, kom help my om die wasgoed te pak", dan kom hy. En terwyl ons die wasgoed pak dan gesels ons lekker. Dan môre as die dokter kom dan vertel ek vir die dokter wat hy gesê het. Met daai manier dan kry dokter maklik om vir hom te behandel. Nee, die dokters hulle vra net vir ons hoe sien ons die*

pasiënte, want die dokters weet die pasiënte beweeg tussen ons soos wat ons skoonmaak en so. En ons wat hier is ons is baie erg oor onse pasiënte. Ons moet kyk, soos nou die dag, ek sien die pasiënt hy speel met die water hierso by die badkamer en ek gaan kyk toe, want daar is warem water daar dat hy nie brand of verdrink nie. (Mm. They are open and free to talk. Most of the patients when they arrive are fearful. It's part of their illness. They feel lonely here. Then we talk to them en inform them that they are safe here (in the hospital): "You came to rest here and once you are well you will go home. And your people can visit you, so don't be scared." And the more we interpret for them the more they become free. They came to love me and are fond of me. Sometimes, they will ask me: "Sisi bring me some tobacco tomorrow." Then I say: "Ok, I will bring you some tobacco tomorrow." Or maybe, since I work in the kitchen, then I will give the patient a sandwich. Then I will give it to that patient seems so lonely and quiet. And maybe I see the patient is improving, then I will ask the patient: "Come help me fold the laundry." Then he will do this and while we are busy with the laundry we chat with one another. Then tomorrow when the doctor arrives then I will tell the doctor what the patient told me. This way, the doctor finds it easier to treat the patient. No, the doctors ask us how we see the patients, since the doctors know that we are around the patients while we clean and so. And because we are very fond of our patients. We have to keep an eye on them. Like the other day, I saw this patient playing with the water in the bathroom. So I went to check that the warm water doesn't burn him or that he doesn't drown.)

In addition, interpreters felt that registrars would not be able to diagnose patients without their assistance, due to language barriers. This would also imply that without their assistance patients may not receive the appropriate medication. See below for the dialogue that arose:

Extract 42:

Researcher: *In other words do you get paid or given money for doing interpreter work?*

Interpreter V: *No, No.*

Researcher: *Now how do you feel about that?*

Interpreter V: *Ja, sometimes I feel bad. Sometimes because we must work like a group in the ward. I try to take easy everything, but sometimes it's difficult because, I*

think if I refuse to that doctor, maybe she gonna be. Erh this patient, he not gonna get a right medication or the doctor is not gonna get a right, "Why do this patient is here?"

Researcher: *Yes.*

Interpreter V: *Now and then I think twice. I must help that erh, erh doctor because I am not gonna get nothing at the end, but because I know how to work in the hospital, I try my best, okay I must help that doctor, but I'm not, I'm not getting nothing, for that.*

Furthermore, during the semi-structured interviews, one of the interpreters (a household aide) reported that while cleaning in the ward the patients told them about their personal stories and problems. However, some patients did not convey the same information to the clinicians. The interpreter felt that it was her duty to inform the clinician of the version of the story she was told by the patient. See below for the participant's comment:

Extract 43:

Interpreter S: *Sometimes because the African patients they don't some they don't understand English and then I talk English to the doctor and then when the patient they go to the doctor and then I can have that chat with the patient sometimes you see the patient and then you chat the patient, you chat the patient. What's going on, what's wrong, what's this and then there's two stories when the patient is going to doctor and when he is going to doctor and then doctor want to, must explain doctor what's going on and then the patient he didn't say the same words he told me and then he change the topic when he see the doctor and then when it's on me as a colleague in hospital, she tell me another story.*

The majority of interpreters reported that patients' stories and problems affected them. One of the interpreters reported that it was painful to listen to patients stories. See below for the dialogue that arose:

Extract 44:

Researcher: *And I know you are also a healthcare worker, but is it sometimes difficult or upsetting for you to listen to the patient's story?*

Interpreter Y: *Yes, it is sometimes difficult to listen to what happened to the patient when I do the interpreting even if I am a nurse, because for example like what happened yesterday. The patient started crying while I was talking to her when she explained what happened to her in the past. It was painful.*

Some of the interpreters reported that patients' stories affected them, because they could identify with patients. For example, one of the interpreters reported that some of the young female patients reminded her of her own daughter. Another interpreter also explained that it was distressing to listen to patients' stories about bewitchment (see Extract 45). The particular interpreter explained that sometimes he believed patients' stories about bewitchment to be the truth. See below for the dialogue that arose:

Extract 45:

Researcher: *And and, and if so how? If you have an example maybe once when you were affected?*

Interpreter T: *Um the other patient told me his story. He said, I didn't know why he is here in St. James, [Sigh.]. The witch him into the forest and I ask him "Why? How?" And he said he didn't know why but the witch and he is coming here in hospital to take him here. I said "How? Because you are always here." He said "I don't know but it's the witch." I said "Did you know the witch, he said yes a witch. And I told the doctor I said the witch coming here at work every day, every night."[Sigh] And he was sick for a long time here in St. James. Maybe he is better today and tomorrow but after three days he is very sick again.*

Researcher: *So that affected you?*

Interpreter T: *Yes because hey.*

Researcher: *How did you feel about it?*

Interpreter T: *Hey I was so worried because I know about the witch.*

Researcher: *Yes.*

Interpreter T: *Hmmm I know. Sometimes it's true. Sometimes it's not true because they are sick. Sometimes you don't understand. Sometimes you understand because she's, he's talking the right way. Sometimes hey, she talk here and she talk here so you don't understand.*

5.3.2 The additional role of ad hoc interpreter

The majority of the interpreters reportedly had ample experience working as ad hoc interpreters at the hospital. At the time of data collection, only one of the interpreters (a healthcare worker) had limited experience working at St. James hospital. This was because she was a visiting healthcare worker and had only been working at the particular ward for a week. Interpreters explained that fulfilling the role of interpreter was something that happened spontaneously and naturally to them. When asked what they meant by this, they explained that since they are Black, spoke isiXhosa and were the only people on the ward who were able to communicate with the Black patients, they were the obvious choice for providing interpreter services. They explained that the registrars and nurses had no choice but to ask the Black employees to act as interpreters, since there simply was no other way for the patient and registrar to communicate. It seems that the interpreters, like the registrars, felt powerless to change the status quo.

While none of the interpreters had any objections to the above criteria (i.e. to act as interpreter because of their race and language skills).T he majority of the interpreters had objections to the fact that interpreting interfered significantly with their official work. Interpreters explained that interpreting was time-consuming, it involved more than simply translating words from one language into another. It also involved establishing a relationship with the patient and assisting the registrar to connect with the patient. See below for one of the interpreters' comments (embedded within the dialogue) regarding the time-consuming nature of the interpreting process:

Extract 46:

Researcher: *You are a cleaner (i.e. household aide) ok. So I'd like to know whether this, because this is an additional role, being an interpreter, right?*

Interpreter V: *Yes.*

Researcher: *It's over and above what you must do. I want to know whether this interferes with your official duties being as, um, a cleaner.*

Interpreter V: *Sometimes, erh, it's difficult to me because I must leave my job and come to help the doctor. Sometimes other patient is so difficult, sometimes other patient don't want even to speak out to the doctor, to talk. I must try to make that patient come to talk to the doctor. To explain to the doctor what's going on, because*

sometimes other doctors, they don't know how to talk to the patient - the isiXhosa patient. It's so difficult because that patient is not even hear what the doctor say. Now first of all, I must try to make a friendship with me and the doctor and the patient. That time my work is waiting for me.

Researcher: *Because it takes time, you say?*

Interpreter V: *It takes time, because other patient is so difficult. Others, they answer the doctor and talk looong. Now, I must try to help that patient. Ok, doctor don't want to ask you this question. He answer the question in the wrong way.*

Only a few interpreters felt ambiguous about the additional role and about the fact that they did not receive financial compensation for the additional work.One of the participants reported that as a healthcare worker she sometimes felt that instead of interpreting she could have attended to her official work. One of the interpreters (a household aide) said that sometimes when called to interpret during her lunch break, she would extend her lunch break the next day. However, the nursing staff did not seem to understand why she extended her lunchtime. This was because they were unaware of the time she spent on interpreting the previous day. The interpreter felt that the ad hoc interpreters should be acknowledge for the work they do. See below for the dialogue that arose:

Extract 47:

Researcher: *Ok, thank you so much for your, your answers that you have given and your experiences you have conveyed today. Is there anything that you would like to add to?*

Interpreter Q: *Like the, like what I told you. If the doctors can recognize what we do for them, just to appreciate it and then, then it can be put in records you know for those because we are helping the patients. We are helping the doctors as well so we are working as a team. It's a team work, you know. So they can put it there for the sisters to know, you know.*

Researcher: *Yes, ok thank you so much.*

Interpreter Q: *Because sometimes maybe the sisters was not there. Maybe it was lunchtime then sister was not there. Then you did it (interpreting) so the sister the sister did not see you. And then maybe I was there for like 15 minutes, ne interpreting and then like, like in my lunchtime and then maybe if I extend that 15minutes. The*

sister will not, doesn't understand because you must extend it, because you were busy with the doctor, but if it's not written down. If they will not be told, there will be no appreciation for that.

Another interpreter seemed to experience guilt when confronted with the request to act as interpreter. The interpreter admitted that sometimes she avoided the registrars and nurses when they were looking for her to act as interpreter. See below for the dialogue that arose:

Extract 48:

Researcher: *Now, when you interpret are you financially rewarded for interpreting? Do you get paid for it?*

Interpreter T: *No.*

Researcher: *And how do you feel about that?*

Interpreter T: *Erh, um (laughing) I feel bad because it's not my job.*

Researcher: *Hmmm.*

Interpreter T: *It's not my job.*

Researcher: *Ok, so when they call you, knowing that you feel bad, do you still interpret?*

Interpreter T: *Yes.*

Researcher: *Why?*

Interpreter T: *(Laughing) Because they ask me so I, I, I sometimes, I don't want to refuse but sometimes you run away because you, you know you get nothing, mos*[9].

Researcher: *Yes, Yes.*

Interpreters' acceptance of their additional work may be due to some perceiving interpreting as part of their official work as healthcare workers. For example, one of the interpreters explained that as a healthcare worker, she is required to help and care for her patients and interpreting was part of her duty, since it also entailed helping patients. Regardless of the reasons for the majority of theinterpreters' silence, the findings suggest that the additional workload negatively affects interpreters' official work, and that it created guilt and conflict. Furthermore, the distribution of work accoriding to race and language skills speaks, for which

[9] The equivalent of the word 'mos' is 'as you know'.

they are not financially remunerated, relate directly to Tronto's (2010) work on the ethics of healthcare.

5.3.3 Training

It was evident that the healthcare workers, compared to the household aides, had some background in psychiatry and this was reflected in their interpreter skills. The interpreter who were also healthcare workers, were more likely to use examples when interpreting the registrar's diagnostic questions. For example, the diagnostic question *'Do you think you have special powers?'* was interpreted as *"Special powers for example to help others"* or *"Can you do things that other people cannot do"*. In addition, the healthcare workers asked their own follow-up questions and engaged in probing to elicit information that the registrar required to make an accurate diagnosis. For example, whenever the patients described their visual and auditory hallucinations these interpreters asked the patient whether other people were also able to see or hear the things that they were able to hear or see. In the example below the interpreter used follow-up questions to determine whether the patient's ability to help others also involved a pathological belief that he could heal others. See below for the dialogue that arose:

Extract 49:

Registrar (Dr.D): *Ok, um does he think he has any special powers?*

Interpreter P: *Ucinga u'ba unazo izinto onazo okanye amandla onawo - i-special powers okanye ungakwazi ukoyisa abanye abantu okanye ungakwazi uthini - izinto ezinjalo okanye ungakwazi ukunceda abantu kanjalo? (Do you think that you have things or a power you possess - special powers, or you can defeat some people or you can do what – things like that or that you can help people?)*

Patient 8: *Mmh, ndingathi umntu xa esithi okanye umzekelo ndingakwazi u'ba endithume into yokuba mandimnantsike okanye into yokuba umntu onengxaki ndikwazi ndimlungiselele. (Mmh, I can say if someone says, or for example I can if she or he sends me something that could, I what-you-ma-call it. Or something like if she or he has a problem I can organize something for him or her.)*

Interpreter P: *Kanjani, uzoyilungisa kanjani? (How, how will you fix it?)*

Patient 8: *Okanye into ayifunayo ndikwazi umlungiselela. (Or maybe I can organize for him/her the thing that s/he needs.)*

Interpreter P: *Into enje ngantoni kaloku? (Something like what?)*

Patient 8: *Ngoba athi "Thatha laa nantsika", ndikwazi ukuyithatha, ndicela undithathele into ethile. (Maybe s/he says "Take this what-you-ma-call it", I can take it, I would like you to take a particular thing for me.)*

Interpreter P: *Oh ungakwazi ukunceda abantu but awunokwazi ukubaphilisa abantu? (Oh, you can help people but you can't heal them?)*

Patient 8: *Mmh.*

Interpreter P: *Ok, no, no the way he is explaining it. He says he cannot heal people but if somebody is asking him to help you know on something, he can help people but not heal people. That is how he put it.*

In comparison, the household aides were less likely to use their own examples or probe patients. In the example below, the patient's response to the question *"Do you have special powers?"* was that she could not do laundry only domestic chores. Clearly, the patient did not understand the intended meaning of the question. However, the interpreter did not probe (i.e. use follow-up questions) or rephrase the question in such a way to assist the patient in understanding the intended meaning. See below for the dialogue that arose:

Extract 50:

Interpreter R: *Uthi mhlawumbi unawo na amandla angaphezu kwabanye abantu, unazo na izinto okwazi uzenza ezingenziwa ngabanye abantu? (She is asking if you have special powers than other people or whether there are things you are able to do that are not done by other people?)*

Patient 1: *Hayibo andikwazi kwenza i-washing nje, ndiyakwazi ukuklina qha. (I cannot do laundry, I can only clean.)*

Interpreter R: *Uyakwazi ukwenza i-washing qha? (You are able to do laundry only?)*

Patient 1: *Andikwazi kwenza i-washing ndikwazi ukuklina qha. (I cannot do laundry, I can clean but not only.)*

Interpreter R: *Sy se sy kan nie wasgoed doen nie, die wasgoed was nie. Sy kan net huis skoonmaak. Dis al wat sy kan doen. (She said she can't do the laundry – wash the laundry. All that she can do is clean the house. That's all that she can do.)*

The semi-structured interviews revealed that none of the interpreters had formal training in interpreting, while five participants had training in psychiatry or in a health-related field. The five participants who had training included the healthcare workers and one of the household aides. The latter reported that he had training in the field of HIV/AIDS. However, he did not explain what this training entailed. One of the healthcare workers reported that it is easier to explain the registrar's questions to the patients in her own words, instead of giving a word-for-word interpretation since she has a background in medicine. See below for the dialogue that arose:

> *Extract 51:*
>
> ***Researcher:*** *And when you do the interpreting do you directly translate the registrar's and patient's words into isiXhosa or do you give your version (in your own words) of what the registrar or patient said?*
>
> ***Interpreter Y:*** *I will give the meaning of what the patient said, because it isn't always easy to give the direct words. Seeing that I've got a medical background, so it's easy for me.*

Although some of the interpreters had limited psychiatric training, they had ample experience in interpreting within a psychiatric institution. Most of the interpreters had two to four years' experience in interpreting at St. James hospital. One of the interpreters had sixteen years interpreter experience working at St. James hospital. However, it appears that their ad hoc interpreting experience was not enough to equip them with the necessary knowledge to ask the type of questions that will elicit relevant clinical information.

5.3.4 Conflicting desires to advocate

The findings suggest that interpreters experienced a conflict in their desire to one the one hand act as the patient's advocate, and one the other hand as the registrar's advocate. For example, one of the interpreters, advocating for the patient, expressed concern over the patient's change in mood. While the same interpreter seemed to advocate for the registrar later during the psychiatric interview. During the session, the registrar asked the patient about

his use of tik[10] and dagga[11]. The patient denied that he ever used tik and without the registrar's knowledge, the interpreter (in an aggressive manner) told the patient that he can lie but that the registrar has a right to do a urine test, and that this will reveal the truth. It almost seemed that in this instance the interpreter tried to get the patient to acknowledge his use of tik. Perhaps this was because the interpreter was under the impression that this was what the registrar expected.

In another session, the interpreter (Interpreter R) only advocated for the registrar and not once for the patient. During the session, the registrar asked the patient to talk about the loss of her unborn baby. The patient on three occasions indicated, in no uncertain terms, that she did not want to talk about the topic. However, without the registrar's knowledge, the interpreter persisted and urged the patient to talk about the topic. Perhaps the interpreter did not want to disappoint the registrar by not providing the registrar with the requested patient information. When the patient eventually became frustrated and raised her voice, the interpreter finally gave up and informed the registrar that the patient did not want to talk about the matter. See below for the dialogue that arose:

Extract 52:

Registrar (Dr.B): *Ek het net so vining deur die leer gegaan en ek sien sy was swanger gewees aan die einde van verlede jaar. Vra vir haar is dit waar. (I had a quick look at her file and I see that towards the end of last year she was pregnant. Ask her if this is true.)*

Interpreter R: *Uthi uva kuthiwa wawukhulelwe kulo nyaka uphelileyo? (She said she heard that you were pregnant last year?)*

Patient 1: *Yinto (inaudible) leyo anduzukube ndiphinda-phindana nayo. (That's a past story and I don't want to go over it again.)*

Interpreter R: *Andiva sisi. (Pardon sister.)*

Patient 1: *Yinto (inaudible) leyo anduzukube ndiphinda phindana nayo (in a raised voice). (That's a past story and I don't want to talk about it).*

[10] Also referred to as methamphetamine.

[11] Also known as cannabis.

Interpreter R: *Kaloku ugqirha ufuna ukuqonda. (The doctor wants to understand.)*

Patient 1: *Andisoze ke, ndithi yinto (inaudible) leyo ANDIZUPHINDA-PHINDANA NAYO (in a raised voice). (I said that's a past story and I DON'T WANT TO REPEAT IT.)*

Interpreter R: *Sisi utheth'uthini? (What do you mean sister?)*

Patient 1: *Andazi ke, uba awusazi isiSotho andazi ke, andazi u'ba uzokwenza njani okanye biza umntu owazi isiSotho azocacisa. (I don't know now, if you can't understand isiSotho I don't know what are you going to do or call somebody who can understand isiSotho to explain to you.)*

Interpreter R: *Sy sê sy kan nie aanmekaar die ding sê nie. Sy sê sy het die ding vir julle gesê (oor die swangerskap). (She said she can't keep on saying the same thing. She already told you about this.)*

It might be that Interpreter R advocated only for the registrar, since she perceived the patient to be difficult. During the brief discussion the interpreter and registrar had after the psychiatric interview, the interpreter informed the registrar that the patient was difficult to work with. In the following example, the Interpreter R reprimanded the patient when the patient became irritated. However, the registrar was unaware of what was happening. See below for the dialogue that arose:

Extract 53:

Interpreter R: *Uthi kutheni usela iipilisi nje, yintoni ebangela uba usele iipilisi? (She is asking why are you using tablets, what makes you take pills?)*

Patient 1: *Kukugula, kuphambana kaloku. (Sickness, insanity.)*

Interpreter R: *Ndithe s'u'phoxa. (I said don't be harsh [mock] when you speak.)*

Interpreter R: *Sy is deurmekaar. (She's confused.)*

5.3.5 Interpreting techniques

The video-recordings revealed that all the interpreters used both a direct and indirect interpreting approach. Interestingly enough, the interpreters who were also healthcare workers, rarely used a direct approach. The only times that they employed this approach were

to interpret short sentences (usually asked during the beginning of the session) such as: *"How do you feel today?"*or *"How did you sleep?"* However, the two household aides used this method frequently, both at the beginning, and during the psychiatric interview. This said, unlike with the household aides, registrars gave the healthcare workers questions that at times required them to use an indirect approach. For example, as can be seen in the dialogue below (Extract 54), the registrar in this instance did not complete her sentence explaining about the possible side effects of the medication. Instead, the registrar ended her sentence by saying: *"So that he knows about the, you know".* See below for the dialogue that arose:

> *Extract 54:*
>
> ***Registrar (Dr.D):*** *With the new medication there is very little side-effects except that thing that we are worried about is that it can decrease the blood count. Just explain to him, so that he knows about the you know.*
>
> ***Interpreter P:*** *Ok.*
>
> ***Interpreter P:*** *Uthi ke into eyenzekayo uyakhumbula ngoku bemana bekutsala amagazi besithi bafuna ukujonga amajoni omzimba ukuba asebenza kanjani na, kumane kusithiwa ahlile ntoni ntoni, uyabona? (She said the thing that happens, do you remember when they were constantly drawing blood to check how your blood cells were working, and sometimes they would say they [your blood cells] had dropped, do you see?)*

During the semi-structured interviews, interpreters explained that their use of interpreting approach (i.e. direct vs. indirect) depended on the complexity of the question and the patient's ability to comprehend the diagnostic questions. Some interpreters explained that they would first use a direct interpretation of registrar's words and switched to an indirect interpretation when the patient did not understand the direct interpretation. Interpreters also explained that a direct interpretation of the registrar's words does not always make sense in isiXhosa, due to issues of equivalency. Furthermore, one of the interpreters reported that she used an indirect interpretation since a direct interpretation was too time consuming.

Registrars were largely divided on whether interpreters should use direct or indirect interpreting methods. Those in favour of an indirect interpretation explained that they are interested in the meaning and as long as interpreters conveyed the meaning, they did not see the need for a direct interpretation. Those in favour of a direct interpretation argue that they

were concerned that with an indirect interpretation interpreters omit important information. Registrars were also concerned that interpreters who provided an indirect interpretation would imply meaning to disordered speech. See below for the dialogue that arose:

Extract 55:

Researcher: *And why do you say you prefer a verbatim translation instead of a summary of what the patient said?*

Participant (Dr.F): *Because obviously they are going to interpret things and maybe try and imply a meaning where it was quite clear that it was disordered speech. I think the whole point of a translator is that they want to make sense of it. They want you to comprehend and obviously what I want to know is if the patient is incomprehensible and I've missed out on that point.*

Researcher: *Ja, so you don't want them to summarize and then leave out some important information.*

Participant (Dr.F): *Yes, and in psychiatry it's so important that, that doesn't happen. I want to know if they are derailing and I want to know the form of their thoughts. So, I don't want somebody, for example if the patient says a sentence that makes no sense, I don't want the interpreter to immediately assume that, that makes no sense and then try and make sense and translate back to me as something that makes sense. When obviously there was a thought disorder, because that would have been useful information. So the forms of people's thoughts are lost in translation, which is very unfortunate in psychiatry.*

Only two patients reported on interpreters' use of interpreting approach. Both patients preferred a direct interpretation and felt that a direct interpretation, particularly of the registrar's words, would ensure that they do not lose information provided by the registrar.

The abovementioned preferences about interpreting techniques may lead to conflict, particularly if the interpreter wants to please both the patient and registrar.

5.3.6 Management of the interpreter-mediated psychiatric interview

I found that to some extent the interpreters and registrars shared certain responsibilities, which I explain below, within the interpreter-mediated encounter. For example, the interpreters were largely responsible for regulating turn taking. This is not surprising since

the interpreter is the only party who understands both the patient and registrar. Interpreters used the following techniques to regulate turn taking:

- Interjection and overlapping speech: Throughout the psychiatric interviews interjection occurred. In most instances interjections served as an essential mechanism for regulating, turn taking and the flow of the conversation. Interpreters used interjection to stop one of the parties from talking. For example, one of the interpreters interjected the patient's sentence to indicate that the patient should stop talking in order for the interpreter to convey to the registrar what the patient said. The interpreter said the following to the patient: *"Khawume, khawume ndibalisele ugqirha le, ngoba ibali lakho lide eli bali lakho." (Wait, wait let me narrate this to the doctor because your story is very long.)*.
- As mentioned previously, interpreters also used the quotative he and/ she says to regulate turn taking. In other words, while speaking to the patient in isiXhosa or while listening to the patient, the interpreter often used the quotative: *"he or she says"* (in English). The use of the quotative in English or Afrikaans (and not in isiXhosa) signaled to the patient that the interpreter wants him or her to stop talking since the interpreter wants to convey what the patient said to the registrar. It seems that the use of "*he or she says"* was effective, since the use of the words in English or Afrikaans signaled to the patient that the interpreter wanted to speak to the registrar. Although one of the interpreters, who was also a healthcare worker, used the phrase *"And then"* (in English), after she had finished a block of interpreting, to indicate that it is the patient's turn to talk. In the case of this particular interpreter the use of the English words *"And then"* in fact signaled to the patient that it was her turn to talk. However, it is important to note that whenever the interpreter used the phrase she turned towards the patient. It seems that this action (i.e. turning towards the patient) together with the English phrase (as I explained previously some of the patients were able to understand some English) was effective in regulating turn taking.

The registrars like the interpreters, used interjection and overlapping speech to regulate turn taking. In addition, one of the registrars regulated turn taking by explicitly asking the interpreter what the patient was saying. See below for the dialogue that arose:

Extract 56:

Registrar (Dr.E): *Wat sê sy? (What is she saying?)*

Patient 13: *Abantwana bomntwana ka-sister wam. (The children of my sister's child.)*

Interpreter Y: *Bathathu? (They are three?)*

Patient 13: *Umtshana wam unabantwana ababini. (My niece has got two children.)*

Interpreter Y: *Hayibo! Kungokuba umtshana wakho unangaphi? (No ways! How old is your niece?)*

Patient 13: *Una-30. (She is 30.)*

Registrar (Dr.E): *Wat sê sy? (What is she saying?)*

Furthermore, the registrar referred to above used her knowledge of isiXhosa to regulate turn taking. The registrar used the words *"Yima mama"* (*Stop mama*) to stop the patient. However, most of the registrars would regulate turn taking by touching the patient's leg or arm to indicate to the patient that he or she should stop talking.

In some instances, the interpreters' management of turn taking was questionable and seemed to frustrate the registrars. For example, at times interpreters did not give the registrars a turn when registrars indicated that they wanted a turn to talk. For example, in the extract (Extract 57) below, the registrar attempts to say something, but the interpreter did not provide the registrar a turn and instead continued speaking to the patient:

Extract 57:

Interpreter Y: *About muthi stuff.*[12]

Registrar (Dr.C): *Can I say…*

(Interpreter interjects)

Interpreter Y: *And ebusuku? (And at night?)*

Patient 2: *Ndiyabethwa zizinto endingazaziyo pha ebusuku ndibethwe xa ndigqib'o thandaza. (I am beaten by things I do not know at night, I am beaten after I prayed.)*

Interpreter Y: *Phi? (Where?)*

[12] The first line of this quote also appeared in Extract 39.

In the example below, the registrar was visibly upset and irritated and raised her voice when the interpreter allowed long turns instead of shorts turns:

Extract 58:

Registrar (Dr.E): *Um, vra gou vir haar is sy toe opgeneem in die hospitaal en vir hoe lank? (Um, quickly ask her was she eventually admitted to hospital and for how long?)*

Interpreter Y: *Wa-admithwa ngeloo xesha esibhedlele? (You were admitted at that time to the hospital?)*

Patient 13: *Ha-ah sisi esibhedlele, ndaye ndafona, ndafonela uMrs Cohen lona ke, sekusebusuku ke ngoku ndisoyika mna nyhani ndingcangcazela, ndaphinda ndafonela iiADT zaza ke ngoku. (No, no sister, at the hospital, I called, I called this Mrs Cohen, it was already night-time and I was really scared, shaking, and again I called the ADT and then they came.)*

Interpreter Y: *Ngelaa xesha. (At that time.)*

Registrar (Dr.E): *IS SY TOE IN DIE HOSPITAAL OPGENEEM (in a raised voice)? (WAS SHE EVENTUALLY ADMITTED TO HOSPITAL?)*

There also seems to be a link between registrars' perceptions of interpreters' skills and the responsibilities registrars ascribed to interpreters. Some registrars had reservations about ad hoc interpreters' skills and competency. Registrars were concerned that because of interpreters' lack of formal training, they may try to make sense of patients' disordered speech and imply meaning where there was no rational meaning intended. Other concerns included the following: interpreters would ask leading questions instead of open questions (allowing the patient to describe his or her feelings); omit important information or psychiatric cues, since they did not understand the importance thereof; polish patients' answers; and answer diagnostic questions on behalf of the patient. Registrars' perceptions and expectations may explain why the registrars allowed the interpreters, who were also healthcare workers, to share some of the clinical responsibilities. For example, the registrars were mainly in charge of introducing topics related to the patient's symptoms and experiences. However, as explained previously, the interpreters who were also healthcare workers at times took on some of this responsibility.

5.3.7 Language equivalence

The following example clearly illustrates the challenges associated with language equivalence and that interpreting is more than the translation of words from one language into another. Although this incident was the only example of its kind emanating from the data, it is worth reflecting on, since interpreters require training to be able to handle situations like this. In one of the sessions, the registrar asked the patient to spell a word from front to back and from back to front. After the interpreter conveyed the abovementioned message to the patient, the registrar announced that the word that the patient had to spell was *'world'*. The patient first attempted to spell the word in English and spelled it as *'w-e-e-l-d'* (as some isiXhosa-speakers pronounced the word in English). The registrar responded by saying that perhaps the patient should rather spell the isiXhosa equivalent of the word *'world'*. The patient and interpreter then in isiXhosa had a discussion over what the isiXhosa equivalent of the word *'world'* was. See below for the dialogue that arose:

Extract 59:

Interpreter Y: *NgesiXhosa kuthiwa yintoni? (In isiXhosa what do we call it?)*

Patient 2: *Sisivakalisi. (It's a sentence.)*

Interpreter Y: *Kusemhlabeni kaloku apha, ngumhlaba u "world' ngesiXhosa ngumhlaba. (We are on earth; "world" is umhlaba in isiXhosa.)*

Patient 2: *Mm.*

At the end, the interpreter concluded that the best equivalent for the word would be *'umhlaba'*, which directly translated, means 'earth'. The patient also had difficulty spelling this word.

5.3.8 The potential loss of face

During the psychiatric interviews, two of the interpreters (both healthcare workers) regularly laughed about something the patient said. This mostly happened when neither the patient nor the registrar was laughing, for example:

Extract 60:

Registrar (Dr.D): *Ok, does he feel that there are things he would like to do or.*

Interpreter P: *Kukhona into orhalela ukuyenza okanye oziva ingathi ungayenza okanye uright ngoku uhlalayo? (Is there anything that you would like to do, or that you feel you can do or do you just feel alright by doing nothing?)*

Patient 20: *Kulo nyaka bekufanele ukuba ndiye ndayokoluka ngenxa yentsangu naku ndilapha. (This year I was supposed to go to initiation school but because of dagga I'm here.)*

Interpreter P: *(interpreter laughs) No, he said (interpreter laughs). He's supposed to go to initiation school this year, but because of the dagga. You know the dagga blocks him. Because of the dagga makes him to be admitted, so you know.*

In some instances, it also seemed that the interpreters laughed whenever they were embarrassed about something. This behavior may relate to the potential loss of face. In other words, interpreters may not want to be identified with patients in certain circumstances. In the example below, the patient said: "*Mhu, andikwazi kuthetha Afrikaans naba bantu kaloku" (No, I can't speak Afrikaans with these people.)*. The interpreter responded by laughing. It might be that the interpreter was embarrassed by the patient's comment since the registrar present was Afrikaans-speaking. During the semi-structured interviews, one of the interpreters referred to past incident in which she felt embarrassed by something the patient said about the registrar. The patient told the interpreter to convey to the registrar that she wanted the registrar in a sexual manner. The interpreter explained that she felt that the patient placed her in an awkward and embarrassing position. Patients may perceive that interpreters are laughing at them and this may discourage them from discussing their experiences.

5.3.9 Gender, power, and age

When asked during the semi-structured interviews whether they thought gender played a role in interpreter-mediated psychiatric interviews, interpreters had different opinions. Some interpreters reported that they only had experience in interpreting at either a male or female ward. It is therefore possible that interpreters did not have experience in interpreting for patients from the opposite sex. However, some interpreters reported that gender played a role in the following scenarios:

- Diagnostic questions related to the patient's sexual behaviour and functioning could be problematic. For example, interpreters explained that it is difficult for a female

interpreter to ask a male patient to answer questions related to his sexual behaviour or functioning. This may influence the interpreting technique used by the interpreters to pose sensitive questions. For example, one of the female interpreters reported that when it comes to asking a male patient about their sexual functioning she would not ask the question as directly as the registrar would, and would use euphemisms. This was because she did want to embarrass the patient. However, it might be that the interpreters themselves wanted to avoid being embarrassed.: See below for a relevant dialogue :

Extract 61:

Researcher: *And based on your weeks work here, you know sometimes gender plays a role, especially if you and the doctor are female and the patient is male. Have you ever picked up that it is sometimes more difficult when you are female and the patient is male or does it not really matter?*

Interpreter Z: *It depends on the question.*

Researcher: *The content of the question?*

Interpreter Z: *Yes, the content for instance if it was something with like sexual questions that would be difficult. Because it is difficult for a female to ask questions to isiXhosa-speaking males about sexual things. Like things related to sexuality and sex. But as a nurse of course you have to ask these questions because it's important. Because like in that context I would not ask directly as the doctor is asking, I would use some euphemisms to put the question to the patient.*

Researcher: *Because you might feel that the patient?*

Interpreter Z: *The patient would feel embarrassed.*

- One of the female interpreters mentioned that during one of the psychiatric interviews she had to touch the male patient to indicate to him to sit down. The interpreter explained that because the patient was not her relative, it made her feel uncomfortable.

Registrars felt that gender played a role particularly when it came to asking sensitive question related to the patient's sexual history and behaviour. Some of the female registrars reported that patients often addressed them as sister and not as doctor. They felt that this changed the

power dynamics since patients naturally perceived the position of the registrar as one with power. Three of the four patients did not think that the gender of the interpreter played a role. One of the participants preferred a female interpreter since he felt that females are more trustworthy. This may imply that the particular patient may be less likely to trust male interpreters.

It seemed that in addition to gender, power also played a prominent role in psychiatric interviews. Based on my analysis of the actual psychiatric interviews the following reflected the registrar's position of power:

- The registrar had the power to decide when the patient's response to a particular question had been exhausted. For example, in some sessions, the registrar told the interpreter *"That's fine"*, after the interpreter conveyed the patient's response. Immediately afterwards, the registrar asked the next question.
- The registrar had the power to verify the interpreter's interpretation of the patient's words by rephrasing the question in a different way.
- The registrar had the power to terminate the session whenever he or she felt it necessary to do.
- The registrar also typically set the pace and would indicate to the interpreter when they needed to move on to the next question.
- The registrar's body posture and tone of voice also portray his or her position of power. For example, in all the sessions the registrar would sit up straight and would speak in a more formal tone of voice. In most of the sessions, the interpreters and patients seemed more relaxed and leaned back in their chairs.

During the semi-structured interviews, registrars explained that due to patients' perception of the registrar as a figure of authority they were less likely to share their true feelings with him or her. Registrars explained that patients felt that they had to please the registrar and therefore, provided information that they regarded as the type of information the registrar wanted to hear. One of the registrars reported that some patients hide information from the registrar since they think that they that this will make them seem less ill and therefore increase their chances to be discharged. For this reasons patients are often more open and share more information with the other hospital staff such as the nurses. In this instance, the

presence of the interpreter (who the patients may perceive as less powerful than the registrars) may encourage the patient to talk about issues he or she would be unlikely to discuss with the registrar. See the registrar's comment below:

Extract 62:

***Registrar (Dr.C)**: And I think these people project what they think is a professional, good, right way to the doctor, as opposed to who I really am. So this is way sisters will get all the good information and tell doctors the right thing because I need to please the doctor. You know no-one wants to upset the doctor or look bad in the doctor's eyes, it's so irritating.*

The interpreters also had power, arguably in some instances more power than the registrars did, since they were able to understand both the patient and registrar. The patient's lack power was primarily reflected his or her tone of voice. Compared to interpreters and registrars, patients commonly spoke in a very soft tone of voice. In a few psychiatric interviews, the interpreter had to ask the patient to speak louder since it was difficult to hear what the patient was saying. Patients did not have direct access to the registrars whom they were dependent on to receive treatment. Sometimes, the interpreters answered on behalf of the registrars, questions that the patients intended for the registrars to answer. However, some of the patients used their limited command of English and Afrikaans to negotiate power for themselves. For example, in extract below (Extract 63), the patient interjected the interpreter because she felt that she still had more to add.

Extract 63:

***Patient 1:** Oh, hayi ke inoba sirayiti for mna esi sibhedlele. Ngoku ke? (Oh, maybe this hospital is right for me. So now?)*

***Interpreter R:** Sy sê… (She said…)*

(Patient interjects)

***Interpreter R:** Ugqibile? (Have you finished?)*

***Patient 1:** Hayi ndisabuza. (No, I'm still asking.)*

***Interpreter R:** Sy sê dis seker maar die regte hospitaal vir haar. (She said supposedly this is the right hospital for her.)*

When it came to the role played by age, the majority of the interpreters did not feel age played a role when it comes to interpreting. However, some argued that in a isiXhosa culture the elderly needed to be respected. Some interpreters mentioned that the elderly are less likely to follow the advice of the registrar since they are more likely to believe in traditional cultural practices than in Western medicine. One of the interpreters mentioned that the younger patients were more determined to be discharged and that they were less likely to see the need for them to be hospitalized. Only one of the patients felt that the age of the interpreter played a role. He explained that he distrusted younger people since they were not honest. Therefore, the patient preferred someone older to act as interpreter, since he perceived them as more trustworthy.

It seems that age, gender and power play a role during interpreter-mediated psychiatric interviews. It is important for registrars and interpreters to be aware of this in order for them to address trust issues. It seems that patients, compared to the registrars and interpreters, has very little power within the interpreter-mediated encounter.

5.3.10 Debriefing

During the semi-structured interviews, nine out of the 11 interpreters reported that they did not receive any form of debriefing. Only one mentioned that after the session the registrar would ask her if she is okay. Consequently, we asked interpreters whether they were in favour of debriefing sessions. The majority were in favour of debriefing. One of the interpreters was clearly traumatised, and said that she needed debriefing since sometimes she would have to go the bathroom to calm herself down and compose herself after listening to some of the patients' heartfelt stories. See below for the dialogue that arose:

Extract 64:

Researcher: *Would you, would you appreciate a debriefing session afterward?*

Interpreter V: *Yes, but, but I don't know when, where, yes.*

Researcher: *But do you think it will help you?*

Interpreter V: *Yes, because sometimes, after, it's so difficult sometimes. Because you feel like, hey, its right I must go to the toilet for just a few minutes to getting calm, you know, and then you come right.*

One of the other interpreters was also in favour of debriefing said that it would allow registrars to become aware of interpreters' experiences and feelings. Only one interpreter mentioned that the practicalities associated with debriefing might be problematic.

The same question about debriefing was posed to registrars. They seemed partly in favour of debriefing, however they had reservations about the practicality of debriefing sessions and some perceived it as unrealistic. They felt that time demands did not allow for debriefing sessions. One of the registrars also explained that debriefing unofficial interpreters made their role more official. See below for the participant's comment:

Extract 65:

Registrar (Dr.G): *I think it's idealistic. I think one of the things that I find really difficult about using interpreters, and I think it's a cultural thing as well. If somebody says something quite bizarre or unusual or very psychotic, obviously I would never react to that. Like I would never laugh, however amused I would be inside, I would never show it. Obviously, I know culturally for me it's not appropriate to react, but I find often, like the sister that helps me on this ward, would just row with laughter. And I don't know if cultural is it fine to laugh and that always happens. It happens with the security guard, it happens with the sister that is trained. And like the patients never seem to be offended. But in terms of debriefing, because maybe it's because the roles are not formalised. So my feeling is don't go down that road because you are actually then saying that it's ok to then use these people in this context, which is not. That's perhaps why I feel reluctant, and perhaps that's unfair for the individual concerned. I think it's a real abuse of these individuals and the way we expose them, and they don't get anything for it, and they are not trained in any way for it. So that's why I'm not debriefing, because I feel that it formalises their role, but I suppose that's quite unfair of me.*

The same registrar also mentioned that she never had thought about the psychological impact interpreting might have on unofficial interpreters. See below for the participant's comment:

Extract 66:

Registrar (Dr.G): *That's a very interesting question. Um, I'm sure that it's a valid point and I think it's another example of how little, how unsung these individuals are on a daily basis. Because like the cleaner and security guard here, almost on a daily*

basis, if there are no isiXhosa speaking nurse, will be interpreting. But it's never even crossed my mind that they might be distressed.

5.3.11 Patient confidentiality

During the semi-structured interviews, I asked interpreters whether they had experience in interpreting for an acquaintance. Only two of the interpreters reportedly had past experience in interpreting for someone from their neighbourhood. The majority interpreters did not think that interpreting for someone they knew was in any way problematic. One of the two interpreters who had experience in interpreting for someone she knew, said that she felt that it was easier for patients when someone they knew from their neighbourhood acted as their interpreter. See below for the dialogue that arose:

Extract 67:

Researcher: *Somebody that you know, from your community or something.*

Interpreter Q: *Like not erh not really. The other one, like the patients when it comes maybe say I'm staying in Phuleni then I'm staying in Phuleni mos for example, I'm in Phuleni and then say no I'm also there in extension and says okay I'm also there in extension 6 but it was a younger one. The mommy came and I know the mommy, so that was the son for for her brother I did interpret for.*

Researcher: *You did, so you knew them a little bit?*

Interpreter Q: *I knew yes and, and as from there I did knew him even I meet now him in my location so I know him now.*

Researcher: *So how did that?*

Interpreter Q: *It was alright for me.*

Researcher: *And for them?*

Interpreter Q: *For the patient it was alright sometimes they are happy when they see somebody that they know, even when they come they are so happy because they know you and then they are so happy because they think you like it's easy for them to tell you: "Please tell my mommy that I want to come back." They, they, they like it like that because they gonna say: "Please tell mommy, mommy must give you my jeans, or something", they think it's easier for them when there is somebody.*

The other interpreter, who had interpreted for someone from her community, had a different perspective on the matter. The interpreter reported that in her case, the patient was shy and embarrassed and the interpreter had to reassure the patient that she was bound by patient confidentiality. See below for the dialogue that arose:

Extract 68:

Researcher: *Okay en het jy vir haar geken? (Okay and did you know her?)*

Interpreter R: *En ek ken vir haar, ja. (Yes, I know her.)*

Researcher: *En hoe hoe het jy? (And how, how did you?)*

Interpreter R: *Sy, sy voel so skaam vir my. (She, she felt so shy towards me.)*

Researcher: *Oh was sy skaam? (Oh, she was shy?)*

Interpreter R: *Iemand wat vir jou ken. Sy voel so skaam eerste keur eerste ding syvoel so skaam omdat sy is hier. By die hospitaal. (Somebody that knows you. She felt so shy the first time because she is here at the hospital.)*

Researcher: *En was sy nie bekommerd dat jy vir almal gaan sê nie? (And was she not concerned that you would tell everyone?)*

Interpreter R: *Dan voel sy so skaam om vir my te sê hoekom is sy hier in die hospitaal en soe. Dan raak sy so moeilik vir my sy is skaam en wil nie vir my sê nie. Dan sê ek vir haar: "Niee waar wil jy so skaam vir my is, jy is siek mos. Kom praat die ding! Ek gaan vir die dokter se wat is dit, ek gaan vir niemand sê daar buite wat en wat nie." (Then she feels shy to tell me why she is here in this hospital and so. Then she's shy and don't want to tell me why she is here. Then I tell her: "Why are you ashamed you are ill. Come let us talk about it. I will tell the doctor what is wrong, I will not tell anyone out there.")*

Researcher: *Oh, het jy vir haar dit gesê? (Ok, you told her this?)*

Interpreter R: *Want ek dra nie die nuus van die hospitaal uit hier nie. Kyk die hospitaal van ons - die geheim van die hospitaal bly net hier in die hospitaal. Ons kan nie die die storie van die hospitaal gaan sê daar buite nie. Dis die wet. Ons kan dit nie doen nie.Ons kan dit nie. Die wat in St. James gebeur, bly net in St. James. (Because I don't talk about things happening in the hospital. Look, this hospital of us - the secrets of the hospital stay in the hospital. We cannot talk about the hospital stories out there. That is the law. We cannot do it. Things that happen in St. James stay in St. James.)*

Three interpreters (who were also healthcare workers) expressed their feelings and concerns regarding the matter of patient confidentiality. These interpreters felt that patients should be able to trust the interpreter, and that interpreters should not share the patient's stories with other colleagues. One of the three interpreters expressed concern over the fact that registrars employed security guards as interpreters, since some of the security guards were from the same neighbourhood as the patients. When the household aides were asked how they handled the effect that patients' stories had on them, the majority reported that they share their experiences and the patient's stories with their colleagues (who are also household aides). See below for the dialogue that arose:

Extract 69:

Researcher: *Do they you know what a debriefing session is to debrief you like when you have heard something very bad and then they take you and then they you know try and get you to talk about it?*

Interpreter T: *Hmmm.*

Researcher: *Do you ever have that?*

Interpreter T: *No, no.*

Researcher: *So how do you deal with the when it affects you how do you deal with it?*

Interpreter T: *Maybe I talk with erh, with my colleagues.*

Researcher: *Yes.*

Interpreter T: *And tell them about that. I said: "Ooooh shame the patient told us about that and that and that."*

Researcher: *Yes.*

Interpreter T: *And we can talk about that.*

Researcher: *Then it helps you?*

Interpreter T: *Hmmm.*

One of the interpreters explained that she discussed the patient's story with her colleague. Her colleague would then speak to the same patient, and they would compare what the patient said to each of them independently. See below for the dialogue that arose:

Extract 70:

Researcher: *Now how do you deal with it say you were affected by a story, how do you deal with it do you share it with a colleague or.*

Interpreter S: *Ja , I share with a colleague because one of my colleague also we are working together and then also my colleague also when I share with my colleague then my colleague give me advice what I can advise that patient and then also even maybe the following maybe after 3 or 4 hours and then my colleague also is going to chat with that patient and then my colleague also come with another story and then we collect that stories and then that stories and then we can investigate maybe what's going on and then okay let's do like this he said to you but my side he said like this like this and then we combine the stories and then if the stories make sense and then we can say no man this patient is, is normal but it's only this problem that makes him ill.*

Three of the patients responded to the question whether they preferred to use an interpreter from the hospital or relatives and friends. All three participants preferred the use of an interpreter from the hospital. The interpreter employed by the hospital would regard it as their work and would therefore be committed to his or her work as interpreter. They felt that relatives and friends were more likely to lie to them whereas the hospital staff could be trusted. One of the participants also said that it would not be practical to make use of a family member since his family was not always available to interpret for him. Another participant explained that family members would misinterpret his words.

In the next chapter, I present a detailed case study.

CHAPTER 6: A CASE STUDY

In this section, I present a case study, consisting of an interpreter-mediated interview, as well as three semi-structured interviews (in which the interpreter, patient and registrar participated in after the interpreter-mediated session).

6.1 Video-recorded interpreter-mediated psychiatric interview

I decided to use the interpreter-mediated psychiatric interview presented in this section, because it is reflective of a broad spectrum of issues 'speaking' to many issues which emerged from the results presented up to this point in the dissertation. The reader will see that I do not provide the complete transcript of the interpreter-mediated psychiatric interview. Instead, I present a number of extracts, which are reflective of some of the central themes I have referred to up to this point in the dissertation. The extracts are grouped into three different segments or categories. The first set of extracts is grouped into the category - *The beginning of the psychiatric interview*. The second set is grouped into the category *Interview proper*, and the third set into the category *The end of the interview*. The categories allow the reader to have a better understanding of the location of each extract in the psychiatric interview. Furthermore, with each extract I provide a short explanation of the relevant issues related to the extract.

On a particular Wednesday morning during 2010, I video-recorded four consecutive interpreter-mediated psychiatric interviews at one of the wards at St. James hospital. The same interpreter and registrar participated in all four psychiatric interviews and all the interviews took place in the meeting room of the particular ward. The specific interpreter-mediated psychiatric interview presented as part of the case study was the third interview that took place on the Wednesday morning. After the second interview the registrar left the room to fetch the next patient while the interpreter and I remained seated in the meeting room. I sat behind my video-camera that was attached to a stand in one corner of the room. On the opposite corner of the room were three chairs organised in a half circle format. The interpreter was seated in one of the chairs and when the registrar returned with the patient, the patient sat in one of the open chairs immediately next to the interpreter. The registrar took her seat next to the patient. In other words, the patient sat in the centre with the registrar on his right hand side and the interpreter on his left. While the patient sat down the interpreter

greeted the patient in isiXhosa and thereafter the registrar asked the first question (signalling the start of the psychiatric interview).

6.1.1 The beginning of the psychiatric interview

During the beginning of the interview (see Extracts 71-74) the patient was asked about his wellbeing; sleeping and eating patterns; and social behaviour. At the start (see Extract 71) of the interview, the registrar used an indirect approach (i.e. referring to the patient in the third person) (see line 1). However, the interpreter used a direct interpreting approach and, unlike the registrar, directly addressed the patient by asking "*How are you*?" (see line 2). In this instance the registrar's use of approach was not echoed by the interpreter. However, the interpreter changed her approach to an indirect approach to interpret the patient's response to the abovementioned question (see line 4). In this instance, the interpreter moved between the role of translation machine and that of mediator. The interpreter interpreted the patient's response ("*I am very well")* as *"He said he is more than fine"*. The interpreter's choice of words could imply that the patient has elated emotions. This is could impact on the patient diagnosis, since extreme feelings of happiness may be suggestive of mania. The registrar responded to the interpreter's rendition of the patient's turn, by asking why it was that the patient was doing so well (see line 6). In response the patient indicated that he simply said that he was well (see lines 8-9). The registrar's follow-up question clarified any potential misunderstanding regarding the patient's emotional state. This example illustrates the importance of an accurate interpretation, particularly within psychiatric care where word choice could have a major impact on patient diagnosis.

Extract 71:

1 ***Registrar (Dr.D):*** *Ok, ask him how he is?*
2 ***Interpreter P:*** *Unjani? (How are you?)*
3 ***Patient 21:*** *Ndiright kakhulu. (I am very well.)*
4 ***Interpreter P:*** *Uh, he is more than fine, he said he is fine.*
5 *(Interpreter laughs.)*
6 ***Registrar (Dr.D):*** *Ok, how so?*
7 ***Interpreter P:*** *He said: "I am right I am right". Uright kakhulu? (Are you very fine?)*
8 ***Patient 21:*** *Ndisitsho nje ndiphilile. (I am just saying I am well.)*
9 ***Interpreter P:*** *He said, he is just trying to say he is well.*

In Extract 72, the registrar seemed to be managing the psychiatric interview by introducing two new topics. The registrar asked about the patient's eating and sleeping patterns (see line 10). The registrar introduced the new topics within the same turn. However, instead of asking the patient about his eating and sleeping patters within the same turn, the interpreter first asked about the patient's eating behaviour (see line 11), and only later the interpreter asked a question relating to the patient's sleeping behaviour. It is important for registrars, working with interpreters, to ask short questions that are easy for interpreters to recall. Also, in the extract below (Extract 72), the interpreter seemed confused by the patient's response. The interpreter addressed this by asking a clarifying question (see lines 15-16). In this instance, the interpreter and not the registrar's action (i.e. the use of follow-up questions) prevented a communication breakdown.

Extract 72:

10 ***Registrar (Dr.D):*** *Sleeping well, eating well?*
11 ***Interpreter P:*** *Utya kakuhle? (Are you eating well?)*
12 ***Patient 21:*** *Nditya kakuhle and andihluthi. (Yes I am eating well and I don't get full.)*
13 ***Interpreter P:*** *Awuhluthi? (You are not getting full?)*
14 ***Patient 21:*** *Yho! Andihluthi. (Yho! I am not getting full.)*
15 ***Interpreter P:*** *Awuhluphi okanye awuhluthi? (You are not irritating or you are not getting*
16 *full?)*
17 ***Patient 21:*** *Andihluthi. (I am not getting full.)*
18 *(Interpreter laughing)*
19 ***Interpreter P:*** *He said he is eating well but he does not get enough, his stomach does not get*
20 *full but he said he is eating fine.*

In Extract 73, the registrar asked a question about the patient's sleeping habits prior to being admitted to hospital (line 21). The patient responded to the question where after the interpreter, without the registrar's knowledge, also asked the patient about his reasons for waking up early at home (see line 26) and what means of transport (see lines 29-30) he used when he travels to the city to find work. The latter question about transport did not relate to the registrar's initial question about the patient's sleeping habits. In this instance the interpreter went beyond providing a rendition of the patient's response and also her own

follow-up questions. In this instance the use of follow-up questions could add to the time pressures that many registrars and other personnel are subjected to within an understaffed healthcare context. Furthermore, when the registrar attempted to move on to the next topic by interjecting, the interpreter continued talking about the patient's sleeping habits (lines 43-47). It seemed in this instance the interpreter ignored the registrar's attempt to move on to the next topic and there seemed to be a conflict in the management of the interview.

Extract 73:

Registrar (Dr.D): *At what time does he usually wake up?*

Interpreter P: *Uvuke ngabani ekuseni? (At what time did you wake up in the morning?)*

Patient 21: *Ndivuke ngo 4 ekuseni. (I woke up at 4 am in the morning)*

Interpreter P: *Elokishini? (In the township?)*

Patient 21: *Ewe. (Yes.)*

Interpreter P: *Wenzeni? (And did what?)*

Patient 21: *Xa ndizawuphangela, ndizama izithuba. (When going to work, searching for vacancies.)*

Interpreter P: *Ok, he said sometimes he wakes up at four when he. Ubukhwela ntoni? (How were you travelling?)*

Patient 21: *Bendihamba ngeenyawo. (I was walking.)*

Interpreter P: *Uye phi mhlawumbi? (Going where?)*

Patient 21: *E-Bellville. (To Bellville.)*

Interpreter P: *Ngeenyawo? (Walking?)*

Patient 21: *Ewe. (Yes.)*

Interpreter P: *Usuka phi? (From where?)*

Patient 21: *EMfuleni.*

Interpreter P: *Yho, he said he was waking up 4 o'clock because he must walk on foot from Mfuleni to Bellville.*

Registrar (Dr.D): *Then he must sleep 6 hours per night then. Ok, but then he's sleeping more than he's used to.*

Interpreter P: *Because when he sleeps at 10 and then*

Registrar interjects

Registrar (Dr.D): *Then its ok, I think. Alright.*

45 ***Interpreter P:*** *That's what I was saying, I said maybe it's because your body and your mind*
46 *is used to sleep at 10 o'clock, that is why because even at home you used to sleep at 10, and*
47 *now here you are sleeping around 10 and 11, so I don't think it's a problem.*

In Extract 74, the registrar asked whether the patient was fighting with other patients in the ward (line 48). The patient responded that he was getting along with the other patients (line 50). The interpreter did not provide an immediate rendition of the patient's response. Instead, the interpreter asked her own follow-up questions. The interpreter asked the patient whether he also talked to the other patients and about the names of the other patients that the patient talked to (lines 51-53). It seems that the interpreter's actions were aimed at verifying patient information. Later in the extract, the interpreter seemed to act as overt patient advocate by answering a question on behalf of the patient (line 62). However, it could also be that the interpreter acted in her capacity as healthcare worker and relied on her pre-existing knowledge of the patient's future plans. The registrar rectified the situation by explicitly indicating that she wanted the interpreter to ask the patient to respond to the question (line 63). The registrar's actions were corrective and allowed the patient to provide his own response to the question.

Extract 74:

48 ***Registrar (Dr.D):*** *Fighting with anybody (in the ward)?*
49 ***Interpreter P:*** *Awuxabani namntu apha ngaphakathi? (Are you fighting with anyone inside?)*
50 ***Patient 21:*** *Hayi ndiyavana nabo bonke. (No, I am getting along with all of them.)*
51 ***Interpreter P:*** *Uyancokola nabo? (Are you chatting with them?)*
52 ***Patient 21:*** *Ewe. (Yes.)*
53 ***Interpreter P:*** *Ngoobani oncokola nabo? (Who are you chatting with?)*
54 ***Patient 21:*** *NguLennox. (With Lennox.)*
55 ***Interpreter P:*** *Ok, he said fine he is not fighting with anyone he is getting along with them.*
56 ***Registrar (Dr.D):*** *Is anybody trying to hurt him?*
57 ***Interpreter P:*** *Akekho umntu okhe wafuna ukuphatha kakubi? (Is there anybody wanting to*
58 *ill-treat you?)*
59 ***Patient 21:*** *Hayi akekho. (No, no-one)*
60 ***Interpreter P:*** *No.*
61 ***Registrar (Dr.D):*** *No, alright what are his plans for when he gets out?*

Interpreter P: *The plan what did we say, mmmh?*

Registrar (Dr.D): *No, no I want to know from him what is he (the patient) planning.*

6.1.2 Interview proper

In the beginning of Extract 75, the registrar asked the patient about his use of tik and cannabis (see line 64). The patient responded that he only used cannabis and did not use tik (see lines 67-69). The registrar, in a respectful tone of voice, responded by saying that the patient also tested positive for tik and that he should realise that this contributed to him becoming ill (see lines 80-81). Instead of conveying the registrar's message in the same tone of voice, the interpreter used a more aggressive tone of voice when conveying the registrar's utterances. The interpreter also made her own additions and told the patient that he cannot lie to them (the interpreter and registrar) about his substance abuse. The interpreter asked the patient whether they were *"On the same page*" (lines 85-94). This tone of voice may be interpreted by the patient as insensitive and disrespectful. This is problematic since the registrar is unaware of the interpreter's tone of voice. It seems that the interpreter overstepped her boundary and took on an authoritative role which may have a negative impact on various aspects such as the doctor-patient relationship.

Extract 75:

Registrar (Dr.D): *So how does he feel about his tik and cannabis use?*

Interpreter P: *Kuthiwa ucinga ntoni ngetiki le ubuyisebenzisa nentsangu? (She is asking, what are you thinking about the tik and dagga that you were using?)*

Patient 21: *Into ebendiyisebenzisa yintsangu itiki andiyazi kodwa intsangu anduzubasaphinda ndiyisebenzise. (I was using dagga, I don't know tik, I won't use dagga anymore.)*

Interpreter P: *Njani ubungayazi itiki? (How come you don't know the tik?)*

Patient 21: *Andiyazi. (I don't know it.)*

Interpreter P: *Ivela phi le nto yokuba ubuyisebenzisa nentsangu? (This thing of using it with dagga where does it come from?)*

Patient 21: *Andiyazi kaloku mhlawumbi ndayifumana ezolini yomntu because benditshaya nabanye. (I don't know maybe I got it in the zol[13] of someone because I used to smoke with other people.)*

Interpreter P: *Ok, he said he used to share a zol with others but he never touches like knowing this is tik, you know. He said maybe it was in the zol or whatsoever but only the thing that he knows that he was using is dagga and he is planning not use it anymore.*

Registrar (Dr.D): *He tested positive so he must realise that his use contributed to he becoming ill, so.*

Interpreter P: *Ja, and njengokuba ndisitsho uyabona isibhedlele, xa usiya ne. (As I am telling you, you see in hospital, when you go.)*

Patient 21: *Ewe.*

Interpreter P: *Noba wena ungasixokisa uthi awusebenzisi itiki okanye okanye awuyisebenzisi intsangu but ooRegistrar banelungelo lokuba xa usiza esibhedlele bateste umchamo wakho uyaqonda?(Even if you were to lie to us, saying you don't use tik or dagga but when you are here in hospital doctors have a right to test your urine, do you understand?)*

Patient 21: *Ewe. (Yes.)*

Interpreter P: *Bajonga into yokuba uyayisebenzisa na itiki okanye intsangu okanye nayiphina. Umchamo uyaxela ukuba yeyiphi na oyisebenzisayo, so itiki nentsangu ziyafunyanwa kuwe, siyavana? (They are checking if you use tik or dagga or whatever. Your urine tells which one you use, so tik and dagga were found in your urine, do we hear each other, are we on the same page?)*

Patient 21: *Ewe. (Yes.)*

In Extract 76, the registrar requested the interpreter, (presumably in her capacity as healthcare worker), to organise rehabilitation (i.e. SANCA) for the patient (line 96). Later in the psychiatric interview, the registrar asked the interpreter to also psycho-educate the patient while he was still in hospital (line 104). Furthermore, the registrar (in the patient's presence) shared her opinion of the patient's condition with the interpreter (see line 100-102). The

[13] Also known as a cannabis cigarette.

registrar, in this instance 'invites' and encourages the interpreter to act in her capacity as healthcare worker.

Extract 76:

Clinician: *Well maybe he can go to SANCA, do you think you can organise that for me?*

Interpreter: *Ok, When he comes back or before he goes or must I call the mother?*

And later...

Registrar (Dr.D): *Well maybe we will just have to psycho-educate him while he is still here.*

Interpreter P: *Ja.*

Registrar (Dr.D): *But I think, he seems to be converting quite well. Is he logical and better? He seems much better. It looks like he's not going to stay here much longer. We will probably discharge him soon.*

Interpreter P: *He is. He is.*

Registrar (Dr.D): *So will you be able to do some more psycho-education?*

Interpreter: *Mm.*

6.1.3 The end of the interview

At the end of the interview (Extract 77) details regarding the patient's treatment plan were finalised and the patient was thanked. In addition, the interpreter, without the registrar asking her to do so, switched from interpreter to her role as healthcare worker and emphasized that it was important for the patient to inform the hospital if he would be unable to attend outpatient treatment due to work commitments.

Extract 77:

Interpreter P: *Ok, he is asking. He said he doesn't have a problem but because sometimes he gets this job that takes a week, so sometimes he won't be able to attend, so what can he do?*

Registrar (Dr.D): *He can come here when he can.*

Patient 21: *Weekend?*

Interpreter P: *Ha-ah, akuziwa nge-weekend. (Ha-ah, they not open on weekends.)*

Patient 21: *Oh!*

Interpreter P: *Uthi xa na mhlawumbi uthathe iveki yonke,ungeza xa ukwazi, kodwa kuziwa ngosuku oluthile kanye ngeveki, uyaqonda.Uba ke mhlawumbi kule veki izayo awukwazanga uphangela ulantike. (She is saying if maybe you took the whole week [at work], you can come*

when you can, but you come on a specific day in a week, you understand. If maybe the next week you are not able to work you must do what you ma-call-it.)

Patient 21: *Ooh!*

Interpreter P: *But ke okubalulekile yoku kuba usixelele uba awuzi kuba uphangele,hayi kuba ungafuni, uyaqonda? (But what is important is that you tell us that you are not coming because you are working, not because you do not want to, do you understand?)*

Interpreter P: *No, I was just explaining that he can come when he can, but what's important is to call and inform us he doesn't come because of work or he doesn't want to, we must know.*

Registrar (Dr.D): *Ja, ja, ja! (Yes, yes, yes!)*

Interpreter P: *So that's what I was explaining.*

Registrar (Dr.D): *Oh! Ok. Thank you.*

Interpreter P: *Enkosi. (Thank you)*

In the next section, I present discussions my colleagues and I had with the interpreter, patient and registrar, who were involved in the above interpreter-mediated psychiatric interview. To remind the reader, the discussions refer to the audio semi-structured interviews conducted after some of the psychiatric interviews.

6.2 Discussions post interpreter-mediated psychiatric interview

In this section, I present the discussions in a similar fashion to the interpreter-mediated psychiatric interview. In other words, I provide extracts from the discussions and a short explanation of the relevant issues related to each extract.

6.2.1 Discussion with the patient

This patient, like the other patients who participated in discussions with my colleague, provided very little information about his experience of the particular interpreter-mediated psychiatric interview and about his opinion on interpreting in general. The patient gave brief descriptions when asked to describe his experiences. This may be due to factors such as power relations mentioned previously, but in this particular case, it may be due to the patient's proficiency in isiXhosa. Although, the interpreter and patient in the above psychiatric interview communicated in isiXhosa, the patient informed my colleague (during a

discussion after the psychiatric interview) that he was a first-language isiSotho-speaker. However, I was unable to establish whether the interpreter and registrar were aware of this during the psychiatric interview. The patient did however inform my colleague that he was proficient in isiXhosa, as well as isiZulu and isiTswana. He also reported that he had a limited proficiency in English and Afrikaans. It may be important for registrars to establish which language(s) the patient speaks prior to the psychiatric interview and in this context not to assume that the patient's first language is isiXhosa.

Extract 78:

128 ***Researcher:*** *UngumSuthu? (Are you isiSotho?)*

129 ***Patient 21:*** *Yes.*

130 ***Researcher:*** *Alright, zingaphi iilanguages ozithethayo? (Alright, how many languages do you*

131 *speak?)*

132 ***Patient 21:*** *Iilanguages endizithethayo, zezi languages zezi zabantu abamnyama bodwa. (The*

133 *languages that I speak are the languages of black people only.)*

134 ***Researcher:*** *Zibale. (Count them.)*

135 ***Patient 21:*** *Nditheth'isiXhosa. (I speak isiXhosa.)*

136 ***Researcher:*** *IsiXhosa. (IsiXhosa.)*

137 ***Patient 21:*** *SiSuthu. (IsiSotho.)*

138 ***Researcher:*** *SiSuthu. (IsiSotho.)*

139 ***Patient 21:*** *SiTswane. (IsiTswana.)*

140 ***Researcher:*** *SiTswane. (IsiTswana.)*

141 ***Patient 21:*** *SiZulu. (IsiZulu.)*

142 ***Researcher:*** *SiZulu, Ooh, ezi zabelungu iAfrikaans, neEnglish? (IsiZulu, Ooh, the white*

143 *people's languages, Afrikaans and English?)*

144 ***Patient 21:*** *I-Afrikaans, neEnglish andizazi. (I do not know Afrikaans and English.)*

145 ***Researcher:*** *Akuzithethi zona? (You do not speak them?)*

146 ***Patient 21:*** *Ndizithetha kancinci. (I speak them a little bit.)*

In Extracts 79, my colleague asked the patient about his experience of the interpreter-mediated session. The patient reported that they (the patient, interpreter and registrar) understood one another and explained that he understood all the questions that the interpreter asked him and that he understood and was familiar with the isiXhosa vocabulary used by the

interpreter. Although the patient understood isiXhosa, he may not be proficient in the language to the extent that he is able to express himself clearly.

Extract 79:

147 ***Researcher:*** *Ok, ungandichazela nje kabanzi ukuba uve njani uba ibinguwe, ugqirha netoliki,*
148 *intetho yenu ibivana? (Ok, can you explain broadly how you felt about the conversation*
149 *between you, the doctor and interpreter?)*
150 ***Patient 21:*** *Ibivana. (We were understanding each other.)*
151 ***Researcher:*** *Eeh, laa mibuzo ibizwa ngusis' Mrs X*[14] *apha kuwe njengokuba ebekutolikela*
152 *nje uye mhlawumbi wayiva njani? (Eh, the questions that were asked by sis' Mrs X as she*
153 *was interpreting for you, how did you understand them?)*
154 ***Patient 21:*** *Yha ndiyive kakuhle. (Yha I understood them well.)*
155 ***Researcher:*** *Uyive kakuhle? (You understood them well?)*
156 ***Patient 21:*** *Ewe. (Yes.)*
157 ***Researcher:*** *Ingaba usis' Mrs.X usebenzise amagama owaqhelileyo, owasebebenzisa*
158 *yonk'imihla? (The words that were used by sis Mrs.X, were they words that you usually use*
159 *every day?)*
160 ***Patient 21:*** *Ewe. (Yes.)*
161 ***Researcher:*** *Alright khange kubekho bunzima kuwe ekuqondeni ukuba uthi loo mbuzo?*
162 *(Alright, you did not find difficulty in understanding any of questions?)*
163 ***Patient 21:*** *Ha-ah-na. (No.)*
164 ***Researcher:*** *Khange ubekho? (There were not any?)*
165 ***Patient 21:*** *Ha-ah-na. (No.)*
166 ***Researcher:*** *Ok, zonke iiquestions azibuze kuwe zilandeleke lula? (Ok, all the questions she*
167 *asked you were easy to follow?)*
168 ***Patient 21:*** *Ewe. (Yes.)*

In Extract 80, the patient reported that prior to his admission to St. James hospital; he had never used an interpreter in communicating with clinicians. For this reason, it may be important for registrars and interpreters to explain the role of the interpreter prior to the

[14] Mrs X is a pseudonym.

session. This may illuminate any unnecessary tension that the presence of the interpreter may cause due to the patient's unfamiliarity with interpreter-mediated communication.

Extract 80

Researcher: *Ok, hayi ndiza kuza omnye umbuzo ongenanto yokwenza nale nto ibiqhubekile apha esibhedlele kugqirha wakho ne social worker. Ndiza kubuza into yokuba ngaphambili mhlawumbi e Day hospital, mhlawumbi kwenye indawo owakhe waya kuyo mhlawumbi komnye ugqirha, wawukhe wakwisituation apho bekufuneka ubenayo itoliki? (Ok, I will ask you a question that has nothing to do with anything that happened here in hospital between you, the doctor and the social worker. I want to ask if you have ever, before this day, maybe in day hospital, maybe any place you visited or with another doctor, been in a situation where you needed an interpreter?)*

Patient 21: *Ha-ah-na. (No.)*

Researcher: *Zange ukhe ube nayo? (You never had an interpreter?)*

Patient 21: *Ha-ah-na. (No.)*

Researcher: *Ok, kuba bendiza kubuza uba ubunokhomperisha njani le yalapha esibhedlele nale yaloo ndawo? (Ok, because I was going to ask you to compare that place with this hospital?)*

Patient 21: *Zange ndiyisebenzise (No, I never used one.)*

In the next extract, Extract 81, my colleague asked the patient about his preference of interpreting approach. The patient reported that he preferred that the interpreter employed a direct interpreting approach. The patient explained that he preferred the interpreter to provide a direct interpretation of both his utterances and that of the registrar. However, the patient did not provide an explanation for his choice in approach.

Extract 81:

Researcher: *Ok, ukuba bekunokuthiwa khetha xa utolikelwa ungathanda ukuba umntu atolike igama ngegama olithethayo okanye ufuna ashwankathele? (Ok, if you were to choose, would you like the person to interpret words word for word what you said or just summarize?)*

Patient 21: *Ndifuna atolike igama ngegama endilithethayo. (I would like him to interpret word for word as I speak.)*

Researcher: *Alright ok, ungathanda ukuba asebenzise mhlawumbi awakhe amagama ukutolika okanye la wakho? (Alright ok, would you like the interpreter to use her words or your words when interpreting?)*

Patient 21: *Kufuneka asebenzise la wam, awakhe hayi. (She must use my own, her own no.)*

Researcher: *La wakho? (Your own?)*

Patient 21: *Ewe. (Yes.)*

Researcher: *Ok, xa esiza nombuzo ovela kugqirha ungathanda into yokuba asebenzise igama ngegama elithethwe ngugqirha okanye ashwankathele laa ntetha kagqirha? (Ok, when she is asking a question from the doctor do you want her to use doctor's words or to summarize the doctor's words?)*

Patient 21: *Kufuneka asebenzise njengokuba iphelele intetho kagqirha. (She must use doctor's exact words.)*

Researcher: *Ayiphelelise? (In full?)*

Patient 21: *Ewe. (Yes.)*

Researcher: *Njengokuba ugqirha eyithethile? (As the doctor spoke them?)*

Patient 21: *Ewe. (Yes.)*

Researcher: *Angayishwankatheli? (She must not summarize?)*

Patient 21: *Ewe. (Yes.)*

In the last part of the discussion, see Extract 82, the patient spoke about issues of trust and the role that it plays in interpreter-mediated encounters. The patient mentioned explicitly that he trusted the healthcare worker to act as his interpreter. This could suggest that the patient trusted the interpreter because she was also a healthcare worker. The patient also reported that should the healthcare worker be unavailable, he would prefer a family member to act as his interpreter. He regarded family as well as female and older interpreters as more trustworthy compared to male and younger interpreters. The official role of the interpreter as healthcare worker, her gender and age, could have a positive impact on the goals of the psychiatric interview. The patient's trust in the healthcare worker could encourage him to talk more openly about his feelings and experiences.

Extract 82:

Researcher: *Ok, so uve njani ukutolikelwa ngumntu ongamaziyo? (Ok, so how did you feel about having an interpreter that you don't know?)*

Patient 21: *Hayi ndizive ndiright ngoba ndimthembile usocial worker. (No, I felt right because I trust the healthcare worker.)*

Researcher: *Umthembile kuba kuba uyi-social worker? (You trust her because she is a healthcare worker?)*

Patient 21: *Ewe. (Yes.)*

Researcher: *Ok, ukuba ngaba ubungatolikelwanga ngu sis' L ubunothanda mhlawumbi utolikelwa ngumntu ovela kulaa ndawo uhlala kuyo? (Ok, if sis [Mrs X] was not interpreting for you would you like may be to have an interpreter who comes from where you live?)*

Patient 21: *Ewe. (Yes.)*

Researcher: *Ubunothanda? (Would you like that?)*

Patient 21: *Ewe. (Yes.)*

Researcher: *Ubunothanda ukutolikelwa sisihlobo or family? (Would you like the interpreter to be your friend or family?)*

Patient 21: *Sisihlobo sam. (My friend.)*

Researcher: *Ifriend? (Your friend?)*

Patient 21: *Ifamily yam, ifamily yam, ifamily yam, ifamily manditsho nje ifamily. (My family, my family, my family let me say my family.)*

Researcher: *Ifamily? (Your family?)*

Patient 21: *Ewe. (Yes.)*

Researcher: *Alright, kutheni unothanda ukutolikelwa yifamily? (Alright, why would like to have a family [member] interpret for you?)*

Patient 21: *Ifamily iyandikhusela. (Family protects me.)*

Researcher: *Alright, ok, yenza umahluko kuwe uba umntu okutolikeleyo abe yindoda okanye umntu obhinqileyo? (Alright, ok, does it make any difference to you to have a male or a female interpreter?)*

Patient 21: *Ndingathanda ibengumntu ongumama. (I would like to have a female interpreter.)*

Researcher: *Ibe ngumntu ongumama? (Do you prefer a female?)*

Patient 21: *Ewe. (Yes.)*

Researcher: *Uthanda into yokuba ibe ngumntu ongumama? (You would like it to be a female person?)*

Patient 21: *Ewe. (Yes.)*

Researcher: *Ngoba? (Why?)*

Patient 21: *Ngoba nguye umntu othembekileyo. (Because she is a person who can be trusted.)*

Researcher: *Othembekileyo umama? (A woman can be trusted?)*

Patient 21: *Ewe kum. (Yes to me.)*

Researcher: *Kuwe? (To you?)*

Patient 21: *Ewe. (Yes.)*

Researcher: *Ngaphezu komntu oyindoda? (More than a male?)*

Patient 21: *Ewe. (Yes.)*

Researcher: *Alright, yenza umahluko kuwe ukuba umntu okutolikelayo umncinci kuwe okanye umdala kuwe? (Alright, does it make any difference to you to have a person older or younger than you as an interpreter?)*

Patient 21: *Abe mdala kum. (She should be older than me.)*

Researcher: *Uthanda abe mdala? (Do you prefer an older person?)*

Patient 21: *Ewe. (Yes.)*

Researcher: *Ngoba? (Why?)*

Patient 21: *Ngoba abantwana abanayo inyani. (Because young people are not honest.)*

6.2.2 Discussion with the registrar

The registrar did not refer explicitly to the particular psychiatric interpreter-mediated session presented in section 61. Instead, the registrar talked about interpreting and language practices in general. The registrar reported that even in the absence of language barriers, doctor-patient communication was problematic due to the patient's psychiatric condition. However, the presence of language barriers complicated matters even further. The registrar gave the following example to illustrate her point (see Extract 83).

Extract 83:

Registrar (Dr.D): *Dit is vir my nogals moeilik want um, um hy is `n bietjie gepreokkupeer met sy ouditoriese hallisinasies ook. So dit maak dit moeilik om te onderskei. Hy is al klaar nie so in kontak met die buite wêreld soos wat mens sou wou gehad het nie. So ek dink al klaar is sy, um persepsies en hoe hy die wêreld evalueer `n bietjie ingekort. (It is somewhat difficult for me, because um, um he is somewhat preoccupied with his auditory hallucinations. So this makes it difficult to distinguish. He is not in contact with the real*

world as one would have wanted him to be. So, I think his, um, perceptions and how he evaluates the world are already a bit restricted.)

Researcher: *So dit maak dit reeds moeilik. (So, this makes it difficult.)*

Registrar (Dr.D): *So, dis alreeds moeilik om met hom te kommunikeer en dan nou as hy dan nou ook nie heeltemal verstaan wat ek bedoel nie, dit maak dit net nog soveel meer gekompliseerd. (So, it is already difficult to communicate with him and then things are even more complicated when he does not fully understand what I mean. This makes it so much more complicated.)*

In the next extract (Extract 84), the registrar reported that cultural background, age and gender played an important role when communicating with patients. The registrar explained that it was easier for her to place herself in her patient's position when the registrar and patient shared a cultural background, gender and age.

Extract 84:

Researcher: *En dink jy in die algemeen, as mens dink oor kommunikasie tussen `n pasiënt en `n dokter, ongeag of daar `n tolk is of nie, dink jy dat goed soos geslag en ouderdom en kultuur speel `n rol? (And do you think in general about communication between patient and doctor, irrespective whether there is an interpreter or not, do you think that things such as gender, age and culture play a role?)*

Registrar (Dr.D): *Oh, definitief. (Oh, definitely.)*

Researcher: *En hoekom sê jy so? (And why do you say that?)*

Registrar (Dr.D): *Ek dink mense voel outomaties meer gemaklik met iemand van dieselfde agtergrond, ouderdom, kultuur. Um, omdat jy voel julle is op dieselfde golflengte. En ja, mens moet soveel meer probeer om jouself met jou pasiënt of in jou pasiënt se skoene te plaas, kultuurgewys, ouderdom, geslagsgewys. Um, um as julle nie daai selfde agtergrond het nie. (I think people automatically feel more comfortable with someone from the same background, age, and culture. Um, because you feel that you are on the same wave length and yes, one has to try so much more to place yourself with your patient, or in your patient's shoes, culturally, age or gender like speaking. Um, um, if you don't have that same background.)*

Researcher: *En dink jy veral dat geslag speel `n rol wanneer die dokter `n ander geslag as die pasiënt is? (And do you think especially that gender plays a role when the clinician is of a different gender to the patient?)*

Registrar (Dr.D): *Ek dink daar is definitief ander kulturele ervaringe, maar ek kom nou net van Gauteng af en ek is nie eintlik so bekend met die isiXhosa kultuur nie. Ek is baie meer bekend met die isiZulu kultuur. Veral die manier waarop mense gerou het en die manier waarop hulle trauma hanteer het baie anders is as wat ons met `n meer Westerse kultuur dit sou hanteer. En ek moes dit altyd ingedagte hou, jy weet is hierdie in konteks met die persoon se kultuur, die gedrag wat hulle nou toon. Al is dit nie noodwendig hoe ek miskien sou gerou het nie, of hoe ek trauma sou ervaar het nie. (I think that there are definitely other cultural experiences, but I'm from Gauteng and I'm not really that familiar with the isiXhosa culture. I'm much more familiar with the isiZulu culture, especially the manner in which people mourned and the manner, in which they handled trauma, is very different than how we with a more Western culture would have handled it. And I had to be cognisant of this all the time, you know is this true to the patient's culture, their behaviour. Even though this is not necessarily the way that I mourned or the way that I would have experienced trauma.)*

In Extract 85, the registrar responded to a question about the role of the interpreter in interpreter-mediated psychiatric interviews. The registrar did not refer to any particular interpreting model when asked about her preference for a particular model. Instead, she reported that registrars and interpreters should discuss prior to the interpreter-mediated encounter, the role that each party should play during the encounter. The registrar stressed that the interpreter should not add or omit information. The interpreter should also be able to identify and convey information pertaining to the patient's thought processes. It seems that one the one hand, the registrar expects the interpreter to act as translation machine. On the other hand, the registrar expects the interpreter to act as mediator. The interpreter may be aware of the conflicting expectations, which may add to the interpreter's pressure.

Extract 85:

Researcher: *Wat dink jy ook is die rol van die tolk in `n psigiatriese onderhoud? Is hulle half `n mede-dokter of `n taalinstrument? Wat is die mees effektiefste, watter rol verkies julle? (What do you think is the role of the interpreter in a psychiatric interview? Are they like a co-clinician or a language instrument? What is most effective, which role do you prefer?*

Registrar (Dr.D): *Ek voel `n mens moet besluit wie is watse rol. En ek dink nie die tolk moet die rol van dokter vervul nie, maar ek dink ook nie die dokter moet die rol van die tolk vervul nie. Ek dink mens moet vooraf baie mooi besluit hoe gaan mens dit doen, hoe gaan die sisteem werk. Dat die tolk kan besef hulle kan nie ekstra informasie gee as `n dokter `n sekere vraag vra nie. Um en as hulle ekstra informasie wil gee moet hulle dit eers met die dokter check. En dieselfde met antwoorde wat die pasiente gee, partykeer kan tolke dink die dokter wil net `n ja of nee antwoord hê. Jy weet hulle het hulle eie idee van wat die dokter eintlik wil hoor. Terwyl die dokter wil partykeer hoor wat is die gedagte proses van die pasiënt en dit is `n geweldige probleem as daar swak kommunikasie is vir `n dokter om te evalueer wat is die gedagte proses van die pasiënt. Hoe sit die pasiënt sy sinne aanmekaar. Jy weet watse abstrak idees is daar, dit is iets wat die tolk sal moet terugvoering gee aan die dokter. En dit is nie noodwendig iets wat mens in `n vraag aan `n pasiënt kan stel nie. Die tolk gaan moet sê hierdie is die gedagte prossese wat ek by hierdie pasiënt sien. En dit is iets wat ons vir ons tolke gaan moet leer om te evalueer.* *(I feel one should decide what role each should play. And I don't think that the interpreter should fulfil the role of clinician, but I also don't think the clinician should fulfil the role of interpreter. I think one should carefully decide beforehand how you would do it. How the system would work in order for the interpreter to understand that they should not add information to the clinician's question. Um, and if they want to give additional information they have to check this with the clinician beforehand. And the same applies to the patient's response, sometimes the interpreters assume that the clinician only wants a 'yes' or 'no' response. You know, they have their own ideas about what the clinician is looking for. While the clinician sometimes wants to have a better understanding of the patient's thought processes and this is a major challenge when there is bad communication. How does the patient construct his sentences? You know, identifying abstract ideas, this is something that the interpreter should be able to convey to the clinician. This is not necessarily something that you can ask in a question. The interpreter has to be able to identify thought processes and convey this to the clinician. This is something we will have to teach our interpreters.)*

Furthermore, the registrar explained (see Extract 86) that it was easier for her to work with interpreters who are also healthcare workers than with security guards and household aides

who fulfill the role of interpreter. The registrar explained that this was because healthcare workers' training in psychiatry made it easier for her to work with them.

Extract 86:

Researcher: *En het jy al van te vore met tolke gewerk in ander psigiatriese hospitale? (And do have you worked with interpreters in other psychiatric hospitals?)*

Registrar (Dr.D): *Ja, toe ek in Gauteng was, het ek partykeer isiZulu pasiënte gehad waartydens ek tolke moes gebruik. Maar dit was gewoonlik nie `n offisiële tolk nie, dit was `n suster of partykeer self iemand wat in sekuriteit gewerk het. (Yes, when I was in Gauteng, I had isiZulu patients for whom I had to use interpreters. However, it was generally not an official interpreter. It was a nurse or sometimes a security guard.)*

Researcher: *En hoe het jy dit ervaar, was daar enige voorbeelde waaraan jy kan dink van iets wat vir jou uitgestaan het? Of enige iets wat jy wil deel? (And how did you experience it? Were there any examples which you can think of that stood out for you? Or anything you would like to share?)*

Registrar (Dr.D)*: Ek moet sê dit was altyd makliker vir my om met die suster te werk as met `n sekuriteitswag, omdat sy die agtergrond gehad het. So ek dink as ons tolke gebruik is psigiatriese agtergrond baie belangrik. (I have to say that it's always easier for me to work with a nurse than with a security guard, because she had the background. So, I think when using interpreters a background in psychiatry is essential.)*

6.2.3 Discussion with the interpreter

In the beginning of the discussion (see Extract 87), the interpreter reported that she was an unofficial interpreter and explained that she did not regard herself as an interpreter. This may explain why the interpreter, during the interpreter-mediated psychiatric interview, frequently moved between her role as interpreter and that of healthcare worker.

Extract 87:

Researcher: *Okay thanks. So first of all are you employed as an official or you an unofficial interpreter at St. James?*

Interpreter P: *I'm an unofficial interpreter at St. James hospital.*

Researcher: *Okay*

Interpreter P: *I am not an interpreter at all.*

Given that the participant did not regard herself as an interpreter, the researcher asked the participant how it happened that she became an interpreter. Presented in Extract 88, is the participant's response to the above question. In essence, the interpreter explained that she was called to act as interpreter because hospital staff knew that she was one of the few isiXhosa-speaking healthcare workers working at the hospital. This statement supports the findings I presented earlier, which suggests that interpreter responsibilities are assigned based on race and language skills.

Extract 88:

Researcher: *Okay, thank you. So now how did it come about that you became an unofficial interpreter here at St. James hospital?*

Interpreter P: *Like for instance if the, like the clinician, even the nurses because you know some of the nurses don't understand the patients, ne. So, if there comes a, a period whereby you know there is no one, you know in in the, in the ward ne, who is speaking isiXhosa. Ja, because you know they know me. I am the only healthcare worker who can speak isiXhosa, then you know they used to call me. Because for instance, we've got ward rounds and, and the, and the, and the doctors want to know how ill, how psychotic is the patients, ne. There are patients who can't even speak English, you know, so you know, the doctors cannot get whether the patient is delusional or what and sometimes they don't know whether what happened or whatsoever. They just maybe get the referral from the clinic, but they don't know from the patient's point of view, you know, so that's where I get in you know, you know to give, you know, the doctors what exactly the patient is saying.*

The interpreter reported that she did not receive any financial compensation for her work as interpreter. In response, the researcher asked the interpreter how she felt about this. The interpreter explained that it did not bother her, since she did the additional work for the patient's sake (see Extract 89). It might be that because the interpreter perceived herself principally as healthcare worker, she perceived the work as interpreter as part of her responsibility as healthcare worker to take care of patients.

Extract 89:

Researcher: *Yes, sho. So are you, thank you for explaining it that well. It was nice thank you. Are you financially rewarded for your work as an interpreter?*

Interpreter P: *Herhum (No).*

Researcher: *And if not, as you said no now, um how do you feel about this?*

Interpreter P: *To be honest, I, I don't have a problem, you know. To be honest, I don't have a problem because as I have said sometimes maybe you go to the patient and then maybe I ask the patient, maybe but the doctor said no I didn't say so, but the doctor doesn't understand what I was saying, you know, some of the patient cannot express themselves even though maybe they can talk a bietjie (some) English, you know, but they can't und, you know express, express themselves, you know so I don't have a problem without getting a reward because I'm doing it for the sake of the patient and*

(Researcher interjects)

Researcher: *Yes, you see the value and the need.*

Interpreter P: *Yes, I see the value and the need of helping them.*

The researcher asked the interpreter about her interpreting approach and whether she used a direct or indirect interpreting approach. The interpreter reported that she used an indirect interpreting approach when providing a rendition of both the clinician and patient's utterances. This was because the interpreter felt that the clinician's questions (when translated directly) did not always make sense to patients (see Extract 90). This suggests that issues pertaining to language equivalence influence the interpreter's choice of method.

Extract 90:

Researcher: *Okay great. Thank you. Now in the interpreting session what do you do, do you interpret word- for-word what the clinician and the patient says or do you convey the message in your own words?*

Interpreter P: *I convey the message in my own words. I don't say exactly what the patient is saying. Like even like I have said, sometimes the questions are not in the way, you know, where the patient can understand. Like the questions of the clinicians, you know, like you know, even when, when, ja maybe it's the skill or what, like for instance when the doctor is like asking like the patient something and then I, I, I make it in the way the patient can understand, not in the way the doctor is giving me, you know, is giving to me. I make it in the way that the patient can understand and then even when giving the feedback back from the receiver, ja back to the doctor, I make, I, I, I just explain how the patient, not giving word-to-word on what is he saying.*

In the next extract (Extract 91), the interpreter talked about the role played by culture and gender in the interpreter-mediated encounter. The interpreter explained that circumcision, for example, was a sensitive matter to discuss in the presence of a female. The interpreter furthermore reported that other cultural phenomena such as amafufunyana played a role in interpreter-mediated interviews.

Extract 91:

Researcher: *Um, do you think that issues related to culture play a role during your interpreting sessions?*

Interpreter P: *Very.*

Researcher: *And please explain your answer if you have an example, you can give an example of were culture played a huge role.*

Interpreter P: *Erh, like for instance, you know, I don't, you know when I was with Sanja*[15]*, you know we were asking the other patient you know about, what was it, but it was around circumcision and whatsoever. Ja, so the patient, you know when it comes to circumcision, like it doesn't matter whether you are a patient or what ne. According to our culture, this is a sensitive stuff. You musn't if you are a woman or a lady, you mustn't know what is happening there or whatsoever. Like, for instance even when the patient is answering, you know, sometimes the patients will say, "We won't, will not give you" I don't know how can i express it, but ja culture, you know is playing a, like for instance as I have said, this is a psych hospital ne, ja and then most patients when they are admitted here the family believe that they've got amafufunyana, I don't know what is amafufunyana in English, ja.*

Researcher: *I understand.*

Interpreter P: *Ja. ja so that is cultural thing, you know and the maybe, you know when the clinicians or the psychiatrists or whatever, when they name it they name it in their own way, you know, so you must explain, you know, you know, amafufunyana, how they, because you know in my culture most of them before, you know they let the patients admitted, they first take the patients to the sangomas or whatsoever.*

[15] The interpreter refers to me in this instance. My colleague conducted the semi-structured interview with the interpreter. However, while making the video-recordings of the four psychiatric interviews (as referred to in the beginning of section 4.3) the interpreter and I had casual conversations in between the recordings.

Based on the extracts below (Extracts 92-93) it seemed that the interpreter perceived her role as that of mediator and not translation machine. This is likely because clinicians asked for the interpreter's input regarding the patient's mental health condition.

Extract 92:

Researcher: *Okay, now. I'd like to know, does the clinician ever ask you for your thoughts on the patient's mental health condition?*

Interpreter P: *Yes, of course. Every time. Ja. Ja, most of the time because like for instance they, I don't know how you call it, a clinician or the consultant ne, sometimes, like for instance there is a time when there is no interpreter or whatsoever, you know, so the doctor, even if the doctor is English speaking, will try by all her means or his means to get what the patient was saying. So we, like when we are together then the doctor will ask me: "Is it the same as what I've got". Sometimes it's not.*

Later in the discussion (see Extract 93), the interpreter was explicitly asked how she perceives her role as interpreter. The interpreter's response seemed to suggest some role confusion on the part of the interpreter. The interpreter reported that her role as interpreter involved assisting patients in expressing their emotions. In addition, the interpreter explained that as healthcare worker she was also required to assist isiXhosa patients and their families in 'buying' into Western concepts, such as rehabilitation. In other words, it seems that the interpreter perceive her role to include that of cultural broker.

Extract 93:

Researcher: *Last question how do you perceive your role as the interpreter and that of the clinician and patient during the interpreting session. How do you see your roles? How do you see your role as the interpreter?*

Interpreter P: *You know the patient cannot express, so I find it very, very important in such a way that the patient is able to express his or her feelings you know. Because I was making an example to Sanja ne, when it, like most of our patients ne they've have got a problem of drug abuse ne and then it is my duty as a social worker to try and discuss the rehab options with the patient and with the family ne. But sometimes most, or especially with isiXhosa speaking people, they don't even want to hear about the rehab because firstly you know erh drugs were not our thing, you know, drugs. We as isiXhosa's or like as Africans, ja we do drink ne , but when it comes to drug, was not so this thing of rehabs and whatsoever, its new thing you*

know. So some it's, you find it difficult when you try to get you know into patient's head or into family's head. They don't even understand what you are saying. Although you are you know, you know expressing it in isiXhosa, but they find it very difficult to understand, like for instance if the patient doesn't want to go for rehab. Even it doesn't matter whether it's out-program or in-patient program ne. Then you can discuss with the mother to for committal whereby the mother or the family will, will go to court you know and the patient will be admitted in a rehab via court. But to us court is for people who break the law.

Researcher: *Yes.*

Interpreter P: *You don't, we don't know that you can go to court you know to get help. Do you understand what I am saying?*

Researcher: *Yes.*

In summary, the discussion with the interpreter, suggests that the interpreter regarded herself as mediator and cultural broker. It seems that instead of perceiving these responsibilities as part of her role as interpreter, the participant perceived it as part of her role as healthcare worker. The interpreter explained that the registrar frequently requested her input regarding the patient's mental condition. This could create the impression that the interpreter is expected to act in her capacity as healthcare worker and not in her capacity as ad hoc interpreter. The fact that interpreters are employed on an ad hoc basis may contribute to this impression. Furthermore, the registrar had conflicting expectations of the interpreter – one the one hand the interpreter was expected to act as translation machine and on the other hand as mediator.

An important issue emerging from the discussion with the patient is that the patient's first language was not the same as that of the interpreter. It is also unclear whether the registrar and interpreter were aware of this. The patient was also unfamiliar with the role of the interpreter. Interestingly, it seems that the patient trusted the interpreter because of her official role as healthcare worker. This could have a positive impact on the goals of the psychiatric interview and encourage the patient to share sensitive information with the trusted interpreter.

CHAPTER 7: UNDERSTANDING THE STUDY FINDINGS

When I started this project, I anticipated that the study findings would provide me with a better understanding of actual language practices unfolding in the psychiatric interview, and how these practices impact on the goals of the psychiatric interview. I did not anticipate that it would also confront me with truths about post-apartheid South Africa and truths about myself.

Let me start with what I learned in terms of language practices and the impact it has on the goals of the psychiatric interview. Where after, I discuss the broader implications of my findings and what the findings revealed about language and race in post-apartheid South Africa.

7.1 The multi-dimensional role of the interpreter

I think that perhaps registrars unintentionally decided not use interpreters even when patients clearly required interpreter services, simply because they did not have confidence in interpreters' skills and psychiatric knowledge. Drennan and Swartz, (2002) argue that clinicians' lack of confidence in their own ability to use interpreters appropriately and a lack of confidence in the skills that an interpreter brings to the psychiatric interview, especially when the interpreter is not trained, can work against the appropriate utilization of interpreters.

My findings support those of others (Bot, 2005; Davidson, 2000; Hsieh 2008; Wandesjö, 1998), whose studies demonstrated that it is unrealistic to expect that interpreters only act as language instruments. I found that within the same encounter interpreters navigated between the roles of translator and mediator. The interpreter's role is pluralistic and also includes the role of co-clinician, cultural broker and advocate.

During the actual psychiatric interviews, interpreters took on the role of cultural broker and explained patients' cultural references to registrars. The interpreter's assumption of the role of cultural broker is not uncommon since language is seen as an aspect of the cultural gap between doctors and patients, and because of this, interpreters are expected to fulfill the role of cultural broker for both parties (Drennan & Swartz, 1999). However, this does not imply that they interpreted all the cultural references. It seemed that interpreters filtered the

patient's references to cultural issues based on how relevant they perceived them to be. This supports the findings of Davidson (2000), who argues that interpreters filter speakers' utterances based on perceived relevance.

Interpreters provided not only cultural information but also information regarding patient symptoms and behaviour. Interestingly, though interpreters acted as cultural brokers without specifically being asked by the registrars to provide cultural information, the majority of interpreters gave their input regarding the patient's condition only when asked to do so by the registrars. Only two of the interpreters who were also healthcare workers provided their input without first being asked to do so. This suggests that interpreters adhered to certain unspoken rules and that the same rules did not apply to everyone. Hsieh (2008) found that not all interpreters operate within the same set of boundaries. I am of the opinion that the two interpreters referred to above felt free to give their input since the registrars encouraged them to do so. In the psychiatric interviews, the registrars were more likely to share their clinical responsibilities with the healthcare workers compared to the household aides. It could be that these interpreters, compared to the household aides, had more experience in working with the registrars. More experienced interpreters that have worked with the same healthcare worker over some time and that feel that the healthcare worker trusts them, are more likely to take on roles other than that of translator (Bischoff, et al., 2012).

In this study, interpreters at times took on the role of overt patient advocate. In other words, some interpreters pursued information, sought services and offered answers, on behalf of patients (Hsieh, 2008). More commonly though, interpreters also seemed to advocate for the registrars by omitting negative remarks made by patients about the hospital and by pressing patients for answers when they were clearly unwilling to talk about certain matters. In addition, interpreters were reluctant to convey patients' questions that they perceived as inappropriate to ask registrars.

7.2 The use of the interpreter

The registrars, in particular seemed confused about the appropriate use of the interpreter. During the discussions I had with the registrars, the majority of them reported that they preferred the translation machine model. However, the registrars' actions during actual

interpreter-mediated conversations were contradictory. As explained in section 5.1, the registrars in my study allowed (some even encouraged) interpreters to take on the role of mediator. Training in the different interpreter models and the appropriate use of interpreter services could limit role confusion.

The employment of interpreters occurred in a chaotic fashion. As I mentioned earlier, it was common practice for registrars to communicate in broken English or Afrikaans with isiXhosa-speaking patients. Based on my discussions with the registrars and my observations while collecting data at the various wards it seemed that the registrars decided on the use of an interpreter based on the nurses' recommendations. No one was able to tell me how the nurses were able to determine patients' command of English.

7.3 The role played by technical factors

7.3.1The management of turn-taking

The interpreters were mainly responsible for managing turn taking. It is not uncommon for interpreters to be largely responsible for turn taking. This is because interpreters are normally the only party within the interpreter-mediated encounter able to understand both the patient and clinician's language (Bot, 2005). Registrars only occasionally took over the responsibility of turn taking by interjecting in the patient and interpreter's conversation. My findings support other studies (Davidson, 2000; Hsieh, 2008; Pöchhacker & Kadric, 1999) which demonstrated that the interpreter is in charge of substantial portions of the interpreter-mediated encounter.

7.3.2 Interpreting techniques

All the interpreters used a combination of the direct and indirect approaches and the interpreters' choice of approach was influenced by the following factors:

- The registrars' use of the third person.
- The complexity and length of speakers' utterance. Searight and Searight (2009) suggest that clinicians provide concise verbalisations and that compound or multiple questions should be avoided.
- Language inequivalence and time constraints: according to the interpreters, a direct interpretation of the registrar's words does not always make sense in isiXhosa because

of language inequivalence. Interpreters also reported that an indirect interpretation compared to a direct interpretation is less time consuming.

- Training and power: The use of interpreting approach also seems to relate to interpreters' training and back-ground in psychiatry and their positions within the institutional hierarchy. The interpreters who were healthcare workers compared to the household aides used an indirect approach more frequently. This supports the findings of Bischoff, et al. (2012) that more experienced interpreters were less likely to use a direct interpreting style.

7.4 The goals of the psychiatric interview

7.4.1 Establishing a doctor-patient relationship

The relationship between the doctor and patient is one of the most important factors contributing to effective patient treatment. Although I focused specifically on communication between the registrar and patient during psychiatric interviews, it is not uncommon for registrars to communicate with patients during other encounters such as ward rounds. The reader should keep in mind that language barriers also have an impact on the doctor-patient relationship outside the psychiatric interview. During the audio-recorded discussions, one of the registrars told me that with her Afrikaans and English-speaking patients she would often start a casual conversation when passing them on the ward. However, she could not do the same with her isiXhosa-speaking patients since she did not always have the time to find an interpreter for having this type of informal conversation. One way to make a connection with the patient in instances like these, is for the registrar to at least have some proficiency in the patient's language, even if only to greet the patient in his or her first language. The impact of this on the patient was clearly illustrated during those video-recorded psychiatric interviews in which the registrar greeted the patient in isiXhosa and also used her knowledge of the language to comfort the patient. It evoked instant eye contact and turned the patient's attention to the registrar.

However, the use of an interpreter does not guarantee the establishment of a good doctor-patient relationship, and may even prevent it. The 'natural' alliance between the patient and interpreter was evident in my findings. Patients, in general, sat closer to the interpreters than to the registrars and patients made regular eye contact with the interpreter while very few

patients made eye contact with the registrars. One should see this in light of the fact that during those psychiatric interviews that were not interpreter-mediated there was regular eye contact between patient and registrar.

During some of the interviews, the interpreter and patient shared 'special moments' which excluded the registrar. During these instances, the registrar - instead of the patient - was alienated. The methods employed by registrars to break through the barriers imposed by the involvement of a third party are discussed in more detail in the next paragraph. However, there were also situations in which the patient was alienated. During those sessions where the healthcare workers acted as interpreters, the registrars and interpreters had discussions about patients in their presence. Tribe and Lane (2009) warn that clinicians should avoid discussing with the interpreter any issues that do not require interpretation since it could make the patient feel uncomfortable and excluded. Complicating this even further is that some of the patients were to some extent proficient in English. In some instances, patients would correct interpreters when they felt interpreters had incorrectly translated their utterances. It is therefore likely that some patients understood the interpreter and registrar's conversations about them during psychiatric interviews.

7.4.2 Fostering open communication

One of the goals of the psychiatric interview is to establish an environment in which the psychiatrist and patient are able to communicate with ease and honesty (Sadock & Sadock, 2003). Technical factors such as the flow of the conversation can influence the content as well as the process of the interview. On a more abstract level, the psychiatrist and patient should be able to address issues that could influence the doctor-patient relationship; and patients should feel that they are heard and understood during the psychiatric interview.

- Flow of the conversation

  During some interviews, the interpreter seemed unsure when she was required to translate the patient and registrar's utterances. This led to a situation whereby patients and registrars explicitly had to ask the interpreter to interpret. This is in line with findings of the study of Davidson (2000).

  I found that uncertainty regarding the regulation of the interpreter-mediated interview inhibited the smooth flow of communication and in addition created frustration and

confusion amongst all three parties. More specifically, the registrar and interpreter seemed uncertain about whose responsibility it was to regulate turn taking. For example, one of the registrars continuously interrupted the interpreter and patient by asking the interpreter "*What is she (the patient) saying?"* This escalated to a point where it became destructive. At times the interpreter had to rephrase her question to the patient, since both the interpreter and patient lost track of what they were discussing prior to the registrar's interjection. In other instances, the interpreter (this happened specifically during those sessions in which healthcare workers acted as interpreters) initiated new topics, without the psychiatrist's knowledge, which did not bear relevance to the psychiatric interview. This was at times disruptive to the flow of the conversation, since it often meant that the psychiatrist had to bring the conversation 'back on track' or rephrase the question later during the interview. The timing of interjections can influence when patients speak and what they do or do not say as they unconsciously try to follow the leads and cues provided by the doctor (Sadock and Sadock, 2003).

However, the interpreter and registrar, independently, also contributed to the smooth flow of the conversation. One registrar who had a limited proficiency in isiXhosa used her knowledge of the language to draw the patient's attention and to regulate turn taking. For example, when the registrar used the words *"Yima mama"* (meaning, *Stop/wait mama*) to get the patient to stop talking, she provided the interpreter with the opportunity to translate the patient's utterance. This seemed also to be effective in establishing eye contact between the patient and registrar. This is significant in light of the fact that patients rarely made eye contact with the registrars during the interpreter-mediated psychiatric interviews. Another effective method employed by the majority of registrars was physical contact. Registrars - in an appropriate manner - lightly touched the patient's leg or arm to indicate to the patient that he or she should stop talking. This had a similar effect on the patient in that the patient immediately focused his or her attention on the registrar.

- **Asking 'uncomfortable' questions**

As psychiatrists are at liberty to discuss sensitive matters with patients, so patients have the right to voice their complaints and concerns regarding the psychiatrist or the quality of care they receive. I found that in some instances interpreters omitted the patient's words

or parts of speech, which involved negative remarks about the hospital or registrar. For example, one of the patient's commented that she was tired of the hospital. Omitting such complaints not only creates a situation whereby patients' concerns are not addressed, but also reinforces the image of patients as passive participants without their own voice (Davidson, 2000). My findings are similar to those of Davidson (2000) who found that interpreters act as filters or informational gatekeepers and will filter out questions or comments that they perceive to be inappropriate or not within the 'rules' of the institution. According to Davidson (2000), interpreters ultimately work for the hospital and are likely to ally themselves with their place of work.

Furthermore, some interpreters were reluctant to convey patients' questions about when they will be able go home, to the psychiatrists. For example, the interpreters who were also healthcare workers told patients that they were not supposed to ask when they would be discharged. From the psychiatric interviews that I video-recorded, it was evident that patients frequently asked when they would be discharged. I am almost sure that this was a frequently asked question. Perhaps for this reason interpreters regarded it as unimportant. However, stresses and strains should be determined to the fullest extent possible (Sadock and Sadock, 2003).

The findings mentioned above, relate to the findings of Hsieh (2008). In the study by Hsieh (2008), interpreters reported that they felt the urge to depart from the default translator role and assume the advocate role, since the role of advocate empowered patients to obtain fair and equal healthcare services. My findings suggest that even though interpreters perceived themselves as agents that empower patients this was not always reflected in practice. Denying patients the right to voice their disapproval about the hospital or registrar, or to ask questions that interpreters' perceive as irrelevant or burdensome, is anything but empowering.

- **Being understood and heard**

At the end of the psychiatric interview patients should feel satisfied that they are heard and understood. Unfortunately, time pressures seemed to interfere with this goal. One of the registrars repeatedly reminded the interpreter in a rushed voice: *"We should hurry*

up". Consequently, the interpreter rushed the patient for a response and when the patient explained that, her story was long and that she did not want to leave out anything, the interpreter reacted by saying: *"Oh my god"*. In another example, involving the same interpreter and registrar, a similar scenario played out. The registrar rushed the interpreter and the interpreter reacted by instructing the patient in a hostile voice to answer the question otherwise they will not be able to finish the session. It is obvious why this would be discouraging and leave the patient feeling that the registrar and interpreter are not interested in hearing his or her story.

I realize that time constraints are a reality and that due to a shortage in human resources they will remain a part of the institutional context. It is also a reality that the use of an interpreter is time-consuming and that it is not uncommon for patients to provide irrelevant information. However, there are more appropriate techniques such as transition (I referred to this technique in section 1.6.2.2), a common technique used in psychiatric interviews, to encourage the patient move on to the next subject.

7.4.3 Establishing rapport

Rapport implies understanding and trust between the doctor and patient. The interviewer's own empathic responses facilitate the development of rapport (Sadock and Sadock, 2003). The establishment of rapport is fostered by factors such as the impression the psychiatrist makes on the patient; mutual respect; and the patient feeling at ease and comfortable. In this section, I will explore these issues in more detail.

- **First and last impressions**

The way in which the psychiatrist begins an interview provides a powerful first impression to patients and could influence the rest of the interview (Sadock & Sadock, 2003). The patient's first impression of the psychiatrist should include perceiving him or her as attentive and interested in hearing what the patient has to say. Particularly during the beginning of the interview, the majority of registrars addressed their patients directly, i.e. abandoning the he or she says approach. As mentioned, when spoken to directly patients were more likely to make eye contact with the registrar. As mentioned before, the one registrar who had some command of isiXhosa, used it to greet the patient in his or her

language. Patients seemed to respond to this positively in that they immediately moved their focus from the interpreter to the registrar.

At the end of the interview, the psychiatrist is expected to allow the patient to ask questions and should thank the patient for his or her time (Sadock & Sadock, 2003). As I explained in section 5.1.2, interpreters were reluctant to convey some of the patients' questions to the psychiatrists.

- **Fostering mutual respect and trust**

Mutual respect between the psychiatrist and patient is essential for the two parties to form a trusting relationship. Patients who feel respected are more likely to be open with the registrar. Sadock and Sadock (2003) also mention that patients are more tolerant of the therapeutic limitations of medicine when there is mutual respect. Some of the interpreters' comments directed at the patients were disrespectful towards them. During one of the interviews, the interpreter asked the patient whether she enjoyed her first sexual encounter. The patient responded by saying that she did not enjoy her first sexual experience, to which the interpreter responded by saying: "*Don't lie"*.

Accusing the patient of lying is disrespectful and does not foster mutual respect and a constructive doctor-patient relationship. In psychiatric interviews, which involve only the psychiatrist and patient, the way that the particular psychiatrist behaves and interacts has a direct impact on the emotional and physical reactions of the patient (Sadock & Sadock, 2003). Given the fact that the patient, to a certain extent, depends more on the interpreter than on the psychiatrist in situations where all three parties are present, the reactions of the interpreter could have an even greater impact on the patient. Patients are often anxious on first encounters with doctors and feel vulnerable and intimidated. Putting the patient at ease is conducive to a productive exchange of information (Sadock & Sadock, 2003).

- **Putting patients at ease**

Prior to asking sensitive questions, registrars used phrases such as *"The following question may seem odd"*. However, some of the interpreters did not convey these phrases, which were aimed at preparing the patient for the sensitive question that was to follow. In instances where interpreters omitted these phrases, patients reacted with shock– the

opposite reaction of what the registrars were aiming for. In addition, interpreters also at times omitted the psychiatrists' words of comfort aimed at the patient. For example, in one of the sessions the patient conveyed that her father committed suicide. The registrar offered words of comfort; however, this was never conveyed to the patient. The registrar's aims to convey empathy and to comfort the patient are 'lost in translation'.

However, in other instances interpreters' own comments and attitude towards patients seemed to put patients at ease. For example, at times when patients become emotional and cried, interpreters offered patients words of comfort. In addition, one of the registrars used humour as method to put patients at ease. After a discussion about the patient's father committing suicide the patient was emotional and the mood seemed somber. The registrar moved on to the next subject and in response the patient said that she did not always want to do the dishes at home. The registrar remarked that he also does not like to do dishes and this led to all three parties laughing about the registrar's comment. It seemed to lighten the atmosphere and the patient appeared more cheerful.

- **Evaluating patients' insight and patient symptoms**

Interpreters' interpretations of patients' words at times suggest that patients appear to be more psychiatrically ill (increasing the risk for over-diagnosis) than it appears when looking at patients' original words in isiXhosa. When looking at the interpreter's interpretation of the patient's words it sometimes seems that the patient has no or very little insight into his or her mental health condition. However, when looking at the patient's original isiXhosa words it seems that patients indeed had insight into their conditions. The interpreter's use of substituted terms and the omission and addition of words paints a picture of the patient as more ill than he or she might actually be. In the example below the registrar asked the patient why she was admitted to the hospital. The patient responded to the question by giving a description of something she saw outside her window on the day she was admitted to hospital. As part of her description, she states the following: "*andikho zingqondweni ndiyaziva*". The interpreter's interpretation of these words is "something in her head was also not so nice". However, the independent translation of these words is "I noticed that I was losing my mind". The interpreter's words do not have the same impact as the patient's original words. In the next example,

the patient explained to the interpreter that she was in love with her priest and she believed they would get married. The interpreter then asked the patient if the patient was in a relationship with the priest to which the patient responded: "*There is no relationship, it's in me inside".* However, the interpreter interpreted these words as *"the man was unaware of this (her feelings towards him)".* The patient's original words have more impact and convey a stronger message of the patient's awareness and insight into her condition. During one of the sessions, the registrar asked the patient why she said to another registrar that people were jealous of her. The patient responded by saying that she cannot remember saying this; however, perhaps she had said this due to her insanity.

In essence, psychiatrists use the psychiatric interview to elicit details related to patient symptoms and behaviour; course of illness; and family and developmental history (Sadock & Sadock, 2003).The interpreters who were also healthcare workers positively contributed to eliciting information pertaining to these factors in two specific ways. Firstly, in their rendition of the registrar's diagnostic question, the healthcare workers made additions to the questions in such a way so that it was more likely to elicit diagnostic information. For example, the registrar's diagnostic question *'Do you think you have special powers?'* was interpreted by the healthcare worker as *'Can you do things that other people cannot do?'* In addition to these additions, healthcare workers were more likely to use their own follow-up questions in order to probe patients about their symptoms. For example, whenever the patients described their visual and auditory hallucinations interpreters would ask the patient whether other people were able to see or hear the things that they were able to hear or see. Secondly, healthcare workers used their knowledge of the patient, gained through their official work at the hospital, to identify behaviour and symptoms and to make the registrar aware of certain diagnostic features. For example, one of the healthcare workers asked the patient why his behaviour during that particular session was different to the day before when the patient and healthcare worker had had a separate conversation. The patient responded by saying he was concentrating on the interpreter's renditions and the healthcare worker informed the registrar of her question and the patient's response. One of the other healthcare workers also provided the registrar with information about the patient's physical condition in response to the registrar's questions about the patient's eating habits. In this case, the

interpreter did not answer on behalf of the patient, instead the interpreter simply supported the patient's response. The patient said that she had difficulty holding the hospitals food 'down' and the interpreter added that the nursing staff also mentioned that the patient was vomiting after each meal.

In comparison, the household aides were less likely to use their own examples and clarify patients' responses. For example, the patient responded to the question '*Do you have special powers?'* by saying that she could not do laundry only domestic chores. However, the interpreter did not probe (i.e. used follow-up questions) the patient or rephrase the question in such a way to assist the registrar in understanding whether the patient believes she has special powers or not. In addition, household aides were also less likely to provide meaningful input when asked by the registrars' about the patient's behaviour during the psychiatric interview. For example, the registrar asked one of the household aid staff whether the patient was reluctant to answer some of the questions. The particular interpreter responded by saying that the patient did not provide the right answers, but she had difficulty explaining to the registrar what she meant by this. It is therefore reasonable to argue, based on the abovementioned instances, that training in psychiatry and language proficiency are essential prerequisites for interpreters.

However, I believe that the abovementioned prerequisites, although essential, do not rule out the possibility for misunderstandings and the misrepresentation of diagnostic clues. Even during those sessions that the healthcare workers acted as interpreters, inaccurate renditions occurred. For example, the registrar asked one patient if she was somewhat happy or very happy. The patient replied that she feels happy; however, the interpreter conveyed that the patient said she is *"Very happy"*. This could be interpreted by the registrar as an indication of excessive happiness, which could imply that manic features are present. One of the other healthcare workers added information, never conveyed by the patient, which could lead to false conclusions about the patient's beliefs. The patient mentioned that on the day that she went to the clinic a pastor came to her house to pray for her. One of the patient's other visitors did not want to be present during the time the pastor prayed for her and this person decided to leave her house. The interpreter then added that the patient was under the impression that the person that left is *"Busy with*

her" and that muthi-practices were involved. However, this was never uttered by the patient. These inaccuracies could easily lead to over-diagnosis or even misdiagnosis.

Besides inaccuracies, the omission of important clues regarding the patient's medical history and significant life events is another aspect that increases the likelihood of misdiagnosis. One of the interpreters, for example, omitted information relating to the patient's pregnancy. In response to the registrar's question about the patient's educational background, the patient replied that she left school in standard four because she fell pregnant, however, the interpreter only conveyed that the patient left school in standard four and did not communicate the reason why she left school. Another interpreter omitted to convey that the patient had fallen on her head. Information related to head injuries is an important factor that should be taken into consideration when making an accurate diagnosis.

7.4.4 Treatment plan and compliance

Compliance, also known as adherence, is the degree to which a patient carries out the clinical recommendations of the treating physician. Compliance increases when clinicians have characteristics such as enthusiasm and a nonpunitive attitude. The doctor-patient relationship, or doctor-patient match, is one of the most important factors in compliance issues. When there are problems in communication, compliance decreases. Non-compliance is associated with clinicians who are perceived as rejecting and unfriendly. Doctors who enlist the patient in establishing a treatment regimen increase compliant behaviour (Sadock & Sadock, 2003).

During one of the interviews, the interpreter (a healthcare worker) on request of the registrar informed the patient that he should be admitted to outpatients once discharged. In between the interpreter's explanations of what outpatient treatment involves, the patient replied by saying *"Oh"*. The patient however mentions that it might be difficult for him to attend outpatient treatment since he plans to find permanent employment once discharged. The interpreter does not translate this to the registrar and after the patient and interpreter end their discussion about outpatient treatment, the interpreter indicates to the registrar that the patient has no problem attending outpatient treatment. The patient never said this; instead, he seemed apprehensive about the practicalities of attending outpatient treatment. If the registrar was

aware of the patient's reservations about the treatment plan, she might have suggested an alternative option. Providing a treatment plan that is more appropriate to the patient's lifestyle could increase treatment compliance. In another instance, the patient informed the interpreter that when she goes home to the Eastern Cape she takes her medicine with her. However, the interpretation suggests that the patient take her tablets only when she is in the Western Cape and not when she travels to the Eastern Cape. This could lead to the registrar regarding the patient's traveling to the EC as a possible source of non-compliance, when in fact this is not the case. A good understanding of the patient's lifestyle assists the registrar in negotiating a treatment plan that is most likely to lead to compliance.

7.5 The use of psychiatric techniques

- **Open and close-ended questions**

  Some interpreters changed the registrars' open-ended question into close-ended questions. For example, Jane changed the registrar's question: *Tell me about your first boyfriend* into *How was sex with your first boyfriend?* The patient was clearly upset by the question and gave an evasive and vague response. Open-ended questions, unlike close-ended questions, which are aimed at eliciting specific, detailed information, are less likely to make patients feel uncomfortable. They allow patients to use their own words as much as possible to talk about sensitive matters. Open-ended questioning is likely to facilitate patients talking about personal information. Although most patients prefer expressing themselves freely, open-ended questions are more time consuming (Sadock & Sadock, 2003).

- **Confrontation**

  It is common for psychiatrists to confront their patients about matters that they believe patients are ignoring or denying. However, the aim of the technique of confrontation is not to offend patients. Instead, its aim is to assist patients, in a direct but respectful manner, to face certain issues (Sadock & Sadock, 2003). During one of the sessions, the registrar asked the patient about what he thought about his use of *tik* and *dagga*. The patient responded by denying that he ever used tik. The interpreter in turn responded to the patient's denial in a hostile manner and with an aggressive tone of voice told the patient that he can lie but that the registrar has a right to do a urine test and this would reveal the truth. This happened without the registrar's knowledge. This did not have the

desired impact (i.e. helping the patient to acknowledge his problem), instead the patient continued to insist that he had never used tik and the registrar moved onto the next topic.

- **Testing memory function**

In one of the sessions, the registrar asked the patient to spell a word from front to back and from back to front. After the interpreter conveyed the abovementioned message to the patient, the registrar announced that the word that the patient had to spell was 'world'. The patient first attempted to spell the word in English and spelled it as 'w-e-e-l-d', as it is pronounced by some mother-tongue isiXhosa-speakers. The registrar responded by saying that perhaps the patient should rather spell the isiXhosa equivalent of the word 'world'. The patient and interpreter then had a discussion over what the isiXhosa equivalent of the word was. Van De Mieroop et al. (2012) also found that when not employed carefully, the role of mediator could significantly alter patients' scores on measurements such as the mini mental interview. The mini mental interview, commonly used by psychiatrists to assess a patient's mental status, consists of a list of predetermined questions. In the study of Van De Mieroop et al. (2012) the interpreter made additions and changed the format of the mini mental interview. This negatively influenced particularly those questions testing memory and literacy. For example, one of the questions requires the patient to spell a particular word backwards. The interpreter in this case hinted to the patient that he still needed to name one more vowel. This facilitated the patient's response and ultimately influenced the patient's score on the mini mental test.

7.6 Talking about language, race and class

7.6.1 Black isiXhosa-speaking patients and equal healthcare access

My findings suggest that due to the lack of official language services, Black isiXhosa-speaking patients at St. James hospital are discriminated against because of the languages they speak. It was clear that all the hospital staff participating in my study had only the best intentions in providing the same level of care to all patients regardless of race, language or ethnicity. However, they are restricted from providing equal access to care due to institutional constraints. The lack of official interpreter posts and the lack of readily available ad hoc interpreter services did not allow staff to offer Black isiXhosa-speaking patients the same level of care as White or Coloured patients, who are speakers of English and/or Afrikaans.

Some of the registrars voiced their concerns over the quality of care that they were able to offer isiXhosa-speaking patients.

Data from the psychiatric interviews that were not interpreter-mediated illustrate how unrealistic it is to expect registrars and patients to communicate without the assistance of an interpreter. Those interviews conducted without the use of an interpreter, compared to the interpreter-mediated interviews, were mostly of approximately 5 minutes in duration. In contrast, the majority of the interpreter-mediated interviews were more than 30 minutes in duration. One could argue that the interpreter-mediated psychiatric interviews were longer due to the use of an interpreter, which is known to be time consuming since the interpretation process takes time. However, my findings strongly suggest that the difference in duration was due to communication difficulties. Patients' limited proficiency in English made it difficult for them to communicate and provide meaningful responses to the registrars' questions. Perhaps registrars felt that it was best to end the psychiatric interviews as soon as possible, since it was difficult to collect reliable clinical information. It is also possible that due to their discomfort with the clinical situation, registrars attempted to curtail their time with patients.

In the psychiatric interviews conducted in English and without the use of an interpreter, patients' responses were mainly restricted to 'yes' or 'no' answers. The goal of the psychiatric interview, as explained by Westermeyer (1990), is to allow patients to respond to questions asking about the presence or absence of symptoms. Patients' difficulty in understanding registrars makes this task very difficult. The restricted nature of patient responses makes it difficult to identify symptoms such as disturbances in thought processes and content. For example, it is impossible to identify thought disorder or word salad when the patient's answer to a question is either 'yes' or 'no' to a question which was intended to elicit a more detailed response. In addition, patient responses often contained the exact same phrase or words used by the registrar in the preceding question. These results suggest that it is likely that patients used the registrars' words since they don't have the necessary vocabulary to respond in their own words. It also raises doubt about the authenticity of patients' responses. During my discussions with registrars, they conveyed their concerns over the reliability of patients' responses, particularly since Limited English Proficient patients were likely to use the same wording used by registrars when phrasing questions.

Interestingly when patients were asked during the semi-structured interviews (conducted in patients' first language) if they understood the clinicians' questions during psychiatric interviews conducted in English, only one patient said that he sometimes did not understand what the clinician said. He also noted that the clinicians did not always understand his pronunciation of certain English words. When patients were asked whether they felt free to ask clinicians to explain questions should they in future have difficulty understanding clinicians' questions, all the patients said that they would have no problem doing this. However, this was not reflected in practice, since not one patient asked for clarification or informed the registrars when they did not understand the questions. Schneider, et al. (2010) found that when the research team in their study interviewed patients, the patients were very critical of the care provided by the hospital. However, when observed during doctors 'rounds the same patients did not voice their opinions and seemed subdued and lacked confidence. Patients' lack of confidence could be ascribed to the power discrepancy within doctor-patient encounters (Schneider, et al., 2010). In the context of my study, however this was also likely due to patients' limited English proficiency. Perhaps patients did not have the necessary words to ask for clarification. This in itself raises serious questions about the ethics of care. In this instance, the institution's lack of language services creates a situation whereby isiXhosa-speaking patients literally become voiceless. As one of the registrars told me during the semi-structured interviews, on days when there were no isiXhosa-speaking staff members on duty, patients (even if they had complaints) could not voice their complaints because no one would understand them.

7.6.2 The distribution of care responsibilities along racial lines

Video-recordings of the actual interpreter-mediated psychiatric interviews showed that all the interpreters were Black. Tronto (2010) argues that institutions should avoid assigning care responsibilities along racial lines. During the semi-structured interviews I asked the ad hoc interpreters how it happened that they became interpreters. Their explanation was simple: it was because they spoke isiXhosa and they were Black. They explained that it was natural that they would be called as interpreters because of the fact that they spoke isiXhosa and so they were the only option clinicians had when interviewing patients that were not proficient in English and Afrikaans.

None of the interpreters seemed irritated, appalled, or even bothered by the fact that were called to act as interpreters because they were Black and isiXhosa-speakers. This could be due to a combination of the following reasons:

- The positive aspects associated with the work of the interpreter overshadowed feelings of anger or resentment. Interpreters were clearly passionate about helping patients. They regarded the role of interpreter as something positive like it was their way of helping others like them. The majority of interpreters felt that they were making a positive contribution to patients' lives through assisting patients in communicating with the clinicians and nurses.
- Interpreters wanted to protect their interpreter work since they felt responsible for isiXhosa-speaking patients. During their interviews with me interpreters told me that they were the only people patients could talk to on the wards and that it was their responsibility to comfort patients. Interpreters also believed that their responsibility toward patients went beyond the interpreter-mediated encounter. A powerful example of this was the cleaner's account of how she went out of her way to befriend isiXhosa-speaking patients. She would offer them sandwiches and engage in conversations since she felt that isiXhosa patients were lonely and scared.
- As Drennan and Swartz (2002) have explained, the lack of formal language services have become institutionalised aspects of everyday healthcare. Thus, it is likely that interpreters regard the role of interpreter as part of their daily work routine and that they no longer think about or question their additional interpreter duties.
- Interpreters don't perceive helping patients as part of the role of interpreter. Instead helping patients (whether this is through assisting the patient to communicate or through other means) are perceived as part of their official work as cleaners or healthcare workers.
- Interpreters are cautious not to be critical of their place of work since they perceive it as disloyal towards the institution and might fear losing their employment.
- Interpreters did not feel comfortable or that it was appropriate to talk me, a white Afrikaans-speaker in a position of authority, about race.

7.6.3 Institutional constraints and their impact

The impact that the current status quo has on registrars and interpreters, albeit only those hospital employees participating in the study, is cause for great concern. The registrars were unanimous in their view that the current situation whereby they had no official interpreters to assist them was frustrating and a great cause of worry for them. This was because, as mentioned above, in instances where the patient and registrar communicated without the use of an interpreter, registrars had concerns over the reliability and validity of the information. Registrars also reported that they felt uncomfortable asking hospital staff, such as household aides and nurses, to act as interpreters partly due to concerns over patient confidentiality and issues of accuracy due to lack of training. They felt apprehensive about taking hospital staff away from their official work duties to do a job (i.e. interpreting) that was very time-consuming. This illustrates Tronto's (2010) point that institutions should explicitly name and describe the care responsibilities of staff; she argues that it is problematic when responsibilities are left vague or unspoken. My findings support those of Schlemmer and Mash (2006) who also found that the lack of language services contributes to tension amongst staff members which was likely to have an adverse effect on patients. During some interpreter-mediated interviews, I sensed that registrars and interpreters became tense. This seemed to be due to unnegotiated roles and role conflict. For example, on one occasion when the interpreter answered on behalf of the patient, the registrar seemed annoyed and firmly told the interpreter that she wanted an answer from the patient. In another interpreter-mediated interview the registrar seemed irritated by the interpreter's regulation of turns and the particular registrar repeatedly asked the interpreter to tell her what the patient is saying. It escalated until the registrar started raising her voice. Consequently, the interpreter rushed the patient whenever she responded to a question. In situations like these patients may feel alienated and that their opinions are not considered important by the registrar and interpreter. The patients are probably not unaffected by these tensions but may not know the source of them.

Some interpreters reported that their role of interpreter interfered significantly with their official work. Although interpreters did not mind the additional responsibilities, they did acknowledge that it was time-consuming. Interpreters explained that interpreting was time consuming since they first had to gain patients' trust, before patients would confide in them.

The role of interpreter also seems to have an emotional or psychological impact on the interpreter. The majority of interpreters reported that patients 'stories had an emotional impact on them; that they experienced secondary traumatisation; and that they did not always know how to cope with their emotions. Interpreters said they could identify with patients' stories. The institution's lack of official language services impacts on interpreter's official work roles as well as on their psychological welfare. It is both unjust and unsustainable for the ad hoc interpreters to fulfil the role of patients' confidant, and to feel personally responsible for them. It is clear that interpreters have difficulty coping with this enormous task. One way of coping was to share their experiences with colleagues, which has implications for the ethics of care.

In the next chapter I will talk in more detail the implications of the study findings for healthcare providers and users as well as the lack of dialogue about race in post-apartheid South Africa and how the issue of language and race can be addressed.

CHAPTER 8: CONCLUDING REMARKS

Just as I am unable to write myself out of the pages of the dissertation, I am unable to write the issue of race out of this study. I believe that Drennan (1999) is right when he argues that when one makes a distinction between race and language one avoids having to name racial discrimination. The truth is that racial discrimination is central to my study's findings about language practices in a particular South African psychiatric hospital.

Personally, it would be easier for me simply to conclude that my findings suggest that patients who are not proficient in English or Afrikaans do not have the same access to healthcare as patients that are fluent in these languages. However, this would mean that I am not being completely honest with the reader or myself. The truth of the matter is that 18 years after the fall of apartheid the South African healthcare system still discriminates against Black patients, who are unable to speak Afrikaans and English. I realize that this study only focused on one psychiatric hospital; however various other studies, referred to throughout this study, reflect similar practices at other psychiatric and general healthcare institutions in the country. In the particular psychiatric institution, that I focused on the following was found to be indicative of racial discrimination:

- Haphazard arrangements are made in terms of language services when black people require healthcare.
- The concerns raised by the registrars about the quality of care isiXhosa-speaking patients received in comparison to Afrikaans and English-speaking patients suggest that isiXhosa-speaking patients are not receiving the same quality of care as other patients.
- In various instances in my study, Black isiXhosa-speaking patients were presented as more ill than is conveyed when looking at patients' original responses.
- When there were no isiXhosa-speaking healthcare staff, Black patients had no one to talk to and no means to communicate to clinicians and nurses.

I acknowledge that one of the limitations of this study is that I did not have access to patient records and the clinical outcomes of the psychiatric interviews that I analysed. The study findings are therefore strongly indicative but not sufficient to conclude that the lack of language services inevitably leads to an inaccurate diagnosis or less than optimal care. The

findings do, however, indicate three levels of unjustness: the lack of language services is unjust towards patients, hospital staff acting as ad hoc interpreters, and LEP patients caught in a system, which construct them as voiceless, dependent, powerless, healthcare users.

Language practices at St. James hospital also impact on ad hoc interpreters and clinicians. Hospital staff (including healthcare workers, cleaners and security guards) were given additional duties (for which they were not compensated) because they were Black. Interpreters reported that they were called to act as interpreters because they were Black and speak isiXhosa. Not only does this lead to a situation whereby these individuals have added work pressure, but it also seems that ad hoc interpreters are unfairly used to compensate for the institution's inability to afford official language services. Ad hoc interpreters have to perform duties for which they have no training or support. It may be argued that the ad hoc interpreters are not forced to undertake the additional duties; however, given their positions within the institution one cannot but wonder if they really have a choice. The discussions I had with the interpreters suggest not only that they feel responsible toward the hospital but also that they feel personally responsible for the patients. These conflicting responsibilities toward their place of work and the patients with whom they share a cultural identity are likely to have a psychological impact the interpreters. The majority of interpreters felt that they were affected by patients' stories. The lack of official language services (and when no ad hoc interpreters are available) furthermore places the registrars in unrealistic situations in which they have to diagnose and treat patients regardless of obvious communication barriers. I have no doubt that the registrars and interpreters participating in this study have only the best intentions when it comes to patient care. Interpreters' accounts were filled with examples of how they went out of their way to comfort and help patients. The video-recordings revealed how the registrars tried relentlessly to understand patients and build a relationship with patients despite language barriers. The registrars used creative means, such as physical contact, eye contact and humour to connect with patients in the absence of a common language. One registrar used her limited proficiency in isiXhosa to build a relationship with her patients. The simple act of greeting and thanking patients in isiXhosa had an effect on them. Hospital staff cannot be blamed for the problems the hospital is facing in terms of language services. It is clear that they are doing the best they can under the current circumstances.

The problem of language access within psychiatric care and healthcare in general is complex. However, the fact that very little has changed with regard to language access post-1994 is undeniable. I believe that the reasons behind the slow progress are due to a combination of factors. Firstly, it is likely that communication barriers have become institutionalized and a routine part of clinicians' and ad hoc interpreters' everyday work (Drennan, 1999). Perhaps because they are used to working in the way they do, they no longer critically think about or question the lack of adequate language services. Secondly, hospital staff who are overworked and overwhelmed by their official work responsibilities, might feel reluctant to acknowledge the problem of language access since that would make them feel responsible for doing something about the problem. One of the registrars explained to me that she did not consider offering ad hoc interpreters debriefing since that would make interpreters' roles official. Thirdly, I believe that the issue of language access is swept under the carpet because we, as South Africans, are anxious to talk about issues that could even vaguely relate to racial discrimination. This is something that I also learned about myself through this study. Perhaps the time has come for us, who are privileged enough to have a voice, to face reality despite of ourselves. Although this study is part of a larger study aimed at training clinicians and interpreters, I have learnt that this probably will not be enough. We may train clinicians and interpreters in one institution, but this will not address the underlying ongoing structural issues.

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